Nottingham and Nottinghamshire
Clinical Commissioning Group

Personal Health Budgets and Integrated Personal Budgets Guidance

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The NHS in this guidance applies to the Nottingham and Nottinghamshire Clinical Commissioning Group (referred to hereafter as 'the CCG').

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1 Introduction

This guidance is relevant in all cases where people have a right to have a personal health budget, or where a personal health budget is being offered as part of the CCG's local offer or health and social care are working together to provide an integrated personal budget.

The aim is to ensure that a consistent and transparent approach is applied to the allocation, approval and review of all budgets.

The guidance outlines the national and local context for Personal Health Budgets and Integrated Personal Health Budgets (hereafter referred to as 'budgets). It details the CCG's process for the allocation, implementation and operation of budgets, along with the responsibilities of the parties involved: what the different types of budgets are; who can have a budget; how it can be managed and used; what it cannot be spent on; how to set up a budget, outlining the six stages and key features of a budget. It includes a section on care and support planning, as this is an essential step in offering good quality budgets and personalised care, following the eight step process to develop outcomes. Along with the criteria that should be followed for managers and panels to approve plans.

The guidance provides detailed information on different elements of budgets: employing personal assistants and delegation of healthcare tasks; direct payments, including financial monitoring and review of direct payments.

This guidance should be used alongside the standard operating procedures and processes and systems for every area where personal health budgets are offered.

2 National and Local Context

2.1 National Context

Personalised Care has a strong presence in the NHS Long Term Plan as it is seen as a delivery model that will support the transformation of the NHS. Chapter 1: A new service model for the 21st century of the NHS 10 year plan sets out five major, practical changes to the NHS service model to bring about the change over the next five years, which includes:

"We will roll out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade". (1.39)

This shift will be delivered by bringing together the six evidence-based components of the Comprehensive Model for Universal Personalised Care to transform 2.5 million lives by 2023/24. The model establishes:

- Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience and make informed decisions and choices when their health changes.
- A proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health conditions.
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive.

Each of the six elements is defined by a standard model:

- Shared decision making
- Care and support planning*
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets*

(*covered in this guidance).

The key commitments of NHSE are that 200,000 people will have Personal health budgets so they can control their own care, improve their health experiences and experience better value for money services over a "one size fits all" approach.

2.2 Local Context

The Integrated Care System (ICS) is committed to delivering Personalised Care, establishing a programme responsible for the coordinated delivery of the NHSE Model across Nottingham and Nottinghamshire. The Programme's vision is to maximise independence, good health and wellbeing throughout our lives, shifting the focus from 'what is wrong with you?' to ***'what matters to you?'***

The ICS was a Demonstrator site for the Comprehensive Model of Personalised Care, signing a Memorandum of Understanding (MOU) for 2019/20 to deliver Personalised Care at scale across the footprint in order to achieve the scale committed to in the NHS Long Term Plan. From April 2020, the ICS continues with the commitment, signing a further MOU, with clear trajectories to achieve scale up of the model which include increasing the number of personal health budgets.

ICS foundation commitments	2020-21	2021-22	2022-23
Promote and offer personal health budgets for people with a legal right to have a personal health budget and in priority local cohorts (as identified in the ICS LTP local implementation plan).	4,350	5,800	7,250

3 Budgets

3.1 What is a Personal Health Budget (PHB)?

A PHB is not new money, but rather enables people to use NHS funding in different ways, in ways that work for them. Personal health budgets are a way of personalising care, based around what matters to people and their individual strengths and needs. They give people with long term health conditions and disabilities more choice, control and flexibility over their healthcare.

A personal health budget may be used for a range of things to meet agreed health and wellbeing outcomes. This can include therapies, personal care and equipment. There are some restrictions in how the budget can be spent.

3.2 What is an Integrated Personal Budget (IPB)?

An integrated personal budget is a joint funded package of health and social care.

An integrated personal budget is where the budget includes funding from both the local authority and the NHS. This could be for health and social care needs and where appropriate, includes education funding. Integrated personal budgets aim to put in place a seamless approach to care, so that people and their families have the same experience of care and support, regardless of whether their care is funded by the local authority or the NHS.

3.3 What is a Personal Budget?

This is a budget that is funded by the local authority for individuals eligible for care and support under the Care Act 2014. This guidance does not cover personal budgets, but is referenced in this section to provide a definition of the three different types of budgets available.

3.4 Who can have a PHB or IPB?

If someone is interested in a personal health budget for themselves or someone they care for, they should talk to the local NHS team or health professional who helps them most often with their care – this might be a care manager or a GP. Certain

groups of people have a legal right to a personal health budget, outlined in the Right to have Guidance (December 2019). All areas across England are expected to offer personal health budgets to additional groups of people, based on local need, including people with a learning disability and/or autism.

Decisions about who can have a personal health budget outside of the legal rights are made by local Clinical Commissioning Groups (CCGs), who are responsible for paying and planning for most local health services. Every CCG should have information made publicly available about who is able to access one locally.

3.4.1 People who are eligible for NHS Continuing Healthcare

All people who are entitled to NHS Continuing Healthcare and living in their own home have a right to have a *personal health budget, and this must be the default offer.* 'NHS continuing healthcare' means a package of on-going care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in 'The National Framework for NHS CHC and NHS-funded Nursing Care'. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness.

3.4.2 People who are on Fast Track Continuing Healthcare

People on Fast Track Continuing Healthcare (CHC) can have their care organised as a personal health budget. Referrals are the means by which care packages or placements can be organised and funded promptly to support people with a rapidly deteriorating condition that may be entering a terminal phase. Clinicians should make a referral if they can demonstrate that the person meets the following criteria:

- The person has a rapidly deteriorating condition; AND
- Their condition may be entering a terminal phase.

If the person already has a personal budget in place (social care personal budget), paid as a direct payment, social care can continue to pay the direct payment on behalf of the CCG and recharge.

3.4.3 Joint Packages of Health and Social Care Services

If a person is not eligible for NHS CHC, they may receive a package of health and social care (rather than be fully funded by the NHS). In these cases, the person will have an integrated personal budget.

There will be some individuals who, although they are not entitled to NHS CHC (because 'taken as a whole' their needs are not beyond the powers of a local authority to meet), but nonetheless have some specific needs identified through the Decision Support Tool (DST) that are not of a nature that a Local Authority (LA) can

solely meet or are beyond the powers of an LA to solely meet. CCGs should work in partnership with their LA colleagues to agree their respective responsibilities in a joint package of care, including which party will take the lead commissioning role.

3.4.4 Continuing Care for Children and Young People

Some children and young people (up to their 18th birthday), may have very complex health needs. These may be the result of congenital conditions, long-term or life-limiting or life-threatening conditions, disability, or the after-effects of serious illness or injury. These needs may be so complex, that they cannot be met by the services which are routinely available from GP practices, hospitals or in the community commissioned by Clinical Commissioning Groups (CCGs) or NHS England. A package of additional health support may be needed. This additional package of care has come to be known as continuing care. After their 18th birthday they transition onto NHS CHC through the adult pathway. In these cases, often social care funding is also available, which means the person will have an integrated personal budget.

3.4.5 Section 117 Aftercare

People entitled to S117 aftercare will be joint funded by health and social care. This means that they have an integrated personal budget. As of the 2nd December 2019, people on Section 117 aftercare have a right to have an integrated personal budget. 'Aftercare' means the help the person gets when they leave hospital. People are entitled to Section 117 aftercare if they have been in hospital under Section 3, 37, 45a, 47 or 48 of the Mental Health Act 1983. The funding for this is split between NHS and the local authority and is agreed at the joint health and social care panel. Section 117 is not CHC and is managed through a separate referral process. It is a joint responsibility between the LA and the CCG. Generally the LA will lead the commissioning of the joint care package.

3.4.6 Survivors of Childhood Sexual Abuse

The CCG is working in partnership with the police and crime commissioner to provide a personal health budget for people who have been identified as survivors of childhood sexual abuse through the Independent Inquiry into Child Sexual Abuse (IICSA) and Operation Equinox.

3.4.7 Wheelchairs

A personal wheelchair budget is a resource available to support people's choice of wheelchair, either within NHS commissioned services or outside NHS commissioned services. Personal wheelchair budgets enable postural and mobility needs to be

included in wider care planning and can support people to access a wider choice of wheelchair.

Since 2 December 2019, people who access wheelchair services, whose posture and mobility needs impact their wider health and social care needs, now have a legal right to a personal wheelchair budget.

The legal right covers people who are referred and meet the eligibility criteria of their local wheelchair service, and people already registered with the wheelchair service, when they require a new wheelchair either through a change in clinical needs or in the condition of the current chair.

Further guidance is available for health and social care professionals on implementing the legal rights to personal health budgets, including personal wheelchair budgets.

More detailed information about personal wheelchair budgets is available in the frequently asked questions section. Wheelchair budgets are delivered by the locally commissioned wheelchair services:

- Nottingham City and South Nottinghamshire - Wheelchair services are delivered by the Mobility Centre based at the City Hospital on Hucknall Road.
- Mid Nottinghamshire – Wheelchair services are delivered by Ross Care based at Mansfield Clinical Assessment Centre.

3.5 How can a personal health budget be managed?

The money in a personal health budget can be managed in three ways, or a combination of these:

3.5.1 Notional Budget

The money is held by the NHS. No money changes hands. The person is informed how much money is available and is invited to talk to their local NHS team about the different ways to spend that money on meeting their individual support needs. The local NHS team will then arrange the agreed support.

3.5.2 Third Party Budget

The money is paid to an organisation that holds the money on the person's behalf. A different organisation or trust holds the money for the person and helps them to decide what they need. After the person has agreed this with their local NHS team, the organisation then buys the care and support the person has chosen. The organisation becomes the legal employer for the person.

3.5.3 Direct Payment

The money is paid to the person or their representative. The person gets the cash to buy the care and support they and their local NHS team agree is needed. The person, or their representative, has to buy and manage services themselves. More details on direct payments can be found in Section 6.

3.6 How can a Personal Health Budget be used?

A personal health budget can potentially be spent on a broader range of care and support than would routinely be commissioned by the NHS, if it is agreed as being appropriate to meet someone's identified needs. This could include funding for a personal assistant to help with personal care at home, and equipment such as a wheelchair. The CCG will not exclude unusual requests without examining the proposal on a case-by-case basis as these may have significant benefits for people's health and wellbeing. Anything agreed in a personalised care and support plan which will meet the person's identified health and wellbeing outcomes, for example:

- Equipment;
- Personal care;
- Physiotherapy;
- Complementary therapies;
- Assistive and supportive technology (e.g. computers, iPads, Kindles).

3.6.1 Adaptations

PHB's cannot be used to fund an adaptation of a person's property. The pathway for an adaptation would be firstly through social care via an application to the Disabled Facilities Grant. Where this has not been successful, the person should look at charitable/grant giving organisations. If after this the person still requires an adaptation then the CCG will examine the proposal on a case-by-case basis as these may have significant benefits for people's health and wellbeing.

3.6.2 Equipment

The pathway for standard equipment requests should be made through the Integrated Community Equipment Lending Service (ICELS). All equipment requests are made following an Occupational Therapy assessment. The CCG panel will approve the request and this is then ordered and delivered via ICELS. Where a specialist piece of equipment that is not available through ICLES, but is still required to meet a person's health need, then a request should be made via the CHC Team to the CCG. The CCG will not exclude unusual requests without examining the

proposal on a case-by-case basis as these may have significant benefits for people's health and wellbeing, improve outcomes and increase their independence.

3.6.3 Holidays

PHB's cannot be used to fund a person's and/or their family's holiday. Where a person wishes to go on holiday and take their employed personal assistant (PA) or staff from a commissioned provider, they must formally request this through the CHC Team to the CCG. The CCG will only normally agree to pay for the staff for the current hours of support that are already agreed in the care and support plan. The PHB will not cover the following costs:

- Flights for the person, their family or staff;
- Hire vehicles;
- Food and beverages for the person, their family or staff;
- Any other request which is not directly related to a person's health and well-being.

The PHB can:

- Cover the additional cost of carer accommodation;
- Fuel costs where a carer is expected to use their own vehicle to provide care and support to a person on their holiday. This excludes fuel costs outside of the UK.

3.6.4 Transport/Mobility Vehicles

Where a PHB includes paid support from a commissioned care provider and/or employed personal assistants, the CCG would expect that where possible, they drive the person's mobility vehicle to transport the person to any day provision or activity. If the person is in receipt of Disability Mobility Allowance, any fuel costs incurred by transporting a person to and from a day provision or any other activity should be paid for using their benefits. However, the CCG understands that depending on the provision and location in the county the funds may not be adequate to cover the transport costs incurred. In these circumstances and with the evidence of it being value for money, the CCG will consider paying the mileage and or petrol costs.

The budget cannot be used to contribute towards the purchase of a mobility vehicle unless there are exceptional circumstances that can be evidenced, where this would achieve a person's outcomes and evidence value for money.

3.6.5 Memberships and Subscriptions

Memberships and subscriptions will be considered, if evidence is provided on how becoming a member of a gym, for example, will support someone to meet their outcomes. However, it will only be approved on a yearly basis and renewal of the membership or subscription will only be considered as part of the annual review.

3.7 What a Personal Health Budget cannot be spent on?

There are a small number of exclusions that are outlined in regulations.

A personal health budget cannot be used to buy:

- Alcohol, tobacco, gambling or debt repayment, or anything that is illegal. There are restrictions on employing friends and close family members living in the same home.
- Emergency care – for example if someone in receipt of a personal health budget had an accident, they would go to A&E like everyone else.
- Primary care services such as seeing a GP services (GP contract).
- Acute unplanned care (including A&E).
- Surgical procedures.
- Medication.
- NHS charges e.g. prescription charges.
- Vaccination/immunisation.
- Screening.

4 Setting up a Personal Health Budget

4.1 What are the key features?

The person with a personal health budget (or their representative) should:

- ➢ Be central in developing their care and support plan and agree who is involved.
- ➢ Be able to agree the health and wellbeing outcomes* they want to achieve, together with relevant health, education and social care professionals.
- ➢ Get an upfront indication of how much money they have available for healthcare and support.

- Have enough money in the budget to meet the health and wellbeing needs and outcomes* agreed in the care and support plan.
- Have the option to manage the money as a direct payment, a notional budget, a third party budget or a mix of these approaches.
- Be able to use the money to meet their outcomes in ways and at times that make sense to them, as agreed in their care and support plan.

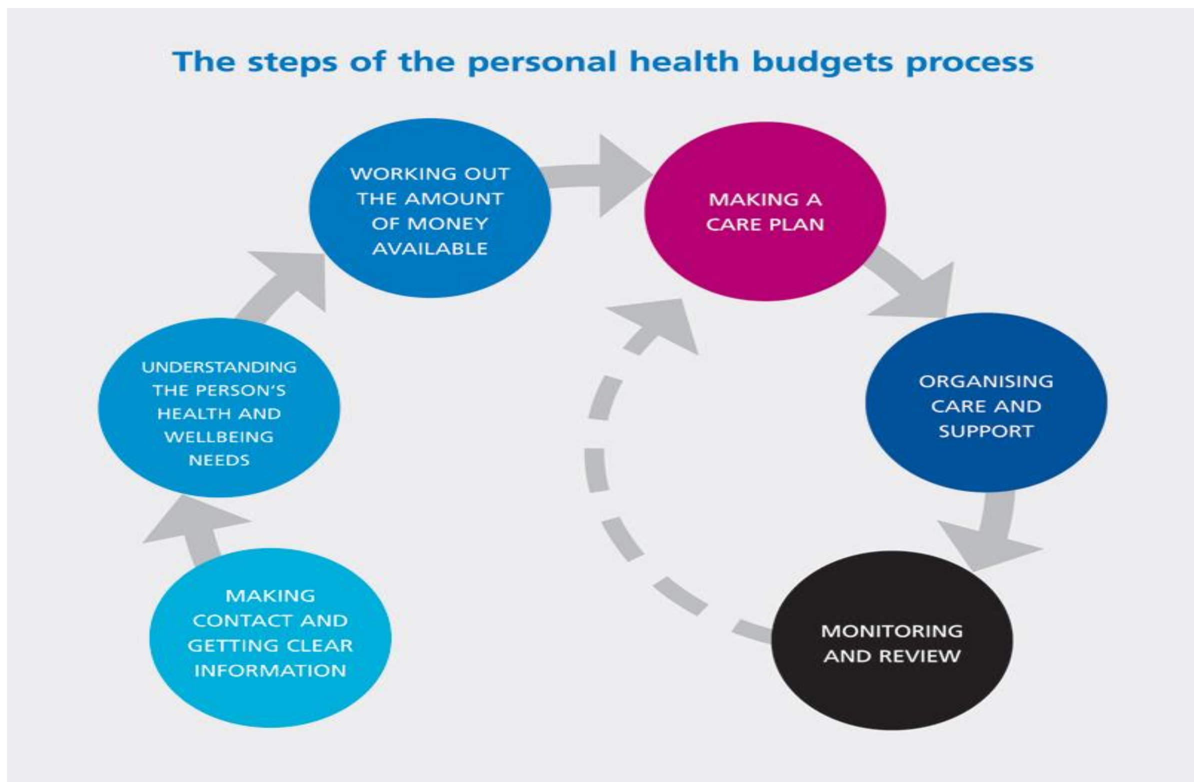
*and learning outcomes for children and young people with education, health and care plans.

4.2 What are the steps of the process?

There are six main stages that need to be followed in setting up a budget:

1. Making contact and getting clear information: a good quality personal health budget begins by helping the person understand that process and providing information to help them understand it.
2. Assessment: Completing the relevant assessment to understand the person's health and wellbeing needs. A PHB can be used to meet health needs that have been identified in the relevant assessment and the indicative budget is calculated based on the level of needs; for more details in the relevant section of this guidance.
3. Setting an Indicative Budget: Working out the amount of money available – allocating an indicative budget. As above the setting of an indicative budget varies depending on the initial assessment and what health and wellbeing needs the personal health budget is being used to meet. See the relevant section for more details. The CCG needs to ensure that the indicative budget is a reasonable amount within which the person's needs can be met.
4. Making a care and support plan: This is an essential step in the offer of a good quality PHB and is expanded on in Section 5. The care and support plan is a partnership between the person and the NHS. Before the care and support can be organised it has to be approved by the CCG. This is to ensure it is lawful; effective; appropriate and represents value for money.
5. Organising the care and support: once the care and support outcomes and how they are going to be met and plan is approved by the CCG, the next step is to get arrange it. The level of organization required depends on which option of a personal health budget has been chosen: notional; third party or direct payment.
6. Monitoring and Review: once the care and support is in place it should be reviewed at 3 months and at least annually. This is done with a review of the care and support plan. The aim is to ensure the care and support plan is current, it is working, and continues to achieve their outcomes. Areas that are

not working should be recorded and alternatives considered. It is an opportunity to consider how they want to meet their outcomes and people may want to have more choice and control by changing from a notional to a third party budget.



5 Care and Support Planning

5.1 How to complete a care and support plan

A care and support plan brings together aspirations, goals and outcomes for a person and outlines how an indicative budget might be used to meet them. It is a responsive process, showing how a person and their carer(s) would like their assessed needs to be met. In general the person will complete the care and support plan, but if this is not possible it can be completed with the assistance of family, other interested parties, carers, advocates, NHS or social care staff.

The key characteristic of a care and support plan is that the person has ownership of the plan and it is developed in partnership with the person and NHS team; both parties need to agree to the plan wherever possible.

Every person's care and support plan should identify:

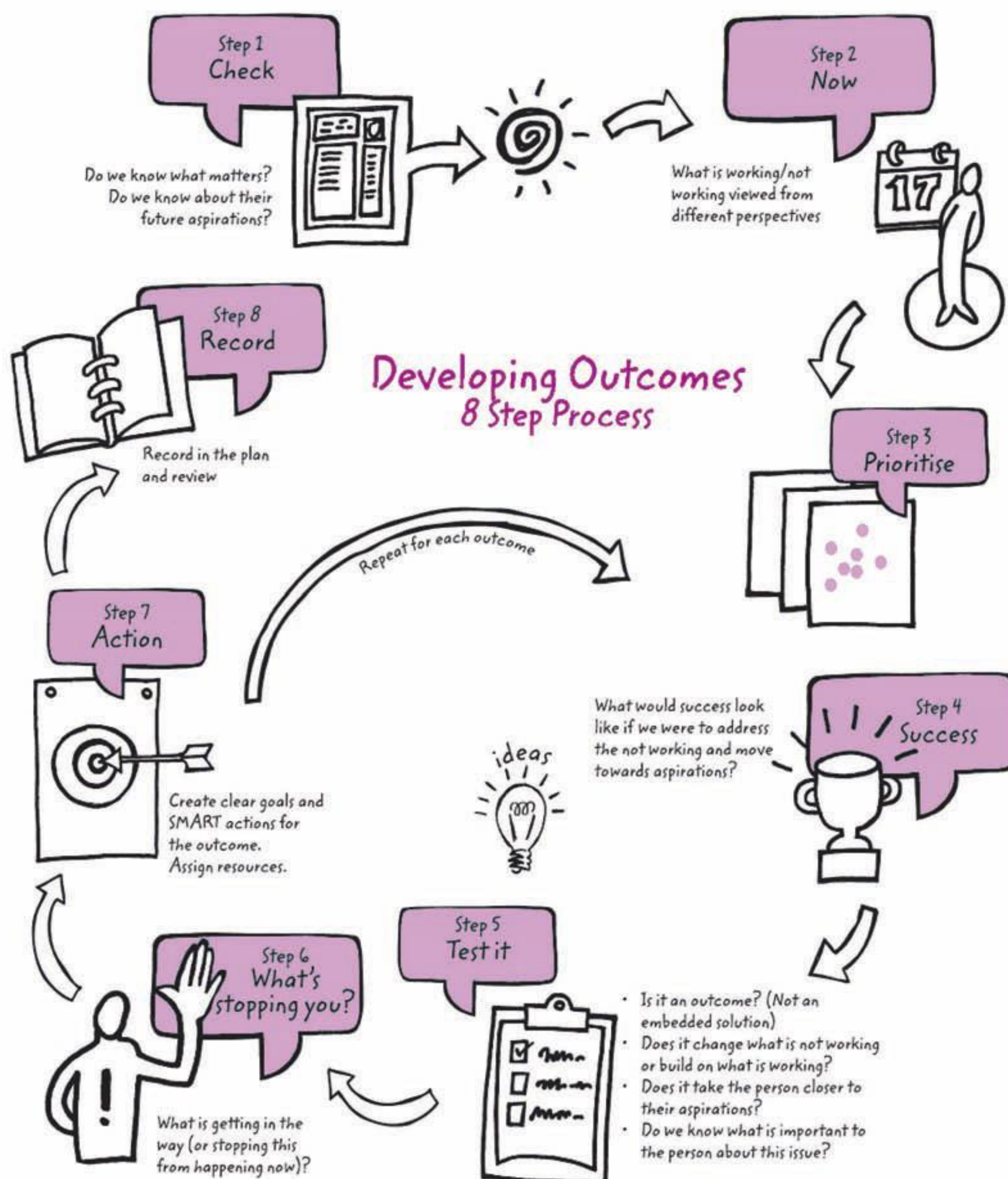
a. Who they are;
b. What they would like to achieve;
c. What things they would like to change or keep the same;
d. Their support needs and priorities;
e. How they intend to meet their assessed needs and support goals using their PHB;
f. What support they need to keep healthy and safe;
g. How they will spend the budget.

Each care and support plan will have the following essential features:

h. Is proportionate to the level of need of the person;
i. Outlines the assessed needs, goals and priorities of the person;
j. The plan is well balanced with the highest needs receiving priority;
k. Details the combination of formal and informal support that will meet the assessed needs of the person and help achieve their outcomes;
l. Shows that universal services, assistive technology and 'free' community resources have been utilised where appropriate;
m. Where applicable other relevant public funding sources including Local Authority provision have been accessed in conjunction with the PHB;
n. Takes account of the views and needs of carers;
o. Is adaptable and flexible, so persons can revise their plans as they learn what works best for them or as their circumstances change.

5.2 How to Develop Outcomes - The 8 Step Process

A straightforward explanation of an outcome is that it is an 'end result' or 'end effect' (concrete or abstract). At an individual level, a good outcome means the benefit or positive difference (end result/end effect) that support can bring to the quality of someone's life, as defined by the individual. For example, as a result of a carer providing a person with support they are able to wash. The outcome is that the person can have a wash. The graphic below provides a useful guide to the process to follow to develop outcomes.



5.3 Assessing Risks

During care and support planning, the person will be supported to undertake a risk assessment to identify how any risks arising from their needs or proposed support will be addressed. Provided the risks are clearly identified and addressed in the care and support plan, the plan will be considered. If, following the care and support planning process any risks remain unresolved, attempts should be made to resolve these as part of the approval process.

A person who has the mental capacity to make a decision, and chooses voluntarily to live with a level of risk, is entitled to do so.

However, the CCG remains accountable for the proper use of public funds and whilst the person is entitled to accept a degree of risk, the NHS is not obliged to fund it. As a commissioner of services, the CCG could be liable if it places people in a position in which they are exposed to risk. There is an important distinction between enabling people to choose to take a reasonable risk and putting people at risk. In such cases, the approval process will provide the means to consider the issue and find the correct balance.

5.4 Approval of the care and support plan and budget

A plan and budget must be sent to the relevant CCG manager or panel to be approved. In order to be approved, it will need to meet the following guidelines:

5.4.1 Lawful

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

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

a. The care and support plan will fulfil the CCG's statutory duty to meet the persons assessed, eligible needs.

b. The measures proposed in the care and support plan must in all cases be lawful.

c. In line with the Mental Capacity Act 2005, if the person appears to lack capacity, the care and support plan must make clear the best interest decision and how their wishes have been ascertained and incorporated into the care and support plan.

d. The person must be made aware of any legal responsibilities they will incur as a result of measures proposed in the care and support plan (e.g. employment law, health and safety).

e. Any service providers identified in the plan must meet applicable regulatory requirements.

f. The person and carers must receive guidance on any health and safety issues or regulatory requirements in relation to any equipment to be used or any adaptations to their home.

It must not include:

g. The purchase of primary medical services provided by GPs, such as diagnostic tests, basic medical treatment or vaccinations.

h. Urgent or emergency treatment services, such as unplanned in-person admissions to hospital.
i. To pay a close family carer living in the same household except in circumstances when *‘it is necessary to meet satisfactorily the person’s need for that service; or to promote the welfare of a person who is a child’.*
j. The employment of people in ways which breach national employment regulation.

5.4.2 Effective

The proposals must make effective use of the funds and resources available in accordance with the principle of best value.

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

a. The care and support plan meets all the assessed eligible needs.
b. The proposed measures will be effective in supporting the person’s independence, health and wellbeing.
c. The proposals represent the most effective use of the resources and funds available.
d. A risk assessment has been carried out and any risks identified in the plan have been addressed.
e. The care and support plan includes measures to address outcomes that will help the person develop their independence or independent living skills and will enhance their health and wellbeing.
f. Where there is a carer, the carer’s needs have been assessed and the proposals take account of their needs too.
g. A clinical decision does not need to be made at the point the person decides to use their budget for therapy. The clinical decision will be made by the psychologist or psychotherapist they want to refer themselves to, following an assessment.
h. The CCG cannot recommend individual therapists, but the therapists must be registered with one of the following BACP/UKCP/HCPC.

5.4.3 Affordable

In deciding whether the care and support plan is affordable it must show that:

a. The care and support plan is within the indicative budget or, if the indicative budget is exceeded, a clear and reasoned explanation is provided to justify the additional spend.

b. In the case of care and support plans that exceed the indicative budget, the plan is thoroughly checked by commissioners before being sourced to ensure best value.

c. All relevant sources of funding have been identified and utilised: the use of universal services; community resources; informal support and assistive technology has been explored.

d. All costs have been identified and fall within the indicative budget allocated and can be realistically met.

e. A suitable contingency amount is included within the care and support plan.

f. The proposals represent the most effective use of the resources and funds available.

g. The care and support plan meets the assessed, eligible needs in the most cost effective way possible.

h. Where the care and support plan requires a budget that is lower than the indicative budget, the lower budget will be approved.

i. The value of the budget does not exceed the value of commissioned services.

The care and support plan's cost is not substantially disproportionate to the potential benefit.

"*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."* [1]

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[1] Para 101: Guidance on direct payments for Healthcare: Understanding the regulations

5.4.4 Appropriate

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

5.4.5 Approval, partial approval or not approved

The care and support plan will be approved, partially approved or not approved, in line with these requirements. The approver should complete a care and support plan approval form to record all the relevant information about the quality of the care and support plan and give a clear reason and rationale for the reasons and outlining what further development is needed before the care and support plan can be re-submitted for approval.

If only one element of a care and support plan can be approved, the CCG will approve the care and support plan with that specific exception, which will then be explored separately with the person. In the interim, the budget can be set up at a level to meet the approved part of the plan.

Once approved, the relevant worker will provide advice, guidance and support to the person to secure the support required to deliver the care outlined within the care and support plan.

5.5 Escalation of decisions

If the issue cannot be resolved, the care and support plan will be considered by a senior manager in the CCG or it will be taken to the CCG high cost and contentious panel for a decision. The high cost panel considers any decisions that are exceptional and all decisions that incur a cost of over £3,000 per week.

Circumstances where the plan and budget is less than £3,000 but may need to be escalated are:

a. The care and support plan is likely to be ineffective.

b. There are unmet assessed eligible needs.

c. There are unmet carer’s needs.

d. The proposals do not represent best value.

e. The care and support plan exceeds the indicative personal health budget by 10%, which is above the level that the commissioning team has authority to agree.

f. The person may lack capacity and there is cause to doubt that this has been properly addressed in the care and support plan and/or concern that the person does not have the capacity to consent to decisions regarding the potential risk.

g. The care and support plan or the risk assessment identifies a risk to the CCG.

h. The risks to the person are such that they cannot be resolved through care and support planning.

i. The plan has risks that could endanger third parties.

j. There is a risk of political or reputational damage to the CCG.

k. There is reason to suspect actual or potential fraud.

l. There are risks relating to the availability or suitability of services or facilities.

m. There are risks relating to wider organisational issues (i.e. not specific to the person or their care and support plan), including potential service failure, financial or budgetary risks that cannot be resolved through the normal approval process.

If the person is unhappy with their NHS services in relation to the care and support plan and PHB, as with any other NHS service they can make a complaint, a compliment, a question, comment or suggestion. This can be made directly to the provider supporting them with the care and support plan and budget, following their procedure. If the person wants to provide feedback to the CCG, rather than directly to the provider they can do this by contacting the CCG's Patient Experience Team.

5.6 Reviewing the plan and budget

A review of the care and support plan must be competed three months from the start date and then at least annually. Ideally, the annual review will be combined with the overall review of the assessment. At this point, the person needs to understand all their options in how the PHB can be used to meet their needs and achieve outcomes.

The review needs to be documented on 'Review of the care and support plan' paperwork. It is not acceptable to simply put updates into the current plan. The review of the care and support plan should provide the one version of the truth on that date; reflect the current circumstances, outcomes and how they are being met and clearly state what is being organised in the present with an accurate breakdown of all the costs.

At a review of the care and support plan, all the guidance in relation to the care and support plan and approval need to be followed. The review should be proportionate to the person and their situation and should include:

- What is working or not working for the person?
- Have the outcomes been achieved?
- Has anything changed significantly since the last review?
- Is the PHB enabling the person to meet the needs and outcomes identified in the plan?
- Is the care agency providing the care that the CCG originally commissioned, are there any concerns about the quality?
- Ensure that the person understands and is provided with information on their options in how they use the budget to achieve their outcomes; notional; third party or a direct payment.

In addition, in the case of a direct payment it should include:

- How has the direct payment been spent?
- Are there any concerns from the financial monitoring? (See Section 7 for details).

The review of the care and support plan needs to be approved by the CCG, in the same way as a care and support plan.

If the change is not in relation to the care and support that is in place and approved, but a financial change e.g. the increased annual cost of a provider, the support planner can add to or amend the care and support plan and PHB that has previously been approved, without a review being required. However, they are required to record an accurate breakdown of all the costs and ensure they are correct in the present and get these checked by their manager. Irrespective of whether the change involved is major or minor, the care and support plan must be looked at as a whole in order to assess the full effect of the change and identify any changes in need.

6 Direct Payments

6.1 What is a direct payment?

Direct payments are monetary payments from the CCG that are made to individuals who request them, in order to meet some or all of their health and support needs. People who take a direct payment choose and pay for their care and support services themselves. Direct payments offer an alternative to managed personal health budgets, which involve the NHS arranging and paying for the care and support services that are needed.

6.2 The requirements of having a direct payment

The requirements to have a direct payment are clearly set out in the National Health Service (Direct payments) Regulations 2013 (as amended)

The regulations must be referred to and followed. In order to have a direct payment, the person must understand the responsibilities and requirements of having a direct payment.

6.2.1 Key points

- The person has responsibility for arranging care and support in line with the agreed personalised care and support plan.
- The budget holder will be accountable for ensuring that the budget is spent in line with the personalised care and support plan.
- If a person does not wish to manage the direct payment they may nominate another person to receive the direct payment on their behalf. In these situations the nominee becomes the budget holder and is accountable for all contractual and financial aspects of managing a direct payment.
- If a person chooses to use their direct payment to directly employ personal assistants, they will become the employer and take on all the responsibilities that this entails.

6.2.2 The Direct Payment Agreement

To receive a direct payment, individuals must sign an agreement with the CCG. This agreement sets out the conditions under which direct payments can be made by the CCG and includes details of what the person and the CCG must do. The agreement reflects the CCG's policy and requires that, although people will use the direct payment to purchase and contract for services in their own right, they will do so within parameters set by the CCG to ensure that arrangements are legal and safe, and that public money is properly accounted for.

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) may also choose to nominate someone (a nominee) to hold and manage the direct payment on their behalf.

The Direct Payment Agreement will be signed by the individual where they have capacity to manage the direct payment themselves and they will take on the responsibilities set out within the Direct Payment Agreement.

In circumstances where the terms and conditions of the direct payment agreement are not met, the CCG will take reasonable steps to address the situation. In the

event that the situation remains unresolved, the CCG will consider whether the direct payment is still an appropriate way to meet the individuals assessed needs. If necessary, and subject to appropriate alternative services being put in place, the CCG will discontinue the direct payment and invoice for any money not used, where bank statements have not been provided for or misuse has been confirmed in line with the Direct Payment Agreement. If the CCG is concerned that there is a misuse of the direct payment, they must refer the case to the local NHS fraud team to investigate.

6.2.3 A Nominee

An individual with capacity can choose to have a Nominee to assist them in managing the direct payment. This person would sign the agreement as a nominated person, but the individual would still maintain responsibility for ensuring that all the conditions of the direct payment are met.

6.2.4 A Representative

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.

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 an ‘authorised person’ in social care.

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 person, e.g. to help develop care and support 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 and support 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). If a representative believes that the person for whom they are acting has regained capacity they should notify the CCG as soon as possible.

If a representative is not a close family member of the person, is 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

list 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 bills. Refer to National Health Service (Direct payments) Regulations 2013 (as amended) for further clarification.

6.2.5 A pre-paid card account

A direct payment will be paid onto a CCG pre-paid card account. The card offers choice and control as:

- Users have flexibility over how and when they pay for their support.
- It is an easy way for people to arrange and pay for their support, especially if they are house bound.
- It is a secure way for people to pay for care.
- The card balance can be checked online or via the telephone with the ability to make online payments, set up direct debits and standing orders.

The card enables the CCG to be assured that NHS public funds are spent and used appropriately, in accordance with the agreed care and support plan. It provides a portal mechanism to upload all audit paperwork and relevant documents to evidence what has been paid for, meaning all documentation is in one place. Alternatives to a pre-paid card account will only be offered in exceptional circumstances e.g. where it is not possible for a person to manage a card account.

Any services and or expenditure via a direct payment should only be made using the card through the following methods:

- BACS – so that the payment is identified on the bank statement.
- Telephone banking – payment will be identified on bank statement.

6.2.6 How much money can be held at any time

The amount that is included in a direct payment must be sufficient to meet the assessed needs that the CCG has a duty to meet. This may include an amount that is not needed on a week-by-week basis but is required to meet additional costs that arise periodically, for example to employ alternative staff, to cover for periods when regular staff are using their statutory leave entitlements. People who receive direct payments may accrue money in their direct payment accounts up to an amount that will be agreed as part of the care and support planning process. As standard, this will usually be a maximum of two weeks' direct payment monies. The CCG will recoup any funds that are in addition to this amount and are not required to meet assessed needs, in line with the care and support plan.

Any legitimate costs that cannot be paid for from the amount held in the direct payment account will normally be met through the provision of a one-off payment. Such one-off payments must be recorded in the care and support plan, which is approved by the CCG.

6.3 Using a direct payment to employ someone

PHBs enable people to have more choice and control over the care and support they receive and the ability for individuals to employ their own personal assistant is one of the biggest opportunities they present. In order to employ staff directly, the person will need to take the option of a direct payment. If they want to the flexibility and greater control, but do not want to be an employer, they can have a third party organise this on their behalf, in which case, the organisation acting as the third party is the employer.

Employing personal assistants (PA) brings with it responsibilities, as the person must follow Employment Law; such as recruitment, tax, National Insurance, paying wages and holidays, sick pay and redundancy. However, there is support available from direct payment support services and this must be included in the care and support plan.

A person needs to be supported to consider the options of employing their own staff with a direct payment, using a third party, or using a care agency with a notional budget. People need to weigh up the pros and cons, based on their individual circumstances. It is like balancing a pair of scales, will the benefits of employment, such as greater flexibility and control, outweigh the responsibilities that come with being an employer and recruiting their own staff. This is up to each budget holder and they may change their mind over time.

6.3.1 What is a personal assistant (PA)?

PAs provide care and support to people, as defined in a person's care and support plan. A PA can either be employed by the person who needs care and support or by their representative, or a third party. A PA's role will vary according on the needs and choices of each person they support, examples of what they may do are:

- Personal care, such as helping someone get washed and dressed.
- Cleaning and housework.
- Shopping.
- Preparing meals.
- Leisure and recreation activities.
- Helping someone to get involved in the local community.
- Delegated healthcare tasks (see delegation of healthcare tasks in Section 8).

6.3.2 Rates of pay for personal assistants

To ensure consistency and transparency in the allocation of budgets, the CCG has agreed three levels of personal assistant pay rates. They are based on the health and social care needs of an adult and are matched to the NHS Agenda for Change banding using an average hourly rate for each band. The table below provides the details of the NHS banding levels and related health care needs and is the maximum hourly rate the CCG will agree to pay.

NHS Band	Average hourly rate	Examples of relevant health and social care need
Low care and health needs Band 2	£9.69	• Personal care • Moving and Handling • Administration of medication • Oral suction • Gastrostomy feeding • Therapies • Seizure management • Psychological and emotional support • Social/leisure support • Able to recognise changes in condition • Working with indirect supervision
Moderate care and health needs Band 3	£10.60	In addition to Band 2, support with: Oxygen, Oxygen monitoring, Oral, nasal, tracheostomy suction, non-invasive ventilation, routine tracheostomy care, enteral feeding (naso-gastric, jejunostomy) use of feed pumps, Able to work without direct supervision.
Complex care and high level health needs Band 4	£11.86	In addition to Band 2 and 3: Full ventilation, humidification equipment, dialysis, complex medication, complex/extensive dressings/skin care. Multiple complex health needs/interventions. May support junior team members.

6.3.3 Sleep in and waking night rates

Sleep in: Where a sleeping night is required then this will be calculated by the number of hours at the national minimum wage. If the carer is woken more than three times in the night and for longer than thirty minutes then they will have to be paid at their normal contracted hourly rate.

Waking night: Where a waking night is required this is to be paid at the normal contracted hourly rate.

6.3.4 Employing close family members

6.3.4.1 Who is a close family member?

A person's close family members are described in the direct payment 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.

6.3.4.2 Employing a family member as a personal assistant

A direct payment can only be used to pay an individual living in the same household, a close family member or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the person receiving care's need for that service; or to promote the welfare of a child for whom direct payments are being made. Employing a family member must be requested to the CCG demonstrate exceptional circumstances are:

- All alternative options have been exhausted; and
- This is the only way support can be provided; and
- The circumstances are significantly different from other families receiving a similar level of support; and
- If all of the above are met, that it is clear that the tasks a family member will be paid to provide are over and above those of a parenting or caring role as a result of the child or adults condition.

Each request for exceptional circumstances will be considered on its own merits and individual circumstances. If it is agreed that a close family member can be employed, it is on the condition that a third party organisation is used, as it represents a conflict of interest. If more than one family member wishes to be employed, the request must be made on every occasion. The agreement of one family member being employed isn't a blanket agreement to further members also being employed.

Family members can only be employed to meet the assessed needs for the supported person. In other words, the decision to employ a family member relates to the specific provision of CCG funded support. The paid employment arrangement would relate only to the overall support that would otherwise be arranged by the CCG. Alternatively, it could relate to:

- The relevant portion of the assessed needs in terms of support over particular time periods that would otherwise be arranged/provided by the CCG.
- Particular types of support that would otherwise be arranged/provided by the CCG.

If family members are employed the supported person must follow Employment Law and government guidance:

- Avoid special treatment in terms of pay, promotion and working conditions.
- Make sure Tax and National Insurance contributions are still paid.
- Follow the Working Time Directive.
- Have Employer's Liability Insurance that covers any young family members.

A family member is not permitted to provide support if the CCG determines that either the family member of supported person is under undue pressure to agree to the arrangement. Or the family member is a guardian or a health and welfare attorney for the supported person. These two inappropriate circumstances can apply - and can thus prevent an employment arrangement - regardless of whether any or all of the appropriate circumstances apply.

6.3.4.3 A family member managing or administering the direct payment

If the person has capacity, but wants to pay close family members living in the same household to manage and/or administer the direct payment the request will be considered on a case-by-case basis. It is not the usual accepted good practice.

This is intended to reflect the fact that in some cases, especially where there are multiple complex needs, the direct payment amount may be substantial. The CCG will not allow a direct payment if there was evidence of a manifest conflict of interest. If it is agreed it will require a higher than usual level of monitoring.

A person acting as the representative or a nominated person for a direct payment cannot be employed as a personal assistant.

6.4 Putting support in place for employment

6.4.1 Skills for care

Where a person is considering employing a Personal Assistant(s), he or she will need to be informed of the legal responsibilities of becoming an employer under UK employment law.

Skills for Care have published useful information and guidance about the roles and responsibilities involved in the **Employing Personal Assistants Toolkit**, which is available to download.

If someone is employing a Personal Assistant for the first time, they should be provided with a copy of the Skills for Care **Employing Personal Assistants Toolkit** (which is also available in an easy read version). Any on-going support needs in relation to employment responsibilities that are identified should be discussed with the individual.

6.4.2 Direct payment support services

Direct Payments Support Services are organisations that are paid to provide help to the service user or Authorised Person, to manage the direct payment. Support should only be made available after an assessment of an individual's capability to manage the various tasks associated with managing the direct payment has been completed and it has been established that help is necessary. The support that is provided should be the minimum that is required to enable the direct payment to be managed effectively and the level of support must be reviewed at least annually.

If they require support, they should be enabled to choose a direct payment support service (DPSS). Any such support will need to be included in the care and support plan and where necessary the associated costs (for example for payroll support) will need to be incorporated into the budget. Where someone is becoming an employer the CCG strongly recommends that they use a DPSS to undertake payroll support to ensure that appropriate HMRC and payroll costs are calculated effectively along with ongoing telephone support.

If someone declines to take advice from a DPSS where they intend to become an employer, a risk assessment should be completed to decide whether the person can use the budget to become an employer. If there is any reason to believe that the person may lack the capacity to be an employer, the appropriate mental capacity tests should be carried out to establish capacity, and the results recorded (see extract of Empowerment Matters Capacity Templates.pdf from Empowerment Matters (guide available in full from https://empowermentmattersweb.files.wordpress.com/2014/09/assessing-capacity-financial-decisions-guidance-final.pdf

Detailed information for direct payment recipients wishing to take on employment responsibilities without using a DPSS is available from the Disability and Tax website, who offer a Disability Tax Guide.

6.4.3 Employers Liability Insurance

The employer needs to purchase the relevant level of cover of Employers Liability Insurance. The worker must ensure that this is in place and it provides the right level of cover to meet the health care tasks that a PA is undertaking. The insurance includes advice on employment issues as part of their standard employer's liability policy, for example a 24 hour specialist HR line is offered by Fish Insurance and Mark Bates Ltd, formerly known as Premier Care.

6.4.4 Using Disclosure and Barring Service (DBS) Checks

In order to determine the responsibilities and requirements for an enhanced DBS and barred list check to be undertaken for PAs being employed using direct payments, two pieces of legislation need to be looked at together. These are the

Safeguarding Vulnerable Groups Act 2006 and the National Health Service (Direct payments) Regulations.

Section 9 of The Safeguarding Vulnerable Groups Act 2006 states that a person commits an offence if they permit an employed individual to engage in regulated activity from which they are barred. The generic role of a Personal Assistant includes tasks that fall within the definition of regulated activity. This means that the recipient of a direct payment risks committing an offence if the Personal Assistant they intend to employ is barred.

The most straightforward way to establish whether someone is barred is to obtain a check from the Disclosure and Barring Service Section 9 of The Safeguarding Vulnerable Groups Act states that a person commits an offence if:

(a) He permits an individual (B) to engage in regulated activity from which B is barred,

(b) He knows or has reason to believe that B is barred from that activity, and

(c) B engages in the activity.

The CCG would therefore expect all direct payment recipients to ensure that an Enhanced DBS and Barred List check is undertaken for each PA they employ. For completeness the CCG would also expect a direct payment recipient to carry out a right to work in the UK check. This would require the direct payment recipient to check that the PA has documentary proof of their entitlement to work in the UK. As with vetting and barring, there are possible criminal sanctions. Section 21 of the Immigration, Asylum and Nationality Act 2006 creates the offence of employing a worker knowing they do not have the right to work in the UK, or having reasonable cause to suspect that they do not have this right.

In cases where a check reveals that a prospective PA is on the Barred List the individual should not be employed as that would constitute an offence under Section 9 of The Safeguarding Vulnerable Groups Act 2006 and alternative support arrangements would need to be sourced by the direct payment recipient.

In cases where a DBS and Barred List check reveals information recorded but the individual is not barred, a “suitability decision” will be required in order to determine whether it is safe and appropriate to employ the person. This process will involve a CCG’s Officer having sight of the DBS certificate and assessing that sufficient measures are in place to safeguard the direct payment recipient from harm. The direct payment recipient as the employer can still choose to employ the Personal Assistant using their own funds.

The costs of a DBS check will be included in the budget. The direct payment recipient will be required to provide evidence to the CCG that the DBS check has been undertaken by providing the DBS ID issue number. Where the DBS check shows that there was a positive disclosure the direct payment recipient should advise the CCG of this so that a suitability decision can be carried out and

consideration of whether the conditions set out in the National Health Service (direct payments) Regulations are satisfied.

In order to use a direct payment to employ people to provide their care and support, prospective recipients must sign a direct payment agreement with the CCG which includes details of the CCG's requirements in relation to DBS and "right to work" checks.

The CCG requires a direct payment recipient to carry out DBS and Barring List checks on PAs every three years. Where a direct payment recipient is already employing a PA, the CCG expects that the status of any DBS check will be checked at the annual review of the care and support plan. Direct payment recipients will be required to sign the direct payment agreement which covers a DP recipient's responsibilities in relation to DBS checks.

An existing direct payment recipient whose PAs do not have a relevant DBS certificate or whose certificate is more than three years old will be requested to undertake DBS checks for these PAs.

The CCG will maintain a record of the disclosure number and issue date for all people who are employed by direct payment recipients for the purpose of ensuring that current DBS checks are in place and are renewed as necessary.

The definition of regulated activity does not cover activity carried out in the course of family relationships, or personal non-commercial relationships. However if the PA receives payment in return for services, that takes the relationship outside the course of family relationships, and makes it a commercial one, even if the PA is related to the direct payment recipient. In these circumstances, a DBS check should be requested when the prospective PA is a family member or has a close personal relationship with the direct payment recipient.

If a direct payment recipient refuses to undertake an Enhanced DBS and Barred List check for the PA they are intending to employ, a decision will need to be made by an Associate Director, as to whether conditions are satisfied. If they are not satisfied, the direct payment cannot be used to employ the person.

6.4.5 Working out the employment status for an employee

This is defined on the Gov.uk website https://www.gov.uk/employment-status/employee. Someone who works for a business is probably an employee if most of the following are true:

- They are required to work regularly unless they are on leave, for example holiday, sick leave or maternity leave;
- They are required to do a minimum number of hours and expect to be paid for time worked;

- A manager or supervisor is responsible for their workload, saying when a piece of work should be finished and how it should be done;
- They cannot send someone else to do their work;
- The business deducts Tax and National Insurance contributions from their wages;
- They get paid holiday;
- They are entitled to contractual or Statutory Sick Pay, and maternity or paternity pay;
- They can join the business' pension scheme;
- The business' disciplinary and grievance procedures apply to them;
- They work at the business' premises or at an address specified by the business;
- Their contract sets out redundancy procedures;
- The business provides the materials, tools and equipment for their work;
- They only work for the business or if they do have another job, it is completely different from their work for the business;
- Their contract, statement of terms and conditions or offer letter (which can be described as an 'employment contract') uses terms like 'employer' and 'employee'.

6.4.6 Self-employed Personal Assistants

Someone's employment status is not a matter of choice and depends on the relationship and tasks being carried out. In order to safeguard persons from potential unforeseen tax liabilities, it is the CCG's view that self-employed personal assistants should not be used, as they would rarely be deemed to be self-employed when the tasks are measured against Her Majesty's Revenue and Customs (HMRC) status indicator tool.

The CCG will not make direct payments available in cases where the prospective recipient proposes to employ an individual who claims to be self-employed without evidence being supplied to demonstrate that the self-employed status is authentic in relation to the specific job role in question.

In order to demonstrate the employment status of the proposed working relationship, the individual must complete the HMRC Employment Status Indicator (ESI) Tool with the PHB Team, Case Manager or social care worker. The answers given must accurately reflect the job description and the terms and conditions under which it is proposed the services are to be provided at the relevant time of the contract, therefore these must be provided to the worker at the time of completing the ESI

tool. HMRC will be bound by the ESI outcome where the employer or their authorised representative provides copies of the printer-friendly version of the ESI result screen, bearing the 14 digit ESI reference number, and the Enquiry Details screen.

In order for a care and support plan to be approved where the personal assistant is self-employed evidence must be provided and recorded; confirmation that the tasks have been checked using the HMRC status indicator tool. The CCG may approve the use of self-employed personal assistants in exceptional circumstances. For example, where the person is employed privately or with a social care direct payment and they are receiving fast track Continuing NHS Healthcare and need urgent care and support.

6.4.7 Issues related to Modern Day Slavery to be aware of when employing Personal Assistants

To minimise the risk of Modern Day Slavery occurring, it is the Council's Policy that where a Personal Assistant is employed using a direct payment, the Council recommends that the direct payment recipient checks that the bank details they are paying the Personal Assistant's wages into matches that of the Personal Assistant providing support. The Council would recommend that where a direct payment recipient employs multiple Personal Assistants that each individual Personal Assistant's wages are paid into separate bank accounts. This would only apply where the direct payment recipient is employing their own staff and not in relation to any agency staff or self-employed Personal Assistants they may use. It is advised that the direct payment recipient asks to see a bank statement for each Personal Assistant they are employing to ensure that the bank account they are paying into is that of their Personal Assistant. The Council strongly recommends that where Personal Assistants are employed by a direct payment recipient that they are not paid in cash.

If a direct payment recipient has any concerns regarding the bank account details they are requested to pay a Personal Assistant's wages into, they should raise this with the Multi Agency Safeguarding Hub (MASH) at the earliest opportunity by calling 0300 500 8080.

6.4.8 Redundancy

The CCG will only consider a redundancy payment to PAs employed through a direct payment or third party PHB. Redundancy payments will not be paid to either self-employed PAs or care agency staff. Redundancy payments will only be payable if:

- The person has given notice to their employed PAs.
- The person dies.

- In both cases the CCG will only be responsible for making the statutory redundancy payment and notice pay if the funds are not available in the DP account or the Employer's Eligibility insurance will not cover the full costs.
- The CCG will follow Employment Law, as outlined in HMRC guidance.
- PAs will be entitled to statutory redundancy pay if they have been an employee and working for the current employer for two years or more.

They are entitled to:

- Half a week's pay for each full year they were under 22.
- One week's pay for each full year they were 22 or older, but under 41.
- One and half week's pay for each full year they were 41 or older.

Length of service is capped at 20 years, there is also a cap in relation to weekly pay and a maximum statutory redundancy pay you can get. For current figures refer to https://www.gov.uk/redundancy-your-rights/redundancy-pay.

Redundancy pay (including any severance pay) under £30,000 is not taxable.

The employer must deduct Tax and National Insurance contributions from any wages or holiday pay they owe you.

6.4.8.1 Exceptions

Employees are not entitled to statutory redundancy pay if:

- The employer offers to keep you on.
- The employer offers you suitable alternative work which you refuse without good reason.

Being dismissed for misconduct does not count as redundancy, so PAs would not get redundancy pay if this happened.

6.4.8.2 Notice periods and pay

Employees must be given a notice period before your employment ends. The statutory redundancy notice periods are:

- At least one week's notice if employed between one month and two years.
- One week's notice for each year if employed between two and 12 years.
- 12 weeks' notice if employed for 12 years or more.

An employer may give more than the statutory minimum, according to the employee's contract, but they cannot give them less.

As well as statutory redundancy pay, the employer should either:

- Pay notice period.

- Pay in lieu of notice depending on circumstances.

6.4.8.3 Payment in lieu of notice

Employment can be ended without notice if 'payment in lieu of notice' is included in the contract. In this circumstance the employee is paid rather than given a notice period.

The employee will be paid the basic pay that they would have received during the notice period. They may get extras such as pension contributions or private health care insurance if it is in their employment contract.

The employer can still offer payment in lieu of notice, even if it is not included in the contract of employment. If accepted, the person receives full pay and any extras that are in their contract.

7 Financial Monitoring and Review

PHBs are public money and commissioning organisations have a responsibility to ensure they are used to meet the health needs and the broader health and wellbeing outcomes of those who receive them. Commissioning organisations also have a responsibility to effectively manage the risks associated with people taking their PHB as a direct payment, including ensuring that the agreed health and wellbeing needs are being met, minimising the risk of fraud and the risk of money being used in ways that are either illegal or otherwise prohibited or do not work towards meeting people's health outcomes.

In managing these risks it is important that people are given genuine scope for choice and control. In practice, this means that the uses of PHB are not overly prescribed and that the person has appropriate flexibility about how the budgets can be spent, as set out in their care and support plan.

When considering the level of monitoring and review required, it is essential that the approach is proportionate to the value and risk of the PHB(s) under consideration.

The direct payments guidance[2] requires an initial review of the budget after three months and a minimum of annually from thereon, for those PHB holders who receive their budget as a direct payment to their bank account.

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[2] https://www.england.nhs.uk/publication/guidance-on-direct-payments-for-healthcare-understanding-the-regulations/

7.1 Role of the budget holder in the review process

PHBs were found to be most effective when the person had greater choice and control over how the money was utilised to meet their health and care needs[3]. This flexibility must not be removed through the monitoring and review process, thus the person has an important role in this aspect of the PHB.

Reviews should be carried out at agreed times and the budget holder should know in advance when a financial review will be undertaken and what will be involved. This should be detailed in the signed PHB agreement, ensuring that flexibility is permitted if the perceived risk level varies. Financial details should not be accessed at other times unless a concern has been raised. If this concern leads to an additional PHB review, the budget holder should be notified prior to this being carried out.

7.2 Assessing financial risk

The level of monitoring and review carried out should be proportionate to the risk factor of the PHB under consideration.

The risk factor of a PHB considers three elements:

- Value;
- Method of payment;
- Personal circumstances of the budget holder.

Risk is usually calculated by assessing impact and likelihood of an event on a scale of 1-4 and taking the multiple, meaning that risks are scored between 1 and 16. In order to make the monitoring and review process simpler, and ensure consistency of approach across all staff, the risk scoring will be carried out as detailed below.

7.2.1 Value scales to manage risks

Value of PHB per week (£)	Risk score
< £500	1
> £500 and < £1000	2
> £1000 and < £2,000	3
> £2,000	4

[3] https://www.phbe.org.uk/index-phbe.php

Method of payment scale

Method of payment	Risk score
Notional budget	1
3rd party managed budget	2
Prepaid card	3
Direct payment to bank account	4

Personal circumstances scale

Personal circumstances	Risk score
Established budget holder with no PHB management problems	1
Established budget holder with minor PHB management problems	2
Developing budget holder (PHB held between 12 and 24 months)	3
Established budget holder with significant PHB management problems	4
New budget holder (PHB held for less than 12 months)	4

These multiplied risk scores give a range from 1 to 64.

A score of 12 or under is a low risk PHB; 16–24 is medium risk; 27 and over is high risk.

Monitoring is carried out in accordance with the perceived risk level, with the following exceptions:

- Notional budgets are not reviewed as part of the PHB financial process. Care and support plan reviews are carried out as normal. Financial monitoring is as part of the standard finance and contract monitoring carried out within the CCG.
- All new budget holders are treated as if they were high risk for the first three months. After that point they revert to the appropriate banding.
- Budget holders with significant PHB management problems will not be eligible for a cash direct payment to their bank account, therefore the highest risk score is avoided in this case. Only if the risk can be managed through a pre-paid card, or a managed third party account, this will be considered and offered.

7.3 Financial Monitoring

The CCG's Personalised Care Team is responsible for the appropriate financial monitoring of direct payments. Each financial review will consider the following items, as appropriate for the payment delivery method:

- Bank statements
- Receipts

- Online account usage
- Timesheets/hours of support paid for
- Invoices
- Statement from 3rd party management organisation.

Once a direct payment is established, following an initial three-month review, reviews will be carried out on a quarterly basis.

- Low risk – annually
- Medium risk – six-monthly
- High risk – three-monthly.

If there is a failure to provide copies of bank statements within three weeks of being requested, a further letter will go out by the CCG's Personalised Care Team, giving the person two weeks to return the information. Telephone contact will also be undertaken. If the bank statements are still not provided a final letter will go out giving one final week to return the information. It will also advise that failure to do so could lead to the direct payment being ended.

7.3.1 Link with clinical reviews

Where possible the financial review will link to a clinical review. This ensures that all information is available to the CHC PHB team to support under or over spends within the budget. Co-ordinating these reviews also enables concerns to be easily raised with the clinical lead, which may impact the care and support plan; for example, an under spend may indicate that the person is not attending a service or group as expected and the plan should be reviewed accordingly.

7.4 Undertaking the review

The CCG's Personalised Care Team will undertake periodic reviews, in accordance with the risk profile of the budget holder, to consider the following:

- That the money is being used appropriately and in accordance with the agreed care and support plan.
- That the funds remain sufficient to meet the needs detailed in the care and support plan.
- Whether a large surplus, or under spend, is being built up.

Queries relating to the spending patterns in the PHB should first be raised with the clinical lead to understand whether the variance is known and agreed. This may be an indicator that a person's needs have changed.

7.5 Resultant actions

If the financial review highlights spend that does not correspond with the agreed care and support plan, the reviewer should first discuss the discrepancy with the CHC PHB team. In some cases variations may have been agreed but the financial reviewer is unaware of the alteration.

Where the CCG identifies potential misuse on an account, they must request that the relevant PHB Team arrange a review to look into this matter within two weeks of being alerted.

Where deliberate misuse of the direct payment is suspected following a review, this may trigger a fraud investigation by the CCG, and/or a criminal investigation by the Police if there is sufficient evidence to suggest that a crime is being committed.

If the monitoring process identifies that funds have been spent inappropriately, the CCG's Personalised Care Team will complete a direct payment alert form and discuss with their manager and the Finance Team to agree the appropriate action that needs to be taken, this may involve a referral to the counter fraud service or the person being given notice for the direct payment.

The CCG's Personalised Care Team will send a letter to the PHB holder to formally highlight where the inappropriate expenditure has taken place. The appropriate Stage 1, 2 or 3 warning letter will be sent if mis-spending or inappropriate use of a direct payment is highlighted.

The PHB is considered to be in surplus if it holds more than two weeks of funding at any given time. This surplus may be a necessary holding in order to pay employment costs or may be held for a specific purpose agreed with the care coordinator or case manager. If the surplus cannot be explained, the CCG's Personalised Care Team will ensure the appropriate action can be taken, such as reducing payments or suspending payments until the surplus has been spent. It should be noted that a surplus may also be indicative of a care and support plan that is not working as expected and may require review.

In all cases, the person should receive written notification of the outcome of the review and any actions to be taken.

Where people have tried things that may not have been as effective as intended, it is important that the CCG does not automatically assume that the PHB is not working. Case Managers should work with people to learn, adapt and use experience of what works and what does not to influence future decisions about the person's care, including within the personalised care and support plan. This will help to ensure PHBs are being used as effectively as possible.

7.6 Retention of records

Records of the review, and the documents supplied, should be retained in accordance with the Records Management Code of Practice for Health and Social Care 2016[4].

8 Delegation of Healthcare Tasks to PAs

8.1 Introduction

For many people, employing a Personal Assistant (PA) or a team of PAs is a central part of creating care and support arrangements that are personalised and responsive to their individual needs and circumstances as an adult or child and as a family. PAs, chosen by the individual and where appropriate their carers, or in the case of children their parents, can help support people living in the community to achieve their personal goals and to have the opportunity to lead their lives and have a family life on their own terms.

A PA's role will vary according to the needs, lifestyle requirements and choices of each person they support. When a PA is providing care and support to someone with healthcare needs, an important component of their role can include carrying out tasks that are of a clinical nature. These tasks must be considered in the care and support planning process and delegated to the PA by a registered practitioner who has the relevant occupational competence.

This section identifies the elements required to support appropriate delegation of a healthcare task from a registered practitioner to a PA, and the responsibilities of all concerned.

It is important to note that registered practitioners are professionals who are regulated by statute and or are specifically accountable to their regulatory body as well as to their employer. This guidance does not circumvent any standards for delegation set by registered practitioner's regulatory body, which they are required to meet (e.g. the Nursing and Midwifery council for nurses, midwives and health visitors, and the Health and Care Professions Council (HCPC) for physiotherapists, occupational therapists, dieticians, and speech and language therapists).

Delegation needs to be recognised as something that is a considered process and properly supported. This will ensure that the best interests of the person are always

[4] https://digital.nhs.uk/article/1202/Records-Management-Code-of-Practice-for-Health-and-Social-Care-2016

paramount, that tasks taken on by PAs are appropriate and that PAs are provided with relevant training and assessed as competent to perform the particular tasks.

8.2 The case for delegating healthcare tasks to PAs

The ability for individuals to employ their own PA or carer is one of the biggest opportunities presented by PHBs. Enabling PAs to undertake routine healthcare tasks is key to the sustainability of PHBs for those with complex needs and some long term conditions. The benefits for the Service Users, PAs and health and social care staff include:

- ✓ Providing a seamless service to service users and their families.
- ✓ Supporting choice and control for individual regarding who delivers their care.
- ✓ Providing continuity of care for individuals when it is delivered by their usual care workers.
- ✓ Releasing limited nursing resources to be used for higher level needs.
- ✓ Supporting service users to manage their own conditions where appropriate.
- ✓ Making best use of staff skills and avoiding duplication of effort.
- ✓ Supporting PAs to develop their careers which will also facilitate the recruitment and retention of the workforce.
- ✓ Encouraging accountability and delegation of the health and social care workforce.
- ✓ Providing learning and development which will ensure that PAs have the knowledge and skills to undertake healthcare tasks.
- ✓ Providing tools to measure the competence of staff to undertake the tasks.
- ✓ Encouraging formal, safer working practices.
- ✓ Promoting service redesign and transformation of services.
- ✓ Promoting co-operation and integration across health and social care (Care Act 2014).

8.3 Governance and assurance arrangements

Delegation occurs throughout the NHS on a daily basis, but as PAs are new to the NHS there is often less understanding of how and when to delegate them. PAs are either employed directly by the person requiring care and support or indirectly by a third party organisation on their behalf, and therefore lines of accountability can appear less clear to NHS practitioners.

It is important that the CCG, as the responsible body for planning and commissioning, has a clinical governance framework in place for delegation to PAs. The need for a robust governance framework to underpin delegation is made clear in the Royal College of Nursing's principles of delegation:

"Any delegation of healthcare tasks to unregistered health and non-health qualified staff must be undertaken within a robust governance framework, which encompasses:

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

PHBs do not release the NHS from their duty of care to people within their care. They increase the level of choice and control that people have but they do not change the statutory duty of care that the NHS has to all individuals.

A registered practitioner who delegates a task remains accountable for the appropriateness of the delegation and ensuring that the person who does the work is able to do it. They cannot delegate that accountability. However, provided the decision to delegate is made appropriately, they are not accountable for the decisions and actions of the PA to whom they delegate. The PA is accountable for accepting the delegated task and responsible for their actions in carrying it out.

8.3.1 The personal health budget holder, nominee or representative acting as an employer

Employers are 'vicariously liable' for their employees. This means that provided that the PA is working within their sphere of competence and in connection with their employment, the employer is also accountable for their actions. It is therefore important that the employer is involved, advised and supported appropriately in understanding and meeting their responsibilities.

In relation to delegated healthcare tasks, the PA's employer should:

1. Check that the job description and person specification reflect requirements in relation to delegated healthcare tasks.
2. When recruiting, have due regard to the candidate's ability to learn the required skill and to seek advice and support in this regard as required.
3. Check that each PA has received training and both the trainer and PA have signed to say they are satisfied that the PA has the competence and confidence to deliver the delegated healthcare task.
4. Not ask the PA to go outside the scope of their training.

5. Not ask the PA to deliver complex care tasks without training and assessment of competencies.
6. Check records to see that the PA has up-to-date competencies and contact their care coordinator or registered practitioner responsible for the delegation if they have concerns.
7. Check that the care plan includes risk assessments and escalation plans for all the delegated tasks, and that these are up-to-date and relevant. Consult with their care coordinator if they have concerns.
8. Support the PA to undertake regular clinical supervision and help ensure they are undertaking delegation in the manner they were trained.
9. Ensure the PA maintains appropriate records of the tasks they have undertaken.
10. Seek advice from the care coordinator or relevant practitioner if concerned about a PA's ability to deliver the delegated healthcare tasks.
11. Check that insurance is in place in relation to the PA carrying out delegated healthcare tasks and consult with the care coordinator or support organisation if there are concerns.
12. Raise any concerns with the care coordinator or commissioners.

It is good practice for the employer of the PA to sign a document alongside the PA and person assessing competence to show their satisfaction with the PA's competency and confidence to carry out the delegated task.

8.3.2 The Personal Assistant

Although PAs are not currently regulated by statute, they remain accountable for their actions in the following ways:

- To the personal health budget holder – the PA has a duty of care and is accountable for their actions and omissions when they can reasonably foresee that they would be likely to injure people or cause further discomfort or harm (e.g. if a PA failed to report that a person had fallen out of bed). The PA could also be dismissed for being in breach of their contract of employment.
- To the public – if a PA were to harm a person in a negligent or deliberate way they could be held accountable and could be prosecuted under criminal law.

The PA's responsibilities include:

1. Taking part in competency training and signing to acknowledge readiness, competence and confidence to accept the delegated tasks.

2. Undertaking delegated healthcare tasks within the training given and the care plan and escalation plans that have been provided.
3. Recording delegated healthcare provided/undertaken in a clear and contemporaneous manner (i.e. recording at the time, or as soon after the event as practicable).
4. Seeking advice and support from the employer and delegator if concerns arise or they come across something not covered in training.
5. Taking part in clinical supervision as required.
6. Ceasing to undertake tasks and seeking retraining if unclear about any aspect of the delegated task.
7. Not undertaking tasks that they have not been trained for or exceeding the limits specified in the delegation of the task.
8. Not using the training received for other people with similar needs without specific training and consent of the delegator.
9. Keeping copies of records of training and expiry dates.
10. Seeking retraining for delegated tasks within a reasonable timescale prior to expiry.
11. Raising any concerns about delegation training and on-going support with the employer.

The CCG is working in partnership with the Nottinghamshire Alliance Hub to develop a sound governance framework for delegation. This will help ensure that roles and responsibilities are understood and that systems are in place to support delegation.

8.4 Process for delegation

The CCG’s local governance framework for delegating healthcare tasks to PAs includes:

- Principles of delegation and clarification of roles, responsibilities and accountability.
- The process to be followed in considering delegating tasks to PAs and how decisions should be made.
- An indicative list of healthcare tasks that might commonly be considered for delegation to PAs (it must be made clear that this is indicative only and that each decision must be made in relation to individual needs and circumstances).
- Identification of the model of training and monitoring of PAs who carry out delegated health tasks.

- Any generic training that will be provided to PAs in core competencies.
- Identification of the related training required for each healthcare task; and how competency will be assessed and signed off.
- How on-going support and advice will be provided to PAs.
- The process for review and reassessment of competence.

8.4.1 Indicative list of delegated healthcare tasks

Delegation of specific healthcare tasks should be considered within the care and support planning process, which is central to the delivery of personal health budgets. It is at this stage of the process, after gathering information and understanding the person's health and wellbeing needs that detailed plans are made. It uses a partnership approach between the healthcare practitioner and the person, along with their family and carers as appropriate.

If the plan includes the employment of a PA, this is the time to consider what tasks the PA will carry out, the competencies required and any training needed. Some tasks may be considered unsuitable for delegation to a PA, and consideration can be given to the best way to deliver these, which may be through existing NHS services or separately purchased care or support.

The plan should make clear the task that is to be delegated, the limits of the delegation and how risks will be managed. It will also need to identify contingency arrangements should there be a gap in service, for example when the PA is on leave or off sick.

The budget must be sufficient to meet all the costs for delivering the care plan, including any training costs necessary for delivery. In some cases there will be more than one PA requiring training and all costs should be met within the budget.

The CCG has a locally agreed ***indicative*** list of tasks (see below) that are commonly delegated to PAs. This list should not be used indiscriminately or used as a barrier to making decisions in relation to other tasks not listed. In every situation the individual context must be taken into account before making a decision to delegate and any list is only a guideline.

Indicative List of Delegated Health Care Tasks
Administration of enema
Administration of epipens, as part of a care plan
Administration of insulin
Administration of rectal medication
Administration/measuring liquid medication
Ambu-bag training
Application of medication patches, with appropriate documentation

Application of Ted (Thrombo-Embolic Deterrent) stockings alongside a risk assessment
Apply male sheath drainage/alternative drainage systems as per care plan
Assisted intermittent catheterisation
Assisting with putting on appliances (e.g. leg callipers, surgical stockings, artificial limbs, special boots)
Autonomic dysreflexia care
Changing leg bags and night bags on catheters (not inserting catheters)
Chest physio
Colostomy/ileostomy care (change and empty bag)
Complex moving and handling
Compromised swallow
Conditions that require management by a non-invasive device both stimulate and maintain breathing, e.g. bi-level positive airway pressure, or non-invasive ventilation
Cough assist
Dialysis
Emergency medication
Expansion of use of inhalers to include new inhalers
Expansion on the use and documentation of creams etc. used as part of personal
Frequent episodes of altered states of consciousness that require skilled intervention to reduce the risk of harm
General observation of users physical and mental well-being
General Wound care
Hickman lines
Intermittent self-catheterisation
Laryngectomy care
Limb physio
Managing pressure sores
Nebulisers
Nebulisers
Oral suction
Oxygen at home
PEG (Continuous and bolus feeds)
Post op nasal spray
Postural Management training
Prescribed ointments
Put in post op ear drops
Put in post op eye drops
Skin care
Stoma care
Sublingual spray
Supporting with the administration of buccal midazolam
Suprabic/urethral catheter care
Tracheostomy and oral suctioning (not changing inner tube)

Tracheostomy care requiring regular suctioning
Trans anal irrigation
Urostomy care

8.4.2 Identify how training and assessment of competence will be provided

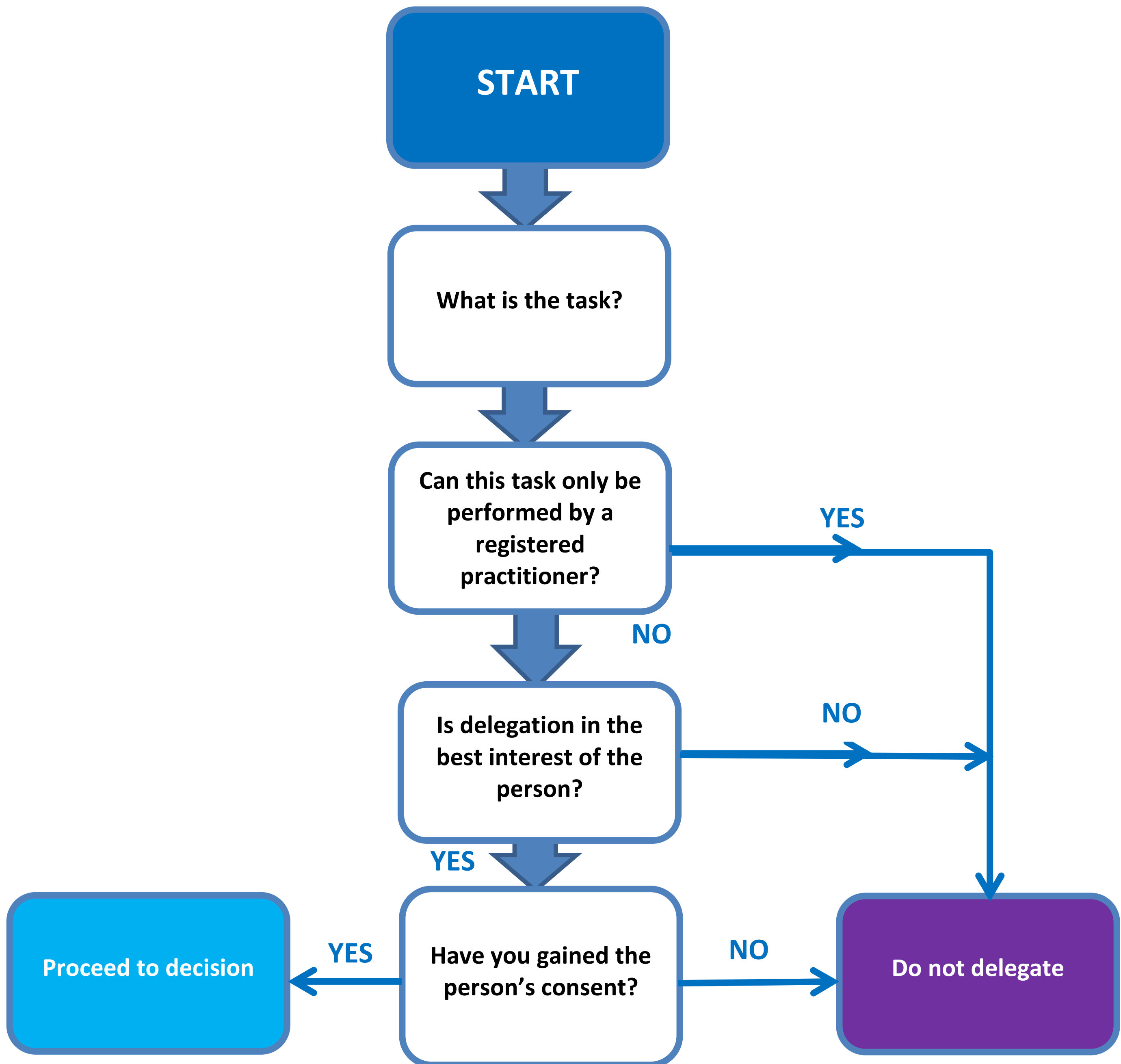
For tasks that can be delegated, the action plan needs to identify how the associated training will be provided and who will be responsible for assessment of competence, on-going support to the PA, and clinical review of the person's needs.

While the knowledge component of learning a task can be provided through use of web-based learning tools or group approaches, the individual skills required will need to be taught and competence assessed in the person's home.

In relation to delegated healthcare tasks, the care coordinator is responsible for ensuring that:

1. A registered practitioner with relevant occupational competence in relation to the specific area of clinical care for the person (in some instances this may be the care coordinator) makes a more detailed assessment of suitability to delegate the identified task and it is the registered practitioner who makes the decision to delegate or not.
2. Arrangements for training and assessment of competence necessary to delegate are clearly specified in the care plan.
3. The person requiring the care or their representative has been consulted as to whether they are happy in principle with the task being delegated to their PA. Where the person lacks capacity to make decisions as to how their care needs shall be met, a formal best interests decision should be made as to whether in this case it is appropriate for the healthcare task(s) to be delegated.
4. Funding is included in the plan to cover any cost of training and assessment of competence necessary to delegate, on-going support and related insurance.

8.4.3 Delegation of a task to a personal assistant



8.4.4 Sign-off and review

The final decision to delegate a healthcare task to a PA should be made by a registered practitioner who is occupationally competent in the task and is accountable in relation to that aspect of clinical care of the client, and will follow on from training and assessment of competence. Delegation must first and foremost be in the best interest of the person for whom the care and support is being provided and it is important that they, or their representative, have been consulted and are in agreement with the arrangements.

It is also important that the PA feels both competent and confident to carry out the task and that the task/function/health intervention is within the remit of their job description.

A written agreement needs to be in place about the extent and limits of the delegation, how support will be provided and competency maintained, and when and how to seek help.

Frequency of review should be documented in the care plan and should take into account the person's clinical needs and changing requirements in relation to healthcare tasks. Review should also include a review of the tasks currently delegated to a PA and a review of training and competency. If a person's condition is unstable or fluctuating, or there is a significant deterioration in their physical condition, cognition or personal circumstances, the nature of the tasks may change and this will require review of the decision to delegate healthcare tasks. At review, if refresher training for the delegated task or training in new tasks to be delegated is required, then the budget allocation may need adjusting to allow for this.

8.5 Support with Confidence

If a person employs a PA they can access training and accreditation for them through the Support with Confidence Scheme. The Support with Confidence Scheme is an accreditation process for PAs that is free and open to all existing and prospective PAs within Nottinghamshire. Support with Confidence offers a free DBS check, access to training and an online forum.

Accredited PAs may also find additional work if they wish by being listed on www.nottshelpyourself.org.uk