

Guidance on Direct
Payments for Healthcare:
Understanding the
Regulations



NHS England INFORMATION READER BOX**Directorate**

Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference: 01295

Document Purpose	Guidance
Document Name	Guidance on Direct Payments for Healthcare: Understanding the Regulations
Author	NHS England Patient Participation Team
Publication Date	20 March 2014
Target Audience	CCG Clinical Leads, CCG Accountable Officers, CSU Managing Directors, Care Trust CEs, Medical Directors, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS England Regional Directors, NHS England Area Directors, Directors of Finance, Allied Health Professionals, GPs, Directors of Children's Services
Additional Circulation List	NHS Continuing Healthcare Leads
Description	This guidance explains the National Health Service (Direct Payments) Regulations 2013 as amended by the National Health Service (Direct Payments) (Amendment) Regulations 2013). Direct Payments are one method of managing a personal health budget which are being introduced across England.
Cross Reference	Personal Health Budget Toolkit
Superseded Docs (if applicable)	
Action Required	CCGs need to comply with the regulations when giving direct payments.
Timing / Deadlines (if applicable)	
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Document Status

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Guidance on Direct Payments for Healthcare: Understanding the Regulations

(National Health Service (Direct Payments) Regulations 2013¹ as amended by the National Health Service (Direct Payments) (Amendment) Regulations 2013².)

First published: March 2014

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¹ http://www.legislation.gov.uk/uksi/2013/1617/pdfs/uksi_20131617_en.pdf

² <http://www.legislation.gov.uk/uksi/2013/2354/contents/made>

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Executive summary

This guidance is intended to help interested parties, including clinical commissioning groups (CCGs) to understand and implement the direct payments for healthcare regulations. Direct payments for healthcare are one way of managing a personal health budget. Although these regulations only apply to direct payments, the information in this guidance will be useful for all types of personal health budgets.

Direct payments are essentially money in lieu of services. They have been available within social care for over 15 years and the regulations are similar in health as in social care, but they are not identical. For example in social care people can be required to contribute towards the costs of their eligible needs whilst in healthcare they cannot do this because this would undermine the core principles of the NHS being comprehensive and free at the point of delivery. Personal health budgets, including direct payments were piloted across England between 2009 and 2012. An independent evaluation of this programme supports their wider use³ and showed that personal health budgets, when implemented well, were cost effective, improved the quality of people's lives and reduced hospital admissions. The benefits were greater for people who need higher levels of care and support regardless of their diagnosis, whether that be a physical or mental health issue.

This guidance is not intended to be a comprehensive “how to” guide covering everything someone needs to know about personal health budgets – it is intended to explain the regulatory requirements. The regulations, and this guidance, include requirements relating to:

- who can have a direct payment;
- who can consent to having a direct payment (an individual or their representative);
- who can hold and manage a direct payment (an individual, their representative, or a nominee);
- the provision of information to help CCGs make decisions about whether to give a direct payment to an individual;

³ https://www.phbe.org.uk/about_the_evaluation.php

- the provision of information, advice and support for people who want or have direct payments for healthcare;
- care planning and what needs to be included in the plan;
- agreeing and reviewing the care plan;
- managing the budget;
- how a budget can be used;
- which NHS services can direct payments for healthcare not be used for;
- what a CCG's responsibilities are in relation to direct payments;
- what an individual, their representative, or a nominee's responsibilities are in relation to direct payments.

More information on personal health budgets is available, including an easy read document which explains what personal health budgets are. This and an extensive toolkit which includes best practice, practical information and personal stories are available on the personal health budget website⁴.

⁴ <http://www.personalhealthbudgets.england.nhs.uk>

Introduction

Who this guide is for

- 1) This guide is intended to help clinical commissioning groups (CCGs) and other commissioners of health and care services understand and implement the direct payment for healthcare regulations. Throughout this document, where the abbreviation CCG is used it refers equally to all other commissioners of NHS funded services such as NHS England, local authorities and commissioning support units.
- 2) It will also be of interest to:
 - people providing support to commissioners;
 - people providing health and care services;
 - voluntary sector groups and user led organisations who have an interest in personal health budgets;
 - NHS England nationally, regionally and at area team level;
 - people receiving NHS care who are considering or are receiving direct payments for healthcare and their carers.

Direct payments and personal health budgets

- 3) Direct payments for health care⁵ are monetary payments in lieu of services - made by CCGs to individuals (or to a representative or nominee on their behalf) to allow them to purchase the care and support they need.
- 4) Direct payments for healthcare are one of the ways of providing all or part of a personal health budget. There are essentially three ways for people to receive and manage their personal health budget⁶:
 - a direct payment;

⁵ Unless otherwise stated when we refer to direct payments in this guidance we mean direct payments for healthcare

⁶ Further information on the 3 ways personal health budgets can be managed can be found at <http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/HowPHBswork/Options/>

- a notional budget;
 - a third party budget.
- 5) Notional budgets (where the CCG makes the arrangements for the agreed care and support) and third party budgets (where someone independent of the individual and the NHS holds the budget and makes the arrangements for the agreed care and support) do not need changes to legislation or regulations. However, while the requirements in the regulations only apply to direct payments for healthcare, most of the steps, such as care planning, budget setting, and the principles around empowering people to make decisions about their own care, will be the same irrespective of the way the personal health budget is provided. Wherever personal health budgets are being provided, the use of direct payments should be considered.

The aim of this guidance

- 6) The aim of this guidance is to assist CCGs to implement direct payments for healthcare in line with the requirements in the *National Health Service (Direct Payments) Regulations 2013*⁷ as amended by the *National Health Service (Direct Payments) (Amendment) Regulations 2013*⁸.
- 7) This guidance includes some information about best practice and links to the personal health budgets toolkit⁹ which contains much more detailed practical information on successfully implementing personal health budgets, including direct payments for healthcare. This includes guidance on financial planning relating to the implementation of personal health budgets.
- 8) Direct payments for healthcare were piloted across England between 2009 and 2012, and independently evaluated¹⁰. The evidence from the evaluation and wider learning from the pilot programme supports their use. However there is much still to learn about implementing direct payments for healthcare. For this reason this document cannot be a comprehensive “how to” guide, rather it sets out the minimum regulatory requirements and refers readers to where they may find additional information. During the pilot

⁷ http://www.legislation.gov.uk/uksi/2013/1617/pdfs/ukxi_20131617_en.pdf

⁸ <http://www.legislation.gov.uk/uksi/2013/2354/contents/made>

⁹ <http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/>

¹⁰ https://www.phbe.org.uk/about_the_evaluation.php

programme a range of best practice and other useful information was developed and this is available in the on-line learning network and toolkit. This document and the personal health budget toolkit give practitioners and professionals the flexibility to explore and develop processes and practices which make sense locally. They are intended to inform local discussions and planning. CCGs will want to build on their existing experience, and continue to share and draw from ideas across the NHS and from social care, where there is over 15 years experience of direct payments which will help inform implementation in healthcare.

- 9) Although CCGs themselves may delegate delivery of direct payments for healthcare to a third party (for example, their local authority or commissioning support unit) they must retain overall responsibility and remain legally responsible for all decisions made under the regulations.
- 10) A national personal health budget delivery team¹¹ is in place to provide support to CCGs as they introduce personal health budgets. The support they provide includes:
- a 'markers of progress' tool;
 - access to a toolkit and frequently asked questions;
 - access to a learning network;
 - access to regional networks;
 - workstreams looking at implementing personal health budgets in particular groups such as for individuals with learning disabilities or mental health needs.
- 11) This support will evolve over time as CCGs and the delivery team gain experience and share learning.
- 12) Equality and diversity are at the heart of the NHS strategy. Due regard to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010)¹² and those who do not share it, has therefore

¹¹ If you want to contact the delivery team, please email england.personalhealthbudgets@nhs.net

¹² <https://www.gov.uk/equality-act-2010-guidance>

been given throughout the development of the policies and processes cited in this document.

Health and social care working together

13) People with a personal health budget will benefit from health and social care working well together and, for some, a joint budget will also be beneficial. The personal health budgets toolkit includes advice and practical information¹³ on integration:

- myths and misconceptions about the barriers to integrated working;
- early learning about how to align health and social care systems to ensure that people experience a joined up approach.

14) Integration of budgets across health and social care should be seen as part of the wider drive to integrate services. On 14 May 2013, the National Collaboration for Integrated Care and Support was launched. The Collaboration consists of thirteen national organisations and bodies publicly committed to a shared vision of integrated care and support to help ensure better outcomes for service users and to create a more efficient system. The initiative includes commitments to extend the use of personal budgets, on the basis that:

“It is more efficient for people to have control over their own budget for health and social care, because they are less likely to duplicate services or choose services that aren’t right for them”¹⁴.

15) The Collaboration is seeking to achieve this aim by creating the conditions nationally for person-centred, coordinated care to flourish locally¹⁵.

¹³ <http://www.personalhealthbudgets.england.nhs.uk/News/item/?cid=8642>

¹⁴ <https://www.gov.uk/government/policies/making-sure-health-and-social-care-services-work-together>

¹⁵ More information can be found at <http://www.england.nhs.uk/2013/05/14/c-care/>

Scope of direct payments in health

Who can receive a direct payment

16) A direct payment can be made to, or in respect of, anyone who is eligible for NHS care [under the National Health Service Act 2006] and any other enactment relevant to a CCG or the Board. This includes aftercare services under section 117 of the Mental Health Act 1983, where they are:

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

and where:

- a direct payment 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 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 Annex A). However, such a person may be able to use another form of personal health budget to personalise their care.

17) 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 paragraphs 63 to 72).

18) 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. The evaluation suggests that people with higher levels of need can experience greater levels of benefit regardless of their diagnosis.

19) The regulations do not go into detail about specific groups to whom a direct payment for healthcare should be offered, as this will be determined by Government commitments, the Mandate to NHS England and local priorities. CCGs will need to ensure that they keep abreast of national policy developments and commitments, the personal health budget website¹⁶ will contain details of any announcements on who should be offered, or have a 'right to ask' or a 'right to have' a personal health budget. As of 1 April 2014, the objectives/commitments are:

- From April 2014, everyone receiving NHS Continuing Healthcare will have the right to ask for a personal health budget, including a direct payment . From October 2014 this will be strengthened and this group will benefit from a 'right to have' a personal health budget. The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013¹⁷ sets out CCGs' legal duties relating to NHS Continuing Healthcare rights and personal health budgets. These include having a duty to arrange for the provision of a personal health budget, including a direct payment, a duty to publicise and promote them, a duty to provide information, advice and support, and a duty to consider requests for personal health budgets.
- The Mandate to NHS England sets an objective that from 2015 personal health budgets, including direct payments for healthcare, should be an option for people who could benefit from one. This includes people who use NHS services outside of NHS Continuing Healthcare¹⁸.

Direct payments for healthcare and personal health budgets more widely do not alter NHS eligibility policy. Only those people who are eligible to receive NHS services will be able to have a personal health budget including a direct payment. The personal health budgets toolkit contains stories told by people who have personal health budgets, which help to show the range of people who may benefit from a personal health budget.

In addition to the requirements above, CCGs will want to be transparent in the way they decide whether an individual could benefit from a direct payment for healthcare. They may want to consult relevant people (see paragraph 55) and request information (see

¹⁶ www.personalhealthbudgets.england.nhs.uk

¹⁷ <http://www.legislation.gov.uk/uksi/2013/2891/contents/made>

¹⁸ www.mandate.dh.gov.uk

paragraph 57). They will want to develop a consistent approach which considers a range of things, for example¹⁹:

- the person's wishes and feelings in relation to their care and support and receiving direct payments;
- their capacity to consent to the making of a direct payment and where appropriate the provision of support in the form of a nominee or representative;
- the benefits to the individual of having a direct payment for healthcare in both the short and longer term;
- whether the benefits of receiving a direct payment represent value for money and, where applicable, outweigh any direct additional financial costs;
- whether it is clear where the money for the direct payment will come from and when it will be available;
- the availability of appropriate support for the individual (or their representative or nominee) to be able to plan and manage direct payments.

Services that direct payments cannot be used for

20) Direct payments for healthcare will not be appropriate for all aspects of NHS care an individual may need.

21) A direct payment cannot be used to purchase primary medical services provided by GPs, as part of their primary medical services contractual terms and conditions²⁰ nor is a direct payment suitable for the following public health services:

- vaccination or immunisation, including population-wide immunisation programmes;
- screening;
- the national child measurement programme; and

¹⁹ This list is not intended to be an exhaustive list.

²⁰ This is because the majority of GP services are already funded through such contracts, which means GPs have already been paid for these services. We would not want to disrupt the holistic care provided to patients by their local family GP.

- NHS Health Checks.

22) A direct payment cannot be used for urgent or emergency treatment services, such as unplanned in-patient admissions to hospital or accident and emergency. This is because by their very nature they are unplanned and so will not have been included in a care plan. Whilst CCGs should not include services which require unplanned emergency access they may want to develop advance directives or crisis planning to ensure that people's wishes are taken into account when a crisis happens or that they have increased support or services to prevent the need for emergency care or hospital admission.

23) A direct payment cannot be used for surgical procedures. Individuals can choose which hospital they are referred to and they should be involved in discussions and decisions about the tests, treatment and management, but a direct payment cannot be used to pay for them²¹.

24) A direct payment cannot be used to pay for any NHS charges, such as prescription or dental charges.

25) A direct payment cannot be used;

- to purchase alcohol or tobacco;
- for gambling;
- to repay a debt (with the exception of debts relating to services specified in the care plan).

In addition they cannot be used to purchase anything illegal or unlawful.

What can a direct payment be spent on

26) In principle, other than the services listed in paragraphs 21 to 25, a direct payment can be spent on a broad range of things that will enable the person to meet their health and wellbeing needs. A direct payment may only be spent on services agreed in the care

²¹ A number of Patient Decision Aids to support shared decision making were developed as part of the Rightcare Shared Decision Making Programme and will be shortly available through NHS Choices (currently available at <http://sdm.rightcare.nhs.uk/pda/>).

plan (see care planning section paragraphs 87 to 102). For brevity, the term 'services' is used throughout this document, although it refers to anything that can be bought and which will meet someone's health needs. The care plan must be agreed by both the CCG and the person receiving care, or their representative. Before signing off the care plan, the CCG must be reasonably satisfied that the health needs of the patient can be met by the services specified in the care plan.

- 27) As far as possible, the person, with support from professionals, carers and others, should make the choices about how their needs are met. It may also be helpful to involve service brokers and advocates in these discussions. People need the right information to make informed decisions about their care. This would include any evidence available about the effectiveness of potential services or treatments.
- 28) CCGs should be careful not to exclude unusual requests without examining the proposal on a case-by-case basis; these may have significant benefits for people's health and wellbeing. The evaluation showed that personal health budgets worked best where people had real flexibility over how they could use their budgets. The personal health budget toolkit includes a number of personal stories, which give a range of ideas of how budgets were used during the pilot programme.
- 29) In some cases, it may be sensible for a CCG to agree a service which would normally be funded by social care, or another funding stream if that service is likely to meet someone's agreed health and wellbeing outcomes. CCGs should not refuse to purchase this because it has been traditionally commissioned elsewhere. In the case of NHS Continuing Healthcare the NHS is responsible for funding all the care an individual needs.
- 30) 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.

Deciding not to offer a direct payment

31) A CCG may decide not to provide someone with direct payments if for example²² it considers:

- that the person (or their representative) would not be able to manage them;
- that it is inappropriate for that person given their condition or the impact on that person of their particular condition;
- that the benefit to that individual of having a direct payment for healthcare does not represent value for money;
- that providing services in this way will not provide the same or improved outcomes;
- that the direct payment will not be used for the agreed purposes.

32) If a CCG decides not to give someone a direct payment they must inform the person, and any nominee or representative, in writing, and give their reasons. This should be in an appropriate format for the people involved to understand.

33) The person, their nominee or representative may request that the CCG reconsiders its decision not to give a direct payment. They may also provide additional evidence or relevant information to inform that decision. The CCG must reconsider their decision in the light of any new evidence, and then notify and explain the outcome of their deliberation in writing. CCGs only need to reconsider the decision not to give a direct payment once in any six month period.

34) Even if someone is not suitable to receive a direct payment, they may still benefit from more personalised care. The CCG should, where possible, consider whether other forms of personal health budget, such as a notional budget or a budget held by a third party, might be suitable, or how else the person's care could be personalised.

²² This is not intended to be an exhaustive list

Consent, capacity, ability to manage and support to manage

Consent

35) Direct payments can only be made where appropriate consent has been given by:

- a person aged 16 or over who has the capacity to consent to the making of direct payments to them;
- the representative (see paragraphs 74 to 80) of a person aged 16 or over who lacks the relevant the capacity to consent²³;
- the representative of a child under 16.

36) The direct payment can be received and managed by the person who gives their consent, or that person can identify a nominee (see paragraphs 63 to 72) to receive and manage it for them. Where a person lacks the capacity to consent, direct payments can be given to their authorised representative (see paragraphs 74 to 80), if they consent to receiving the payment on the person's behalf. In the case of children, direct payments can be received by their parents or those with parental responsibility for that child.

37) As well as giving people more control and independence, direct payments carry with them greater responsibilities for individuals than traditionally commissioned healthcare. The person receiving direct payments (the individual themselves if direct payments are made to them, or their nominee or representative) will be responsible for ensuring that the money is spent in line with the care plan. People may also be taking on additional responsibilities as employers (see paragraphs 145 to 150) or by entering into contracts with people to provide services (see paragraph 144).

38) When providing direct payments, CCGs must be satisfied that the person receiving the direct payment understands what is involved, and has given informed consent. Where necessary obtaining this consent might be a process involving a number of discussions, rather than a single event, and should be part of the wider care planning process. This is an area where people may need additional support, which can be provided by the CCG directly, or by another organisation working in partnership with the CCG. This

²³ In this document, when we refer to people who lack capacity we mean people who lack capacity to consent to the making of a direct payment to them.

support might include information about how people using direct payments are supported, the different options for managing a personal health budget, what to expect when receiving direct payments, and/or access to advocacy services.

39) When offering direct payments, CCGs should make it clear that receiving direct payments is voluntary and that it is possible to use another form of personal health budget, or not have one at all. It should also be made clear that it is possible to use a combination of different ways to manage the money.

Capacity to consent

40) CCGs must assume that a person aged 16 and over has the capacity to make decisions about the making of direct payments to them, unless the person is assessed to lack capacity.

41) Under the *Mental Capacity Act 2005* a person lacks capacity if they are unable to make a decision because of an impairment of, or a disturbance in the functioning of, the mind or brain²⁴. Broadly speaking, 'mental capacity' means the ability to make a decision in question at the time it needs to be made. Where there is reasonable belief that a person is unable to make a decision about the making of direct payments to them, CCGs must assess the person's capacity to consent.

42) 'Mental capacity' should always be assessed on an individual basis (see Box 1), in relation to the specific decision to be made and at the material time. A person should not be assumed to lack mental capacity simply because they have a particular condition, such as dementia or mental illness or because they make what might be seen by some as an unwise decision.

43) When assessing someone's capacity to make a decision for themselves, people should use a two stage test of capacity:

- does the person have an impairment of the mind or brain, or is there some disturbance in the functioning of their mind or brain? (It does not matter whether this is temporary or permanent);

²⁴ Section 2(1) of the *Mental Capacity Act 2005* (c.9)

- if so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?²⁵

44) As far as possible, people should be supported to make decisions which affect them. The Mental Capacity Act requires that a person should not be treated as unable to make a decision unless all practicable steps to support them to do so have been unsuccessful.²⁶ Therefore, before deciding that someone lacks capacity, CCGs should satisfy themselves that they have taken all practicable steps to try and help the person make their own decision.

Box 1: Assessing capacity

When assessing capacity to make a decision, professionals should consider:

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, sign language, or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful? Can anyone else help the person to make choices or express a view (for example, a close family member, carer or advocate)?
- Is there a need for a more thorough assessment (perhaps involving a doctor or other professional expert)?

Mental Capacity Act 2005: Code of Practice, Chapter of Health 2009, p.23

²⁵ Chapter 4 of the *Mental Capacity Act 2005: Code of Practice*.

²⁶ Section 1(3) of the Mental Capacity Act 2005.

Fluctuating Capacity

- 45) Where a person who has agreed to a care plan and consented to the making of direct payments to them subsequently loses their capacity to consent, the CCG may, where it is satisfied that the loss of capacity is temporary, allow a representative to be appointed to receive direct payments on their behalf, or an existing nominee to continue to receive them, until they regain capacity. In these circumstances, the role will be similar to that of a representative for someone who has been assessed to lack capacity on an ongoing basis.
- 46) Where someone's capacity to consent fluctuates, for example where a person's mental illness is such that it impairs their capacity to make decisions at certain times but not others, it is important that there should be continuity of care, and any disruption should be as minimal as possible. CCGs may find it helpful to work with people with fluctuating conditions to draw up advance decisions under the *Mental Capacity Act* and contingency plans to ensure that their care in a crisis better meets their wishes, including the identification of a nominee or representative who may take control of the direct payment at such times.
- 47) When a person with fluctuating capacity gains or regains their capacity to consent, their consent is needed to continue the direct payments. If they consent, the representative or nominee must agree to continue their role in respect of the direct payment until a review is held. This is because it is the representative, not the person who has gained or regained capacity who, consented to the arrangements. This allows direct payments to continue until the CCG can arrange a review, which it must do as soon as is reasonably possible. At this review, the CCG and the person receiving care will review and if necessary develop a new care plan. However, if the person who has gained or regained capacity, does not consent to the representative or their nominee continuing in that role until a review is held, or if the representative or nominee does not wish to continue in that role, then direct payments must stop. As in all circumstances when direct payments stop, alternative provision should be made to ensure continuity of care until the required review takes place and new arrangements, which may include direct payments, are put in place.

Ability to manage direct payments

48) It does not necessarily follow that if someone has the capacity to consent to receive direct payments, they are also able to manage them. When deciding whether or not someone has the ability to manage direct payments, CCGs should especially consider:

- 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 health care or social care direct payment in the past, and if their circumstances have changed; and
- 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.

49) If a representative (see paragraphs 74 to 85) receives direct payments on someone's behalf, or the person receiving care appoints a nominee (see paragraphs 63 to 72) to manage the direct payments on their behalf then the CCG needs to be confident that the representative or nominee is able to manage direct payments on the person's behalf.

50) Where a CCG is concerned that a person who wishes to receive direct payments may not be able to manage them, they should additionally consider:

- the person's understanding of direct payments, including the actions and responsibilities required on their part;
- whether the person understands the implications of receiving or not receiving direct payments;
- what kind of support the person might need to manage a direct payment;
- what help is available to the person; and
- what arrangements the CCG or the person could make to obtain the necessary support

- 51) A judgement by a CCG that someone is unable to manage direct payments should be on an individual basis, taking into account the views of the individual, and the help available to them. CCGs should not make blanket assumptions that groups of people will or will not be capable of managing direct payments. For example, they should not assume that people with learning difficulties will automatically be incapable of managing direct payments alone or with support.
- 52) When considering whether someone is capable of managing direct payments, the CCG should take into account the support available to that person, and should consider whether providing additional support would enable them to receive direct payments (see paragraphs 58 to 62).
- 53) If the CCG concludes that someone would not, even with assistance, be able to manage direct payments, it is important to discuss this with them, and if appropriate with family and friends. They should also consider whether a nominee (see paragraphs 63 to 72) could manage the budget.
- 54) If a CCG decides that someone is not suitable for direct payments, the CCG should inform them in writing of their decision, giving their reasons and as discussed in paragraph 31 to 34 the person, their representative or a nominee can ask for a review of this decision. The CCG also should consider other means of personalising that person's care, including through a notional budget held by the CCG, or through a third party budget. People should not be disadvantaged by not being able to manage direct payments.

Who should the CCG consult when considering whether to make a direct payment

55) Where there are questions about whether or not a person is suitable to receive direct payments and would be able to manage them, there are a range of people that a CCG may consult if they believe one or more of them may have information relevant to the decision to make direct payments. The CCG may consult:

- anyone identified by the person involved as someone to be consulted for these purposes;

- if the person is aged between 16 and 18, the person with parental responsibility for them;
- the individual primarily involved in the person's care (e.g. a personal assistant, community mental health nurse);
- anyone else who provides care for the person (e.g. a occupational therapist or community matron);
- an independent mental capacity advocate or an independent mental health advocate appointed for the person;
- any health professional or other professional individual who provides healthcare to the person (e.g. a GP);
- the person's social care team;
- if the person has one, a deputy appointed by the Court of Protection in relation to matters in respect of which direct payments may be made;
- a donee of a lasting power of attorney²⁷ with the power to make the relevant decisions;
- a person vested with an enduring power of attorney²⁸ with the power to make the relevant decisions;
- where relevant, anyone named by the person for whom direct payments are to be made, when they had capacity, as a person to be consulted for this purpose, and
- anyone who the CCG considers is able to provide relevant information about the person. CCGs should be particularly aware that carers will have particular insights, and should be seen as partners in care wherever possible.

56) If the person lacks capacity, the CCG may consult people listed in paragraph 81 to establish whether or not that person would want to receive direct payments if they had capacity to consent.

²⁷ see section 9 of the *Mental Capacity Act (2005.)*

²⁸ see schedule 4 of the *Mental Capacity Act (2005)*

Information that may be requested when considering whether to make a direct payment

57) The CCG may ask the person receiving care, their nominee or representative to provide information about:

- their overall health;
- the details of the condition(s) 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.

Information, advice and support

58) The evaluation of the pilot programme clearly demonstrates that having the right information and support is key to successful outcomes with personal health budgets. CCGs must make arrangements to provide the person to whom direct payments are made (including representatives or nominees) with information, advice and other support. This can be provided either directly or by another organisation working in partnership with the CCG. The CCG should ensure that the person receives adequate information and support at every stage of the process, including during the discussion about whether to receive direct payments, during care planning discussions and in managing and accounting for them correctly. Information and support for individuals, representatives or nominees who are using their direct payments for healthcare to employ staff is included in paragraphs 145 to 150.

59) It is important to ensure that whatever support arrangements are made available, they are adequate to meet the full range of requirements that people receiving direct payments will have. The regulations do not specify either the type of support or the information that CCGs must provide, as there are a number of possible options available. Examples given in the regulations to assist CCGs to meet this obligation are²⁹:

- specifying the amount of a patient's direct payment and how this payment is calculated;

²⁹ This is not intended to be an exhaustive list

- how a patient, representative or nominee can request a review of the patient's direct payments and care plan;
- the circumstances in which a patient may no longer qualify for direct payments;
- the restrictions on how a direct payment may be spent;
- the process involved in drawing up and agreeing the care plan;
- provision for advocacy services, whereby a third party assists a patient, representative or nominee in relation to the terms of a care plan, or the management of any contract under which services secured by means of direct payments are provided, or otherwise;
- provision for commissioning services, whereby a person assists the patient, representative or nominee in procuring services that may be secured by means of direct payments;
- provision for payroll, training, sickness cover or other employment related services to assist a patient, representative or nominee where an employee provides services secured by direct payments for the patient; or
- where the patient is also in receipt of direct payments to secure relevant services for social care, information on integration of both direct payments and the arrangements between a health body and a local authority for joint working and co-operation.

60) CCGs should ensure that the support they give is comprehensive, relevant, up-to-date, and accessible. This may include using different forms of media, and different formats or languages, depending on the groups they are aimed at. The 'Advice, Advocacy and Brokerage' document in the personal health toolkit provides detailed information on information, support and advice.³⁰

61) Many local authorities have already commissioned support services for people with social care direct payments, and CCGs may find it helpful to work with them to develop joint or integrated support services. CCGs may also want to consider consulting with

³⁰ <http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/HowPHBswork/Info/>

and using the expertise of voluntary, user led, community, carers or peer support organisations when discussing or developing their ideas.

62) While support may be provided directly by the CCG, it may also be appropriate for people to purchase their own support, for example purchasing a payroll service to help when employing a care worker. This should be discussed within the care planning process and the care plan should specify any requirement for information, advice or other support. This can then be funded as part of the care plan, within which it must be costed and agreed in the same way as for any other service to be purchased by the individual.

Nominees for people with capacity

63) If a person aged 16 or over who is receiving care has capacity, but does not wish (for whatever reason) to receive direct payments themselves, they may nominate someone else to receive them on their behalf. A representative (for a person aged 16 or over who does not have capacity or for a child) (see paragraphs 74-80) may also choose to nominate someone (a nominee) to hold and manage the direct payment on their behalf.

64) It is important that CCGs and their commissioning and provider partners understand 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 described below in Box 2. People aged 16 or over with capacity and representatives receiving direct payments for healthcare, and those who act as their nominees need to be made fully aware of this particularly if they have previous experience of appointing or acting as a nominee under the social care arrangements.

Box 2: What is a nominee?

A nominee is responsible for managing the direct payment on behalf of the person receiving care. They are responsible for fulfilling all the responsibilities of someone receiving direct payments. These include:

- a. acting as the principal person for all contracts and agreements with care providers, employees, etc;
- b. using the direct payment in line with the agreed care plan; and
- c. complying with any other requirement that would normally be undertaken by the person receiving care as set out in this guidance (e.g. review, providing financial information).

65) 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. This is an area where people may particularly welcome advice, support and information around what they should expect when managing direct payments on someone else's behalf.

66) Before the nominee receives the direct payment, the CCG must also give their consent. CCGs should, in particular, consider whether the person is competent and able to manage direct payments, on their own or with whatever assistance is available to them (see paragraphs 48 to 54). In reaching their decision, the CCG may also:

- consult with relevant people (see paragraph 55 to 56);
- require information from the person for whom the direct payments will be made on their 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 relating to the account into which direct payments will be made.

- 67) The people whom the CCG may consult in deciding whether or not to make direct payments to a nominee are the same as those they may consult before deciding to give a direct payment (see paragraph 55 to 56).
- 68) If the proposed nominee is not a close family member of the person (see Box 3 following paragraph 154), living in the same household as the person, or a friend involved in the person's care, then the CCG must 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 list³¹ 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 bills³².
- 69) 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. In these circumstances there is no legal power to request these checks.
- 70) An organisation (including one such as a Trust established for the purpose) may agree to act as nominee. Where this is the case, that organisation must identify the individual who will, on their behalf, have overall responsibility for the day-to-day management of the direct payments and paragraphs 65-67 will apply to that person.
- 71) A person who has chosen to appoint a nominee may withdraw or change that nomination by writing to the CCG. If this occurs, the CCG must consider whether to stop paying the direct payment, consider paying it to the person directly, or paying it to another nominee; and they should review the direct payment and care plan as soon as is reasonably possible.
- 72) 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.

³¹ This is an enhanced DBS check including suitability information relating to vulnerable adults.

³² Such activities fall into "the provision of assistance in relation to general household matters to an adult who is in need of it by reason of age, illness or disability", which is a regulated activity relating to vulnerable adults under Part 2 of Schedule 4 to the *Safeguarding Vulnerable Groups Act 2006*.

The status of support organisations with regard to the role of nominee

73) An organisation which does not have the status of a nominee but provides financial management and support services to the person who receives and manages direct payments for an individual, their representative or nominee, is not considered to be acting as a nominee as defined by the regulations. In this situation the individual, their representative or nominee remain fully responsible for the direct payment, including acting as the employers of any personal assistant/s and the making of decisions about their direct payment. The organisation may offer advice and support around a number of elements including being an employer, in addition to coordinating the financial element of the direct payment but they do not take on full responsibility for the person's care and budget.

Representatives

74) If a person does not have capacity and so may not receive direct payments personally, the CCG should establish whether someone could act as that person's representative. In some cases someone may already be acting as a representative in another capacity. In others it may be appropriate for the CCG to appoint someone to act as a representative. This should occur if the person receiving care would benefit from direct payments, and there is no-one else who is able to act as a representative (i.e. no-one falling into categories a to e in paragraph 79).

75) A representative is someone who agrees to act on behalf of someone who is otherwise eligible to receive direct payments but cannot do so because they do not have the capacity to consent to receiving one, or because they are a child. Representatives are responsible for consenting to a direct payment and fulfilling all the responsibilities of someone receiving direct payments. This is similar to the appointment of a 'suitable person' in social care.

76) Before someone can be a representative, they must give their consent to managing the direct payment. Like all decisions involving consent, CCGs should ensure that people are fully informed, and provided with sufficient advice and support when making their decision. In a similar way to the process for appointing nominees, the CCG should also

consider whether the person is competent and able to manage direct payments, on their own or with whatever assistance is available to them.

77) A representative may identify a nominee (see paragraphs 63 to 72) to receive and manage direct payments on their behalf, subject to the nominee's agreement and the approval of the CCG.

78) An appointed representative could be anyone deemed suitable by the CCG. However, it will be important for CCGs to take into account previously expressed wishes of the patient, and as far as possible their current wishes and feelings. Where possible, CCGs should consider appointing someone with a close relationship to the person, for example a close family member or a friend. As far as is reasonably practicable, the CCG should also take into account the views of the people in paragraph 55 before appointing someone as a representative.

79) A representative can be:

- a. a deputy appointed by the Court of Protection³³ to make decisions relevant to healthcare and direct payments ("the relevant decisions");
- b. a donee of a lasting power of attorney³⁴ with the power to make the relevant decisions;
- c. a person vested with an enduring power of attorney³⁵ with the power to make the relevant decisions;
- d. the person with parental responsibility, if the patient is a child³⁶;
- e. the person with parental responsibility, if the patient is over 16 and lacks capacity;
- f. someone appointed by the CCG to receive and manage direct payments on behalf of a person, other than a child, who lacks capacity.

80) When considering whether a representative is suitable, the CCG should where appropriate, be aware of the terms under which someone has been appointed under a

³³ under section 16(2)(b) of the *Mental Capacity Act (2005)*.

³⁴ see section 9 of the *Mental Capacity Act (2005)*.

³⁵ see schedule 4 of the *Mental Capacity Act (2005)*.

³⁶ defined as anyone under 16.

Lasting Power of Attorney made by the patient or by the Court of Protection as the patient's deputy. The attorney or deputy may only make decisions about the person's healthcare and securing services on the person's behalf to meet their care needs if they have been appointed to deal with these matters.³⁷ If an attorney or deputy lacks suitable powers, they will not be able to manage the direct payment. In such circumstances, the CCG may appoint another person as a representative³⁸.

The role of the representative

81) A representative is responsible for managing direct payments on behalf of the person receiving care. They, or their nominee, must:

- act on behalf of the person³⁹, e.g. to help develop care plans and to hold the direct payment;
- act in the best interests of the person when securing the provision of services;
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the direct payment in line with the agreed care plan;
- comply with any other requirement that would normally be undertaken by the person as set out in this guidance (e.g. review, providing information).

82) If a representative believes that the person for whom they are acting has regained capacity they should notify the CCG as soon as possible (see paras 45-47 on fluctuating capacity).

Deciding whether to make direct payments to a representative

83) When deciding whether or not to make direct payments to a representative, the CCG is required to act in the best interests of the person receiving care⁴⁰ and should, in particular, consider:

³⁷ A Lasting Power of Attorney can cover matters relating to the patient's personal welfare as well as property and financial affairs, but can be subject to a range of exclusions and restrictions.

³⁸ Under regulation 5(4).

³⁹ Further guidance about making decisions in the patient's best interests is in Chapter 5 of the *Mental Capacity Act 2005: Code of Practice*

- whether the person receiving care had, when they had capacity, expressed a wish to receive direct payments, or have someone receive them on their behalf;
- 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 if deciding whether to consent or not to receiving direct payments; and
- as far as possible, the person's past and current wishes and feelings⁴¹.

84) When considering whether to appoint a representative, the CCG may also consult the person receiving care and all or any of those people identified in paragraph 55.

85) If a representative is not a close family member of the person (see Box 3 which follows paragraph 152), living in the same household as the person, or a friend involved in the person's care, then the CCG must require the representative to apply for an enhanced Disclosure and Barring Service (DBS) certificate (formally a CRB check) with a check of the adults' barred list⁴² and consider the information before giving their consent. If a proposed representative 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 bills⁴³.

When a child reaches the age of 16

86) When a child on whose behalf a representative has consented to direct payments reaches 16, the CCG may continue to make direct payments to the representative or their nominee in accordance with the care plan, providing the child who has reached 16 and the representative and, where applicable the nominee, consent. If the child who has reached 16 does not consent the CCG must stop making direct payments. In either

⁴⁰ In accordance with section 4 of the Mental Capacity Act 2005.

⁴¹ Further guidance about making decisions in the patient's best interests is in Chapter 5 of the *Mental Capacity Act 2005: Code of Practice*.

⁴² This is an enhanced DBS check including suitability information relating to vulnerable adults.

⁴³ Such activities fall into "the provision of assistance in relation to general household matters to an adult who is in need of it by reason of age, illness or disability", which is a regulated activity relating to vulnerable adults under Part 2 of Schedule 4 to the *Safeguarding Vulnerable Groups Act 2006*.

case, the CCG must as soon as reasonably possible review the making of direct payments.

Care planning and direct payments for healthcare

Care planning

- 87) The care plan is at the heart of a personal health budget. Drawing up of a care plan should involve a series of discussions between the person receiving the care, their nominee or representative, their care coordinator (see paragraph 112) and the appropriate health and social care professionals involved in the individual's care. The personal health budget toolkit includes information and examples that provide CCGs with additional information on care planning⁴⁴.
- 88) Wherever possible, CCGs should work with local authorities and other healthcare providers to ensure that the person has a single plan covering their health and wellbeing needs across both the NHS and social care. This could include all the services and support provided, whether traditionally commissioned or through notional or third party budgets, as well as direct payments. For children with special educational needs and disabilities, who have a single education, health and care plan, this could also include their educational needs.
- 89) The regulations and thus the use of the term 'care plan' in this guidance only applies to that part of a person's care plan related to services purchased by direct payments for healthcare, although the principles are applicable to all ways of managing a personal health budget.
- 90) The care plan is an agreement between the CCG and the person receiving direct payments, and includes responsibilities on both sides. It is therefore vital that people are supported throughout the care planning process. This will help ensure that they are able to make informed decisions in their best interests, and that they do not find the process overly burdensome or overwhelming. This support could take many forms - it may be from their healthcare professional, but some people may prefer an independent person to guide them through the process and liaise with the relevant parties. As with each

⁴⁴ <http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/HowPHBswork/Care/>

aspect of personal health budgets, the best approach is to enable choice and not assume that the same option suits everyone. The personal health budget toolkit contains information and examples which will help CCGs and others consider the best ways for supporting their local population⁴⁵.

- 91) As a result of the care planning discussion, the care plan should clearly set out the health needs that the direct payment is to address. These may be reasonably broad, but it should be clear to both the CCG and the people involved what the direct payments are meant to achieve.
- 92) Having set out the health needs, the care plan should also set out the outcomes that are intended to be achieved. These may relate to both health and 'wellbeing' outcomes. CCGs have broad powers to address people's health and wellbeing needs, and a good care plan should address people's needs holistically.
- 93) Having set out the health needs and the intended outcomes, the care plan must specify the services to be secured by the direct payment in order to achieve these. This should be done in such a way to enable the CCG to be satisfied that the health needs and identified outcomes are likely to be met.
- 94) The CCG must make arrangements for the person, their representative or nominee to obtain information, advice or support in connection with the direct payments. These arrangements should be specified in the care plan and could be a service for which direct payments may be made.

What must be included in the care plan for direct payments to be made

- 95) Before a direct payment can be made, a care plan must be agreed between the CCG and the person, their nominee or representative. This must set out:
- the health needs of the individual and desired outcomes to be achieved through purchase of services⁴⁶ in the care plan;
 - what the direct payment will be used to purchase (see paragraphs 26 to 30);

⁴⁵ <http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/HowPHBswork/Info/>

⁴⁶ the term 'services' is used throughout this document, to refer to anything that can be bought and which will meet someone's health needs

- the size of the direct payment, and how often it will be paid (see paragraphs 115 to 120);
- the name of the care coordinator responsible for managing the care plan (see paragraph 112);
- who will be responsible for monitoring the health condition of the person receiving care;
- the anticipated date of the first review, and how it will be carried out (see paragraph 176 to 185);
- where necessary, an agreed procedure for discussing and managing any significant potential risks (see paragraphs 104 to 111);
- where people lack capacity or are more vulnerable, the plan should consider safeguarding, promoting liberty, and where appropriate, set out any restraint procedures; and
- the period of notice required if the CCG decides to reduce the amount of the direct payment.

Agreeing the care plan

96) When agreeing the care plan, the CCG must be satisfied that:

- the health needs of the patient can be met through the purchase of services in the care plan (see paragraphs 26 to 30 for more information on what direct payments can be spent on);
- the amount of money in the care plan will be sufficient to cover the full cost of each of the specific services in the care plan;
- the care plan will be reviewed as required (see paragraphs 176 to 185);
- any significant potential risks have been discussed with the person, their representative or nominee and appropriate procedures to eliminate, reduce or

manage these risks have been included in the care plan (see paragraphs 106 to 113);

- where people lack capacity or are more vulnerable, procedures such as safeguarding, promoting liberty and if required, necessary restraint procedures have been included appropriately in the care plan.

97) The individual or their representative must also agree that:

- the person's care needs will be met by the services agreed in the care plan;
- the amount of direct payment is sufficient to cover the full cost of the care plan; and
- the care plan will be reviewed (see paragraphs 176 to 185) and their needs may be re-assessed as part of that review.

98) No service should be included in the care plan if the CCG considers that the benefits are outweighed by the possible damage to health.

99) Where NICE has concluded that a treatment is not cost effective, CCGs should apply their existing exceptions process before agreeing to such a service. However, when NICE has not ruled on the cost effectiveness or otherwise of a specific treatment, CCGs should not use this as a barrier to people purchasing the service, if it could meet the individual's health and wellbeing needs. People need the right information and support to enable them to make an informed decision about how to use their direct payments. Where relevant, individuals should be given the opportunity to review the underpinning evidence and the conclusions drawn up by NICE. NICE provide a lay version of their guidance that can help people make decisions about this type of healthcare.

100) CCGs should consider all proposals where it can be demonstrated that the use of the budget is a reasonable way to meet the individual's health and wellbeing needs.

101) The sign off of a care plan should be a joint process between the individual and the professional in which all requests have been discussed and any risks and issues identified. Further information about sign off of care plans can be found in the toolkit⁴⁷.

⁴⁷ <http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/HowPHBswork/Care/>

102) If a CCG decides to refuse a service as part of the care plan, the person, representative or nominee may request an explanation from the CCG. The person can also ask the CCG to reconsider their decision and provide additional evidence or relevant information to inform that decision. The CCG must reconsider their decision in the light of the new evidence, and then notify and explain the outcome of their deliberation in writing. If the dispute persists, the CCG should refer the person to the complaints procedure (see paragraphs 186 to 191).

Reviewing and revising the care plan

103) The care plan should be open to review and revision as necessary, and should be reviewed at clinically appropriate intervals. It must be initially reviewed within the first three months, and then at least annually (see paragraphs 176 to 185 for more information on monitoring and review). In case of a change in an individual's condition, it is important that the care plan is reviewed, adapted to meet their changing needs and agreed as soon as possible.

Managing risk

104) During the care planning process, the CCG should have a detailed discussion with the patient, representative or nominee about potential risks, and how to manage them. This should be part of an ongoing dialogue between the people and the CCG on how to effectively manage risk.

105) The care plan must contain details of any proportionate means of eliminating, reducing or managing the risks, and this should be informed by a discussion about the significant potential risks and their consequences. The CCG must also agree with the individual, nominee or representative about the procedure for managing significant potential risk, and this must be included in the care plan.

106) Some of the risks that may be included in this discussion are listed below. This is not an exhaustive list, and CCGs should ensure that they adequately address potential risks on a case by case basis which could include:

It may also be useful to read the 'Choice, Risk and Decision making' guide for professionals that looks at how decisions can be made to help sign off care plans.

<http://www.personalhealthbudgets.england.nhs.uk/library/Resources/Personalhealthbudgets/Toolkit/MakingPHB Happen/TrainingandDeveloping/ChoiceRiskDecisionMaking.pdf>

- the risks to the person's health;
- the medical or surgical risks of different treatments;
- the risk arising from employing members of staff;
- the risk of purchasing services from a provider with inadequate or no insurance or indemnity cover;
- the risks of purchasing services from a provider with inadequate or no complaints procedures;
- the risk of the direct payment being misspent, going missing or being subject to fraud; and
- where people lack capacity or are more vulnerable, issues such as safeguarding, promoting liberty and where appropriate, setting out any restraint procedures.

- 107) Any discussion about risk should be realistic and aimed at enabling people to make decisions that are right for them. This may require balancing potential risks and consequences with the benefits associated with any particular decisions. There is a delicate balance between empowerment and safeguarding, and providing choice whilst managing risk.
- 108) Practical examples of how to manage risk are including in the personal health budgets toolkit.
- 109) The balance between risks and benefits will be different for each person, and will depend on their individual circumstances and health condition. CCGs should ensure that they do not impose blanket prohibitions, and are sufficiently flexible to tailor their risk management processes to the needs of each individual.
- 110) During the process of discussing risk with individuals, CCGs should ensure that all relevant people have the opportunity to contribute. CCGs should ensure that the individuals, if they want to be involved, are included in these discussions, and if appropriate, their family or carers. It is also important to get the input of healthcare professionals who have the knowledge of the identified risks, and other people involved

in the person's care, for example, social workers or care workers. CCGs should strive to get the right balance between the views of individuals and those providing them with support, while also maximising choice and control for the person receiving care as far as possible. This should be done along with ensuring that the individual's clinical needs are being met.

111) The discussion about risk and benefit should be part of an ongoing discussion within care planning between the individual and the CCG. As people's circumstances and conditions change, the balance between risk and benefit may also change. At each review, the identified risks and the agreed means of mitigating them should be discussed and recorded to ensure that decisions made are still relevant and appropriate.

Named care coordinator

112) For each person receiving a direct payment, the CCG must name a care coordinator, and this must be recorded in the care plan. The care coordinator is responsible for:

- managing the assessment of the health needs of the individual as part of the care plan;
- ensuring that the individual, or representative and the CCG have agreed the care plan;
- undertaking or arranging for the monitoring and review of the direct payment, the care plan and the health of the person; and
- liaising between the CCG and the person receiving the direct payment.

113) The care coordinator should normally be someone who has regular contact with both the individual receiving care, and their representative or nominee if they have one. They do not need to have 'care coordinator' in their job title - the important thing is that they fulfill the responsibilities above and that the direct payment recipient is aware of who they are and their role. While they are able to arrange with others to undertake actions, such as monitoring or review, the care coordinator should be the primary point of contact between the individual and the CCG. This is a similar role to the care

coordinator in many mental health services and community matrons in NHS Continuing Healthcare.

- 114) It is the responsibility of CCGs to decide who is best placed in their organisations to take up the role of care coordinator. Different services such as mental health services already have best practice guidance around the role of the care coordinator. CCGs may also find it helpful to build on the experience of local authorities.

Managing the money

Setting the amount of a direct payment

- 115) Direct payments must be set at a level sufficient to cover the full cost of each of the services agreed in the care plan.
- 116) When calculating the budget, CCGs should ensure that they recognise the additional 'hidden' costs. For example, if someone is employing an assistant, they must ensure that there is sufficient funding available to cover the additional necessary costs of employment such as tax, National Insurance, training and development, pension contributions, any necessary insurance such as public liability, emergency cover and so on.
- 117) Direct payments must cover the full cost of the care agreed in the care plan. However, they do not circumvent existing Government policy around additional private care. In no circumstances should the budget be set at a level where someone is expected to pay for care privately in order to meet their agreed health needs. If someone wishes to purchase additional care privately, they may do so, so long as it is additional to their assessed needs, and it is a separate episode of care, with clearly separate lines of clinical accountability and governance.
- 118) If the amount of a direct payment is not set at a suitable level, it must be reviewed and adjusted.
- 119) CCGs may wish to consider including a contingency fund in the direct payment, either for the individual or as part of a collective risk pool, to ensure that the budget is available to fully fund the care plan.

120) The personal health budget toolkit contains two budget setting documents which set out the learning from the pilot programme - one focuses on budget setting in NHS Continuing Healthcare and the other explores different methods used by pilot sites to set budgets beyond NHS Continuing Healthcare.

Receiving a direct payment

121) NHS services are free at the point of delivery. Direct payments must be paid in advance. Under no circumstances, should people have to pay for services themselves and be reimbursed, even if receipts are available for services agreed in the care plan.

122) With the exception of one-off direct payments (see paragraph 124), direct payments must be paid into a separate bank account used specifically for this purpose and held by the person receiving them. That person may be the person receiving care, or a nominee or representative. This account may also be used to receive money provided by the Government for other care or services. These include direct payments for social care, direct payments for children with special educational needs and disabilities single assessment and care plan, payments made by the Independent Living Fund, and other money paid to disabled people to secure relevant services. The bank account should only be accessible to people agreed to by the CCG, which should normally be limited to the person purchasing services.

123) When receiving direct payments, the person holding the account should keep a record of both the money going in and where it is spent, for example, through keeping bank statements and receipts. Where different funding streams are paid into a single account, this may require taking copies of statements, as there may be different monitoring and review processes. As far as possible, CCGs should endeavor to join up with other statutory services, to ensure that monitoring is not onerous and to limit the amount of duplication.

124) Where 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). A one-off payment is used to buy a single item or service, or a single payment made for no more than five items or services, where the individual is not expected to receive another direct payment in the same financial year. Individuals will need to provide evidence that the direct payment was used as agreed in the care plan. However, for one-off direct

payments, this could be done by producing receipts of items/services purchased, rather than by providing copies of bank statements.

Stopping or reducing a direct payment

- 125) See paragraphs 176 to 185 for requirements on monitoring and review of direct payments. The CCG may increase or decrease the size of the direct payment at any time, if they are satisfied that the new amount is sufficient to cover the full cost of the current care plan.
- 126) Before making a decision to stop or reduce a direct payment, wherever possible and appropriate, the CCG should consult with the person receiving it to enable any misunderstandings or inadvertent errors to be addressed, and enable any alternative arrangements to be made.
- 127) Whenever a direct payment is reduced or stopped, the CCG must ensure that the person receiving the direct payment is given reasonable notice, and an explanation regarding the reasons for the CCG's decision. This must be done in writing, and it should be accessible and understandable to the person involved.
- 128) Direct payments may be reduced:
- where the CCG is satisfied that a reduced amount is sufficient to cover the full cost of the current care plan;
 - if a surplus payment has accumulated that has remained unused. A surplus may indicate that the individual is not receiving the care they need or too much money has been allocated. As part of the review process, the CCG should establish why the surplus has built up. Under these circumstances, a reduction in direct payment in any given period cannot be more than the amount that would have been paid to them in the same period.
- 129) Where direct payments have been reduced, the person receiving care, a representative or nominee may request the CCG to reconsider the decision, and may provide evidence or relevant information to be considered as part of that deliberation. Where this happens, the CCG must inform the person receiving care and any representative or nominee in writing of their decision after reconsideration, and state the

reasons for the decision. The CCG is not required to undertake more than one reconsideration of any such decision. If the person is still unhappy with the decision to reduce the direct payment, they should be referred to the local NHS complaints procedure.

130) A CCG must stop paying direct payments if:

- 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 direct payments continuing; or
- a representative withdraws their consent to receive direct payments, and no other representative has been appointed.

131) A CCG may stop making a direct payment if they are satisfied that it is appropriate to do so. For example where:

- the person no longer needs care;
- direct payments are no longer a suitable way of providing the person with care;
- the CCG has reason to believe that a representative or nominee is no longer suitable to receive direct payments, and no other person has been appointed;
- a nominee withdraws their consent, and the person receiving care or their representative does not wish to receive the direct payment themselves;
- the person has withdrawn their consent to the nominee receiving direct payments on their behalf;
- the direct payment has been used for purposes other than the services agreed in the care plan;
- fraud, theft or an abuse in connection with the direct payment has taken place; or
- the person has died.

132) If, for whatever reason, the person receiving care is no longer able or willing to manage the direct payment, the CCG is responsible for fulfilling the contractual obligations the person entered into. After a direct payment is stopped, all rights and liabilities acquired or incurred as a result of a service purchased by direct payments will transfer to the CCG.

133) In some cases, it may be necessary to stop the direct payment immediately, for example if fraud or theft has occurred. In these cases, 'reasonable notice' may include immediate termination of the direct payment. In these circumstances, the CCG should endeavor to protect public money as far as possible, whilst being mindful that they are still under a duty to provide healthcare if the individual requires it. No person should ever be denied the care they need. Where possible, CCGs should also endeavour to continue to provide a personalised service and maintain a continuity of care. For example, an independent user trust could be established to manage the budget or the CCG could directly commission the services agreed in the care plan.

Repayment of a direct payment

134) In some circumstances, the CCG may ask for all, or part of, the direct payment to be repaid. The decision to seek repayment, and the amount of money to be reclaimed, is at the discretion of the CCG. CCGs may choose to waive reclaiming all or part of the direct payment.

135) Direct payments may be reclaimed if:

- they have been used to purchase a service that was not agreed in the care plan;
- theft, fraud or other offences have occurred;
- the person receiving care has died, leaving part of the direct payment unspent;
- the care plan has changed substantially resulting in surplus funds;
- the individual's circumstances have changed substantially, such as admission to hospital resulting in the individual not using the direct payment to purchase their care; or

- a significant proportion of the direct payment has not been used to purchase the services specified in the care plan resulting in money being accumulated.
- 136) CCGs should be aware that genuine errors can occur. The power to reclaim direct payments should not be used to penalise people for making mistakes or when the individual has been the victim of fraud.
- 137) If a substantial amount of money accumulates in the individual's account due to an underspend for any reason, the CCG should consider whether it is appropriate to reclaim that money. In some circumstances, it may be more appropriate to simply reduce subsequent direct payments, factoring in the existing surplus. CCGs should also assess the reasons for the build up of the surplus as part of the review process – either the individual is not receiving the care they need or too much money was allocated.
- 138) When reclaiming money from someone with a representative or nominee, the CCG should approach the person holding the money, rather than the individual receiving care. The CCG should also ensure that, as far as possible, the person receiving care is also aware of their intention, and the reasons for this.
- 139) When reclaiming money from the estate of someone who has died, the CCG must approach the personal representatives of the individual to seek repayment. They should do so sensitively, and may wish to leave a period of grace to allow the executors of the will to ensure the estate is in order. The CCG should bear in mind that if the person, their representative or nominee was an employer, their employees will have employment rights, which may include a paid period of notice or redundancy payment.
- 140) In some cases, the person may also be approached by the local authority and other public body seeking to reclaim direct payments, for example in cases where someone has a joint care plan. In these circumstances, the CCG should co-ordinate with the local authority (LA) and other bodies to agree a common approach. CCGs should be aware of their responsibilities under the Data Protection Act (1998) and should inform the relevant individuals before contacting the LA or other bodies.
- 141) If the CCG has decided to seek repayment, they must give the relevant person reasonable notice in writing, stating:

- the reasons for their 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.

142) On receipt of notice from the CCG, the person, representative or nominee may request the CCG to reconsider their decision. They may also provide additional evidence or relevant information to inform that decision. The CCG must reconsider their decision in light of any new evidence, and then notify and explain the outcome of their deliberation in writing. The CCG can only be required to reconsider their decision once. If the person is still unhappy with the decision, they should be referred to the local NHS complaints procedure.

143) If the CCG is seeking to reclaim money as a result of theft, fraud or another criminal offence, they may seek for that sum to be summarily reclaimed as a civil debt. In these circumstances, CCGs should seek legal advice. This power does not affect any other method of recovery, for example, under the *Proceeds of Crime Act (2002)*.

Using a direct payment to employ staff or buy services

Using a direct payment

144) When using a direct payment to buy services as agreed in the care plan, the person receiving the direct payment purchases those services themselves, including contracting directly with the provider or employing people directly and so normal NHS procurement processes do not apply. See guidance on the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 published by Monitor for more details⁴⁸.

⁴⁸ http://www.monitor.gov.uk/sites/default/files/publications/SubstantiveGuidanceDec2013_0.pdf

Using a direct payment to employ staff

- 145) People may wish to use their direct payment to employ staff to provide them with care and support. CCGs should support them to do so whenever possible, while ensuring that there is appropriate practical support.
- 146) For some people who receive direct payments, it may be their first experience of being an employer, and it will be vital that there is good support available to them, if they want it. This support could include provision for payroll, training, sickness cover or other employment related services. There is further advice available from the Skills for Care personal assistant toolkit 'Employing Personal Assistants'⁴⁹. The personal health budgets toolkit includes guides and best practice examples including:
- Options for managing the money; and
 - Personal assistants: delegation, training and accountability.
- 147) Where direct payments are being used to employ one or more people, the person receiving care, the representative or the nominee, should be made aware of their legal responsibilities as employers. CCGs should ensure that individuals are fully aware of their responsibilities, and of any potential risks and should be supported to manage them (see paragraphs 104 to 111).
- 148) Concern about becoming an employer should not discourage people who would otherwise be willing and able to manage a direct payment. People should be informed of the local support available in relation to being an employer and the different options in relation to taking on staff, such as use of agencies. This should be done accurately and responsibly, making recipients aware of what is involved without overstating the extent and complexity of these responsibilities.
- 149) There will also be costs associated with employing a member of staff directly, such as National Insurance, training, insurance costs and emergency cover. When setting the budget and agreeing the care plan, CCGs should ensure that the full cost of

⁴⁹ <http://www.skillsforcare.org.uk/Employing-your-own-care-and-support/Support-for-individual-employers/Employing-personal-assistants-toolkit.aspx>

employing someone is included, and people must not be expected to bear any of these costs themselves.

- 150) As one of a range of support services, individuals or CCGs may wish to include payroll services, which will take responsibility for administering wages, tax and National Insurance for direct payment recipients. If it is agreed that this should be paid for via the direct payment, the cost should be factored in when setting the budget.

Paying family carers

- 151) A direct payment can only be used to pay an individual living in the same household, a close family member (see Box 3 for a definition of a 'close family member') or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the person receiving care's need for that service; or to promote the welfare of a child for whom direct payments are being made. CCGs will need to make these judgements on a case by case basis.
- 152) These restrictions are not intended to prevent people from using their direct payments to employ a live-in personal assistant, provided that person is not someone who would usually be excluded by the regulations. The restriction applies where the relationship between the two people is primarily personal rather than contractual, for example if the people concerned would be living together in any case.

Box 3: Who is a close family member?

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

- a. the spouse or civil partner of the person receiving care;
- b. someone who lives with the person as if their spouse or civil partner;
- c. their parent or parent-in-law;
- d. their son or daughter;
- e. son-in-law or daughter-in-law;
- f. stepson or stepdaughter;
- g. brother or sister;
- h. aunt or uncle;
- i. grandparent; or
- j. the spouse or civil partners of (c)-(i), or someone who lives with them as if their spouse or civil partner.

Safeguarding and employment

- 153) When deciding whether or not to employ someone, people 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.
- 154) CCGs should ensure that there is readily available advice and accessible services in relation to the provision of DBS checks for individual employers.
- 155) 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 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 care⁵⁰.

156) 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.

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

158) 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.

159) 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.

⁵⁰ These are examples of regulated activity relating to vulnerable adults and children within the meaning of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006 ("regulated activity"). An enhanced Disclosure and Barring Service check including a barred list check may be obtained to assess a person's suitability to engage in regulated activity. Refer to sections 113B, 113BA and 113BB of the Police Act 1997 (c.50) and S.I. 2002/233 and 2009/1882.

Box 4: Advice about employing someone using direct payments

When giving information to people about employing someone using direct payments, it may be helpful to suggest that they should:

- make a list of the things they want to ask a potential employee;
- be suitably cautious. If they have any doubts about the individual, do not employ them;
- always ask for two written references and check them carefully – following up with a telephone call is often advisable;
- ask all the questions that are important to them, for example about smoking and eating habits or what their hobbies are. If they are employing someone to look after their child, they need to find out where the child might be taken, and any other individuals the child might have contact with when being cared for;
- get a friend, parent or someone they trust to spend some time with them and their new personal assistant initially;
- make sure that the person they employ has their support and welfare, or that of their child, as their priority;
- if they are unhappy with the person caring for them, seek advice and try to find someone else to employ in their place.

In addition, when employing someone to look after a child, or where the employer is a 16 or 17 year old, it may be helpful to suggest:

- if the person is eligible for a Disclosure and Barring Service check it should include a check of the children's barred list;
- they should take notes and listen to everything that their child is communicating about the care they receive. Especially with non-verbal children, take note of unusual or regressive behaviour;
- try to spend time ensuring that their child is able to settle with the new person;

- do not employ someone under the age of 16 to undertake a paid caring role as people under 16 are unlikely to be sufficiently mature to take on such a responsibility; and
- information about the risk of child maltreatment should be clear and straightforward without unnecessarily raising anxieties.

More information is available from *A parent's guide to direct payments*.⁵¹

In the case of a representative employing someone on behalf of an adult who lacks capacity:

- If the potential employee is eligible (see paragraphs 153-159 above) for a DBS check then a decision should be taken about whether it is in the best interests of the adult who lacks capacity to ask the potential employee to apply for a check. As far as is reasonably practicable, take note and listen to everything that the person lacking capacity is communicating about the care they receive. Consult family members, friends and carers who might have particular experience of communicating with the person.
- Anyone who thinks that someone might be abusing a vulnerable adult who lacks capacity should contact their local council or the Office of the Public Guardian or seek advice through the Community Legal Service or the Police.

Indemnity

160) Direct payments for healthcare 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 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

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A parent's guide to direct payments at <http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00321/DN>: This document has been archived now

found in the 'Personal assistants: Delegation training and accountability' document in the toolkit.

- 161) 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.
- 162) Providers of some services may need to conform with prospective legislation which will implement the Finlay Scott Recommendations (June 2010)⁵² on indemnity cover and Article 4(2)(d) of Directive 2011/24/EC⁵³. We will provide further guidance on what this covers in due course⁵⁴.
- 163) PAs employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover if practising unless they are a member of a regulated health profession (see Box 4), even if carrying out activities which might otherwise be performed by health professionals. 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.
- 164) The person buying services needs to be aware of whether the provider needs to comply with prospective legislation discussed in paragraph 162. 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.
- 165) 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

⁵² <https://www.gov.uk/government/publications/independent-review-of-the-requirement-to-have-insurance-or-indemnity-as-a-condition-of-registration-as-a-healthcare-professional>

⁵³ Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare -OJ L 88, 4.4.2011

⁵⁴ This will be available in the toolkit.

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.

- 166) If the person buying the service asks the CCG to undertake these checks on their behalf, the CCG must do so. CCGs 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.
- 167) Regardless of who carries out the initial check, the CCG should review this as part of the first review, to ensure the checks have been made and are appropriate.

Registration and regulated activities

- 168) If someone wishes to buy a service which is a regulated activity⁵⁵ 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.⁵⁶
- 169) If a person employs a care worker directly, without the involvement of an agency or employer, the employee does not need to register with CQC. CQC guidance makes it clear that where a person, or a related third party on their behalf, makes their own arrangement for nursing care or personal care, and the nurse or carer works directly for them and under their control without an agency or employer involved in managing or directing the care provided, the nurse or carer does not need to register with the CQC for that regulated activity. 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.

⁵⁵ The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, S.I 2010/781

⁵⁶ <http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/regulated-activities>

- d. A trust established for the purpose of providing services to meet the health or social care needs of a named individual.
- 170) 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.
- 171) 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.
- 172) If someone wishes to use a direct payment to purchase a service which is not a regulated activity, they may do so.
- 173) 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.
- 174) 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 to 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.
- 175) 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. However, 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.

Box 5: Which are the statutory regulatory bodies?

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

Monitoring and Review

Monitoring and reviewing direct payments

- 176) It is essential to check at appropriate intervals how the direct payment is being used, the health condition of the person and, whether the care plan is achieving the agreed outcomes. This forms part of the duties of the care coordinator. It should be ongoing, and worked into best practice and local processes around delivering care.
- 177) Reviews that focus on outcomes rather than processes can be the most effective way of identifying what works well and what doesn't work well for the person. Depending on what is agreed at the review, changes can be made to the resources, support or controls described in the care plan. Reviews are a crucial part of personal health budgets and of safeguarding, and need to be carried out effectively. The ultimate aim of review is to strengthen the person's ability to achieve the outcomes they want.
- 178) Reviews should be proportionate to the person's circumstances, and should place as few burdens on people receiving care, representatives and nominees as possible. Some people will need more frequent monitoring and detailed review than others for example; people who lack mental capacity, are particularly isolated or have a degenerative or fluctuating condition or where other particular risks are identified at care planning that need regular monitoring. CCGs should consider working with local authorities, or other statutory services, to develop joint approaches to reviews, in order to minimise duplication and to reduce the burden on individuals.
- 179) As a minimum, all care plans must be reviewed formally within three months of the person first receiving a direct payment. Following this, reviews should be at appropriate intervals, but at least yearly. A review should consider:
- whether the care plan adequately addresses the health needs of the person, and whether the agreed outcomes are being met. This includes considering whether their health needs have changed, and if so whether the care plan is still appropriate;
 - whether the direct payment has been used effectively;
 - whether the direct payment is sufficient to cover the full cost of each of the services;

- whether the person, or their representative or nominee, has used the direct payment appropriately and fulfilled their obligations, including where relevant their obligations as an employer to pay employment tax and National Insurance;
- whether the risks have changed, and whether the risk management is still effective;
- if it is the first review, or if a service has been changed, reassesses indemnity and registration; and
- if the person lacks capacity or is vulnerable CCGs should consider safeguarding and also whether their liberty is being promoted by the care plan.

180) When carrying out a review, the CCG may:

- re-assess the health needs of the person;
- consult anyone mentioned in paragraph 55, and where relevant paragraph 79;
- review receipts, bank statements and other information relating to the use of direct payments; and
- consider evidence around whether direct payments have been effectively managed, including evidence as to whether service providers have or had appropriate indemnity and registration.

181) During the care planning discussion, there should be discussion about what the review will look at, and the information that will need to be provided by the person, the representative or the nominee. This information must be:

- legible;
- accompanied with authorisation for the CCG to make copies or take extracts;
- 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 person has been unable to provide.

- 182) If a CCG becomes aware, or is notified, that the health of the person has changed significantly, the CCG must consider whether it is appropriate to carry out a review of the care plan to ensure the individual's needs are still being met.
- 183) If the CCG becomes aware, or is notified that the direct payment has been insufficient to purchase the services agreed in the care plan, they must carry out a review as soon as possible.
- 184) The person, the representative or nominee may request that the CCG undertakes a review at any time. If this happens, the CCG must decide whether or not to undertake this review, taking into account local practices and circumstances.
- 185) Following a review, the CCG may:
- amend the care plan;
 - decide to pay the direct payment to the person receiving care, rather than the representative or nominee;
 - decide to pay the direct payment to a representative or nominee rather than the person;
 - increase, maintain or reduce the size of the direct payment;
 - require that a direct payment is not used to purchase a service from a particular individual;
 - require that the person, representative or nominee provide additional information; and
 - take any other action the CCG considers appropriate. This should normally be to ensure the safe and effective running of the direct payment or care plan, or to protect public money if there is a significant risk of abuse.

Complaints

- 186) In addition to informing an individual of their right to request that a CCG reconsiders a decision it has made in relation to a direct payment, as part of the

discussion around the care plan, there should be a discussion around how people can make complaints if something goes wrong.

- 187) The NHS complaints procedure will continue to apply to any decision made by the CCG. CCGs should ensure that people are aware of the process for accessing that procedure.
- 188) For complaints relating to providers, people will need to use the provider's complaints procedure. A complaints process is a requirement for services registered with CQC, and people should contact the provider to explore how to use that process. CCGs should consider how best to support people who wish to make a complaint about their provider, and may wish to work with both parties to resolve disputes.
- 189) In some circumstances, providers will not have a complaints procedure (for example, if they are a small organisation that is not registered with CQC). This should not necessarily be a barrier for people to purchase services from them, though the implications should be discussed as part of the discussion around risk.
- 190) The Health Service Ombudsman can also investigate complaints about any service purchased by a direct payment that is referred to them. The CCG should ensure that if someone has a complaint and wishes to escalate it to the Ombudsman, they should be informed of how to do so. Generally, other mechanisms to resolve complaints should be explored and exhausted before appealing to the Ombudsman. The Ombudsman will be concerned to ensure that the actions of CCGs and providers are reasonable, and CCGs should ensure that proper records of all decisions are kept, including explanations for those decisions.
- 191) If an individual stops an employee from providing care (e.g. personal care or healthcare), because they have caused harm to that person, the individual can refer that person to the DBS. The DBS can then make a decision about whether that person should be barred from working with adults or children. There is information on making referrals on the DBS webpages⁵⁷.

⁵⁷ <https://www.gov.uk/government/organisations/disclosure-and-barring-service/about>

Annex A- Persons excluded from direct payments

A person is unable to receive a direct payment if they are:

- a. subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003 (drug rehabilitation requirement)⁵⁸, imposed by a community order within the meaning of section 177 (community orders) of that Act,⁵⁹ or by a suspended sentence of imprisonment within the meaning of section 189 of that Act (suspended sentences of imprisonment)⁶⁰;
- 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)⁶¹, 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)⁶² 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)⁶³;
- 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)⁶⁴;

⁵⁸ 2003 c. 44. Section 209 was amended by paragraph 88 of Schedule 4 to the Criminal Justice and Immigration Act 2008 (c. 4) and by S.I. 2008/912

⁵⁹ Section 177 was amended by paragraph 82 of Part 1 of Schedule 4 to the Criminal Justice and Immigration Act 2008 (c. 4).

⁶⁰ Section 189 was amended by S.I. 2005/643.

⁶¹ 1991 c. 53.

⁶² 1997 c. 43.

⁶³ 2000 c. 6. Sections 41 and 51 were repealed, with savings, by Schedule 37 to the Criminal Justice Act 2003 (c. 44) ("the 2003 Act").

⁶⁴ Section 52 was repealed, with savings, by Schedule 37 to the 2003 Act.

- 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 2008⁶⁵ (“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)⁶⁶; or
- 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.)⁶⁷ 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)⁶⁸ and subject to a condition that they submit to treatment for their drug or alcohol dependency.

⁶⁵ 2008 c. 4

⁶⁶ 1995 c. 46 Section 228 was amended by paragraph 21 of Schedule 1 to the Crime and Punishment (Scotland) Act 1997 (c.48), by paragraph 1 of Schedule 6 to the Crime and Disorder Act 1998 (c.37) by paragraph 122 of Schedule 7 to the Criminal Justice and Court Services Act 2000(c.43), by sections 42(11) and 89 of the Criminal Justice (Scotland) Act 2003 (asp 7) and by S.I. 1998/2327, S.I. 2001/919, S.I. 2001/1149, S.I. 2003/288 and S.I. 2008/912. Section 229 was amended by section 49(4) of the Criminal Proceedings etc. (Reform) (Scotland) Act 2007 (asp 6). Section 229A was inserted by sections 12(2) and 24 of the Management of Offenders etc (Scotland) Act 2005 (asp 14) (“MOSA”) and amended by S.S.I. 2006/48. Section 230 was amended by Schedule 6 to the Adults with Incapacity (Scotland) Act 2000 (asp 4), by sections 135, 331 and 333 and paragraph 8 of Schedule 4 and Part 1 of Schedule 5 to the Mental Health (Care and Treatment) Scotland Act 2003 (asp 13) and by S.S.I. 2005/161 and S.I. 2009/1182. Section 234B was inserted by section 89 of the Crime and Disorder Act 1998 and amended by S.I. 1998/2327.

⁶⁷ 1989 c.45. Sections 22 and 26 were repealed, with savings, by Schedule 7 to the Prisoners and Criminal Proceedings (Scotland) Act 1993 (c.9).

⁶⁸ 1993 c.9. Section 1 was amended by paragraph 98 of Schedule 8 to the Crime and Disorder Act 1998, by section 1(2) of the Convention Rights (Compliance) (Scotland) Act 2001 (asp 7) and by section 15(2) of MOSA. Section 1AA was inserted by section 15(3) of MOSA.

Annex B- Useful references

General

The personal health budget toolkit contains a range of best practice, people's stories and other useful information gathered during the pilot programme. It will continue to evolve and develop as our understanding of how best to implement personal health budgets grows. The toolkit can be found at www.personalhealthbudgets.england.nhs.uk.

Details of the independent evaluation of the personal health budget pilot programme can be found at <https://www.phbe.org.uk/>.

Legislation and Statutory Instruments

National Health Service (Direct Payments) Regulations 2013	http://www.legislation.gov.uk/uksi/2013/1617/pdfs/uk_si_20131617_en.pdf
The National Health Service (Direct Payments) (Amendment) Regulations 2013	http://www.legislation.gov.uk/uksi/2013/2354/pdfs/uk_si_20132354_en.pdf
Mental Capacity Act (2005) (c.9)	http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1
Safeguarding Vulnerable Groups Act 2006 (c. 47) as amended by the Protection of Freedoms Act 2012 (c. 9)	http://www.legislation.gov.uk/ukpga/2006/47/contents As amended by http://www.legislation.gov.uk/ukpga/2012/9/contents