NHS
Liverpool
Clinical Commissioning Group

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

Policy & Practice Guidance

2018

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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

Contents

1.0 Purpose & Introduction

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

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

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

1.1 Ratification

This policy and practice guidance will be ratified by NHS LCCG (LCCG) Governing Body.

1.2 Scope

This policy applies to all employees of NHS Liverpool CCG, Midlands and Lancashire Commissioning Support Unit, NHS Providers and Non- NHS Providers commissioned to deliver services for LCCG.

1.3 Other Relevant Legislation

- Care Act 2014, HM Government. London
- Human Rights Act 1998, including the Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination
- The Data Protection Act 1998
- The Carers (Equal Opportunities) Act 2004 provides carers with the right to receive assessment for support and a duty on various public authorities to give due consideration to a request to provide services to carers.

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

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

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

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

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

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

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

2.0 Overview

2.1 History

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

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

2.2 What is a PHB?

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

For Eligible Persons there is a duty on CCGs to:

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

There are five essential characteristics of a PHB.

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

1. be able to choose the health outcomes they want to achieve, in agreement with a healthcare professional
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, including the right to ask for a direct payment
5. be able to spend the money in ways and at times that meet their assessed eligible needs and make sense to them, as agreed in their care plan.

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

2.3 Principles

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

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

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

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

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

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

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

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

2.4 Standards for self-directed health support

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

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

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

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

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

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

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

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

3.0 PHB eligibility

3.1 Who can have a PHB?

From 1 October 2014, all Eligible Persons acquired a ‘right to have’ a PHB including by way of a direct payment. Whilst the offer was initially only for CHC and Continuing Care (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 Liverpool CCG this includes:

- Individuals who are registered with a General Practice within the Liverpool CCG locality at the time of confirmed eligibility
- 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 Liverpool CCG and Liverpool City Council, have the right to explore whether their needs can be met by utilising a personal budget. The integrated personal budgets under joint funding arrangements for Liverpool CCG will be managed by Liverpool City Council, 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 when continuing care is being received, the child and/or family will have an, education, health and social care plan in place (EHCP) or will be in the process of transferring over to an EHCP. For children, personal health budgets can contribute to some or all of the social, health and educational elements of this plan. Within Liverpool CCG this will be provided by the SEND ‘local offer’, the joint funding arrangements will be managed via Liverpool City Council as a direct payment. Children across Liverpool 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. In a notional budget the money is held by the NHS.

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

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

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

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

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

5.0 How do PHBs work?

5.1 Informing people about PHBs

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

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

Health professionals will also seek to identify other patients who do not fall within the scope of the "right to have" but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a

voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

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

The CCG has made arrangements for non NHS support services to provide information, advice and guidance to prospective and existing PHB recipients, and their families. A choice of organisations will be offered to all patients and families where appropriate.

The services provided by these organisations will include:

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

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

5.2 Budget Setting

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

The CSU and CCGs are using a ‘ready reckoner’ approach to set the level of the PHB. This approach uses an existing care plan / package of support to calculate an *indicative budget.* Where there is no existing care plan or package of support

already in place, the budget will be based on a standard hourly rate (see below). Whilst the 'ready reckoner' approach is based on existing services, it can be simpler to use, more transparent and easier to understand.

The PHB amount is therefore based on:

- The cost 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 agreed hourly rate 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 or because they are a child.

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

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

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

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

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

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

5.5 Lead Health Professional

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

- Managing the assessment of the health needs of the individual as part of the care plan;
- Ensuring that the individual, representative and CSU / CCG clinician have agreed the care plan;
- Undertaking or arranging for the monitoring and review of the care plan and health of the person;
- Liaising between the individual (or their representative or nominee) and the CCG/CSU 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 member of staff. This is to provide robust governance processes, to ensure that the PHB support plans are clinically safe and meet the needs of the individual. This process includes reviewing, agreeing and signing off the Care Plan which includes a risk identification and management plan. A PHB checklist has been developed to ensure consistency and adherence to the law and guidance.

The CSU 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 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 3.

5.8 Assistance to manage PHBs

The CCG has arranged for non NHS 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 Processes.

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

5.9 Monitoring and Review

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

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

In respect of continuing care for children, the care package should be reviewed after three months and then at least every 6 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
- 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 carry out sufficient financial checks to gain assurance that the individual is not in receipt of other health related benefits, before considering whether a direct payment is suitable. These may include, but not be limited to:

- Checks for receipt of carers allowance
- Checks for local council funding for care packages
- Checks for health funding from other NHS organisations
- Checks with Department of Work and Pensions for any other relevant benefits that may be impacted by, or impact receipt of, a direct payment

The CCG will consider whether the individual will be able to manage the direct payment (see section 6.3 below). Included within this consideration will be an assurance check that the individual can comply with the financial duties aligned to receiving a direct payment. These include, but are not limited to:

- Ensuring the individual is can provide bank statements showing expenditure of the direct payment
- Ensuring that the individual is fully aware of the requirement to provide ALL expenditure receipts relating to the direct payment
- Ensuring that the individual has access to online banking for their nominated direct payment account
- Ensuring that the individual has computer access and printer access to be able to provide statements and accounts (where required) when required

- Ensuring that the individual is fully aware of HMRC regulations with regards to employment of carers and tax implications.

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 including the consideration of managing and meeting the financial duties required when in receipt of a direct payment.

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

When a recommendation has been made in relation to PHB, the patient, representative or nominee will be informed of the outcome of the decision and the reasons for the decision. 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.

6.7 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 CCG will make a decision regarding a request for reconsideration of a refusal to provide a direct payment using a panel process. The membership and terms of reference of the 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 4.

No member of the panel will have had previous involvement in the case.

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

6.8 Representatives and direct payments

Information surrounding the appointment of Representatives is set out earlier in this Policy. When the use of direct payments is being considered, the CCG must be

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

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

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

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

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

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

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

6.9 Nominees

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

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

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

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

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

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

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

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

If the proposed nominee is not a close family member of the person, 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. 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, Liverpool 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 CCG has 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.

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

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

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

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

Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of the non NHS support services. 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 1st 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 is required to 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, which can be requested by the CCG at any time, and at least annually.

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 care provision should be performed within three months of the first direct payment and then annually.

Financial monitoring will take place quarterly by the CCG, and recipients must be able to provide sufficient evidence, i.e. receipts and bank statements, that show the payment has been used in line with their care plan. Financial reviews will be completed by the non NHS support service.

The CCG will check at appropriate intervals (in line with CHC reviews at 3 months post eligibility and annually) how direct payments are being used. The recipient must provide to the CCG bank statements, receipts and invoices on a quarterly basis to ensure the audit can be carried out.

The individual, their representative or their nominee (as applicable) should retain for audit purposes (for 6 years after the CCG has paid the first direct payment):

a. Bank Statements
b. Cheque and paying-in books
c. Invoices and receipts
d. PAYE, NI and other payroll records
e. Any other information relating to the use of the direct payment.

The CCG will ensure that the recipient is clear as to what information may be required as part of its review and that this information must be:

- Legible
- Accompanied with authorisation for the CCG to take extracts or make copies
- If requested by the CCG, accompanied with an explanation of the information provided
- If requested, accompanied with a statement informing the CCG where information is held which the individual has not been able to provide.

This monitoring and review requirement applies equally to personal health budgets delivered in the form of a Third Party Budget.

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

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

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

6.16 Stopping or reducing direct payments

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

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

Before making a decision to stop or reduce a direct payment, wherever possible and appropriate, the CSU / CCG should consult with the person receiving it to enable any

inadvertent errors or misunderstandings to be addressed, and enable any alternatives to be made.

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

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

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

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

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

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

It should be noted that, after a direct payment is stopped, all rights and liabilities acquired or incurred as a result of the service purchased by direct payments will be transferred to the CCG. This should therefore be considered. However, in some

cases, it may be necessary to stop the direct payment immediately, for example, if fraud or theft has occurred.

6.17 Reclaiming a direct payment

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

- they have been used to purchase a service that was not agreed in the care plan;
- there has been theft or fraud
- the recipient has died leaving part of the direct payment unspent
- the support plan has changed substantially resulting in surplus funds
- the individual accumulates a significant under spend for any other reason; 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, then 1 month 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 CCG has arranged for non NHS support services who will 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 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 3 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, even if carrying out activities which might otherwise be performed by health professionals. Lead health professionals, the CSU & CCGs will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and outcome recorded in the Care Plan.

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

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

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

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

7.5 Registration and regulated activities

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

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

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

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

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

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

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

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

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

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

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

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

8.0 Service User Evaluation

It is vital that CCG's have systems and processes in place to review the effectiveness of PHB's to provide assurance that the individual support plans are; clinically safe, effective and meeting individual needs and outcomes. To facilitate evaluation the CCG will utilise 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.

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 Liverpool 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

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.

2.0 Process

2.1 The CCG 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 agreement for a PHB, the relevant direct payment support services and non NHS support service are required to invoice the 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 Care Management System (CMS) 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 'PHB Approval Form' for all PHBs. The form will include the following details as agreed by the CSU:

- CMS 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 CMS.
- Sent to the relevant direct payment non NHS support service in order for them to promptly raise an invoice to the CCG.

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

2.5 If the non NHS support service has not received payment by the agreed date then it should escalate the issue to the named contact at the CCG finance team.

Appendix 2

PERSONAL HEALTH BUDGET SUPPORT PLAN

Patient Name		NHS Number	
Database ID		Patient Date Of Birth	
Type of PHB	Children's ☐ Adult ☐ Joint ☐		
Person Completing the form	Name	Company (If appropriate)	Contact
3rd Party Broker name and contact			
Date Form Completed			

Section 1: What are my health conditions?

What is my health condition(s) and how does it impact on my life? (*E.g: State name of condition(s) and if it prevents you from doing anything)*

Section 2: What is Important to me?

What is important to me? (*Think about family, friends, carers, pets, hobbies & interests)*
What is working well in my life?

(E.g: The care that you have, living at home, being able to do things you enjoy)
What is working not so well in my life and what I would like to change? *(E.g: change time of care, choose an alternative form of care or therapy)*

Section 3: What support do I need to meet by health and wellbeing needs?

Patients Heath Needs	Activity Provision	How this will be met in a PHB	How will this be measured
i.e Immobility, Inability to complete cleaning tasks,	*2 x carers to assist in transfer, Assistance of 1 with household tasks*	*Care provider 4 x per day, Informal support from family/friends*	*Patient will be able to state if this is working*

Section 4: How will I manage my support?

What is required?	Who will manage this?
Support for sourcing package of care, Agency or PA's?	
Recruitment support – Tax, NI, Pension, employment rights/laws?	
Are DBS checks needed?	
Training and competencies? What will be needed?	
Insurance cover (Public Liability ect.?	

Any contracted Health Professional are registered with governing body?	
Who will collect any evidence for Audit, what will they collect?	
Staff Rota's and oversee care?	
Are the formal providers CQC checked?	
Any other?	

Section 5: Contingency

In case there are unexpected events, what would be your contingency plans? *(E.G.Think of staff sickness, being acutely unwell, needs changing, any other potential risks)*

Section 6: The cost of my support

Show weekly and occasional support, who is providing the support, the costs Also include other sources of support including support from unpaid carers (family & friends)	

Weekly support and who is providing this support.	**Cost (£)** **£**
Other support, or other things I am using my budget for. **3% Contingency**	**Cost (£)** **£**
Total of the Personal Health Budget	
If Joint funded, what is the breakdown who will pay what amount?	

Section 7: Agreeing the support plan

I agree with the contents of this Support Plan and understand that a copy will be held by Midlands and Lancashire Commissioning Support.

Individual (or representative, where applicable):

Name:……..

Signed: ……. Date: …….

Nurse Assessor:

Name:……..

Signed: ……. Date: …….

Commissioning Manager:

Name:……..

Signed: ……. Date: …….

Appendix 3

PERSONAL HEALTH BUDGET AGREEMENT

Patient Name		**NHS Number**	
Database ID		**Patient Date Of Birth**	
Type of PHB	**Children's ☐ Adult ☐ Joint ☐**		
Date Form Completed			

1. **Information about You and Community Services**

2. **Basis of the agreement**

3. **Responsibilities of your Nominated Representative (if you have one)**

4. **About your Personal Health Budget**

5. **General Rules on How to Use the Money**

6. **Using a care agency**

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')

Name and address of The 3rd Part Management or Broker

PLEASE PRINT:

First Name(s) ___ _____

Surname _____ _____

Relationship to 'you' _____

Address _____

_____

Post Code _____

<u>Your representative, if applicable and agreed by us is:</u>

Name and address of Representative or chosen decision maker/ Parent in case of a child.

PLEASE PRINT:

First Name(s) ___ _____

Surname _____ _____

Relationship to 'you' _____

Address _____

_____

Post Code _____

2. Basis of the Agreement

This agreement is made on the basis that:

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

Any payment made under this agreement will be subject to regular audit and monitoring by the non NHS support service and us which may be reviewed by the Personal Health Budget Programme Board.

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 Personal Health Budget, are not able to manage the PHB, or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

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 About your Personal Health Budget

Start Date:

Review Date:

Show weekly and occasional support, who is providing the support, the costs **Also include other sources of support including support from unpaid carers (family & friends)**	
Weekly support and who is providing this support.	**Cost (£)**

	£
Other support, or other things I am using my budget for. **3% Contingency**	**Cost (£)** **£**
Total of the Personal Health Budget	
If Joint funded, what is the breakdown who will pay what amount?	

The frequency of your payments will be discussed with you. However, payments are usually made to you on a monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs

change. Any variances to this will be discussed with you on an individual basis.

How you will receive your money

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

1. **A direct payment.**
2. **A 3rd party managed budget by a non NHS support service**
3. **A 'Notional' budget**

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

☐ **A Direct Healthcare Payment**

A direct payment is where your Clinical Commissioning Group pays money directly to you. The money will be paid into a bank account set up for this purpose.

If you have received a direct payment from Social Care in the past then it will be possible to use the same bank account for your Personal Health Budget.

- **Your Personal Health Budget will be paid into a Bank Account, which will be opened in your name and managed by you or your nominated representative.**

- **You will need to sign an agreement and BACS payment form with the Clinical Commissioning Group.**

- **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.**

☐ **A 3rd Party Managed PHB**

A Managed Bank Account is where the Clinical Commissioning Group pays your allocated budget into a bank account that is opened in your name (or your nominated representative's name) on your behalf.

- **The bank account will be opened and managed by a brokerage company**

on your behalf. This will be in your name.

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

- **Payments made will be paid by BACS payment to the Broker company.**

- **The bank account will be audited by the brokerage and therefore it is important that you submit all 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 support plan.**

5. 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 or your Representative, as appropriate.

6. Using a Care Agency

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

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you, your Representative 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 the CSU.

7. 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. The CSU and Broker (if 3rd party managed) can support you to access training as an employer and for your Personal Assistant(s).

We strongly recommend that a CRB (Police Check) 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 Statutory sick pay and Maternity Entitlements and Responsibilities, Paternity 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 which will be funded as part of your initial payment.**

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 with an Organisation that supports people to direct their own care for information and advice about becoming an employer. You can employ a relative as long as they are not living with you.

You cannot employ family members living in the same house as you in normal circumstances. This will be allowed only under exceptional circumstances. Any variation to this need is to be discussed and agreed with the CCG

8. Record Keeping and Audit

You are required to keep basic records.

If you receive a direct payment your accounts will be audited directly through you.

If you use a Managed Bank Account, your bank account will be audited. Only payments that have been agreed in your support plan can be made. The records will be subject to audit arrangements and will be audited within the first 12 weeks then annually (as a minimum).

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

9. 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 the CSU.

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 <u>not</u> included in your budget.

If your needs change or something is not working, you or your Representative or Nominee, must contact the CSU.

10. 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.

11. 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.

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.

12. 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.

13. 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:

Broker (Where applicable) – The person who will provide oversight and management as well as recive the moneys into a bank account in the patients name.

Signature: _____

Date: _____

4th Party:

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

Signature: _____

Date: _____

Appendix 4

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.