NHS
Haringey
Clinical Commissioning Group

PERSONAL HEALTH BUDGET POLICY

(Including Direct Payments Guidance)

1	**SUMMARY**	Policy update of previous Personal Health Budget policy, following completion of PHB pilot phase. Government policy to offer PHB to all adults and children eligible for continuing healthcare and continuing care funding from 1 October 2014.
2	**RESPONSIBLE PERSON:**	Shelley Shenker
3	**ACCOUNTABLE DIRECTOR:**	Jill Shattock, Director of Commissioning
4	**APPLIES TO:**	Children & Young People eligible for Continuing Care and Adults eligible for Continuing Healthcare (hereafter in this document referred to as 'CHC' for both adults and children and young people unless otherwise specified).
5	**GROUPS / INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY:**	Personal Health Budget Steering Group
6	**GROUPS WHICH WERE CONSULTED AND HAVE GIVEN APPROVAL:**	On 9 September 2014 commissioners met with a Healthwatch representative and parents of a child with a disability who have had experience of direct payments. They were asked for feedback on their experiences/ the experiences of others and their views have informed the final draft of the policy. The Mental Health Support Association has advised on the development of the care and support planning documentation.

7	**EQUALITY IMPACT ANALYSIS COMPLETED:**	**Policy Screened**	X	**Template Completed**	X
8	**RATIFYING COMMITTEE(S) & DATE OF FINAL APPROVAL:**	Governing Body - 24 September 2014			
9	**VERSION:**	1			
10	**AVAILABLE ON:**	**Intranet**	x	**Website**	x
11	**RELATED DOCUMENTS:**	Haringey CCG CHC Policy, Haringey Continuing Care Policy, Pan-London and Haringey Safeguarding policies.			
12	**DISSEMINATED TO:**	Personal Health Budget Steering Group			
13	**DATE OF IMPLEMENTATION:**	October 2014			
14	**DATE OF NEXT FORMAL REVIEW:**	September 2015			

DOCUMENT CONTROL

Version	Date Released	Change Notice	Pages Affected	Remarks
1.1	**18 Sept 2014**			

Haringey Clinical Commissioning Group

Personal Health Budgets Policy

September 2014

List of Appendices

1. The aim of this policy

The introduction of personal health budgets is one of a range of national policies designed to improve personalization, choice and empowerment in the delivery of healthcare. The CCG is strongly committed to these policies and this document sets out how we will implement personal health budgets locally. In doing so the CCG will follow all national guidance (see **section 3**). It is not intended to repeat the guidance in this policy but to illustrate how the CCG will use local resources and procedures to ensure that this guidance and associated best practice is met.

2. Introduction to personal health budgets (or PHB)

2.1 Definition of a personal health budget

NHS England defines a personal health budget as follows:

An amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their nominee/ representative, and the local clinical commissioning group (CCG). At the centre of a personal health budget is the care and support plan. This plan helps people to identify their health and wellbeing goals, together with their care co-ordinator, set out how the budget will be spent to enable them to reach their goals and keep healthy and safe.

2.2 Five essential components of a personal health budget

The person with the personal health budget (or their representative) must:

- Be able to choose the health outcomes they want to achieve.
- Know how much money they have for their health care and support.
- Be enabled to create their own care plan, with support if they want it.
- Be able to choose how their budget is held and managed.
- Be able to spend the money in ways and at times that make sense to them, as agreed in their plan

2.3 Different types of personal health budgets

A personal health budget (PHB) can take three forms:

- Notional budget - the CCG holds the budget and makes arrangements for the agreed care and support.

- Third Party – where an organisation independent of the patient and the CCG holds the budget and makes arrangements for the agreed care and support. Such arrangements may vary, with some organisations providing pay roll services only and some also recruiting staff on behalf of the patient. These services should not be confused with the role of a representative or nominee (see **section 4.4** below).

- Direct payment – where monetary payments are made by the CCG to the patient or their representative to allow them to purchase the care and support they need.

3. Statutory requirements and national guidance

Minister of State for Care Services Norman Lamb announced the national roll out of personal health budgets on 30 November 2012 following a three year pilot and an evaluation. From October 2014, CCGs must offer PHBs to adults who meet the eligibility criteria for NHS continuing healthcare and children who meet the criteria for continuing care. The right applies to people already as eligible as well as those who become eligible after October 2014. For children, the right relates to the health elements of their care package which meet continuing care needs and not the education and social care elements. The CCG may also provide PHBs to other patient groups. The NHS mandate sets out a commitment for further roll out of PHBs from April 2015, to people with long term conditions, although guidance is awaited.

From 1st August 2013, the Direct Payment in Healthcare regulations came into force across England. These regulations enabled CCGs to lawfully offer patients PHBs in the form of a direct payment. Haringey CCG's PHB policy is based on NHS guidance about these regulations:

http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/2014/Guidance_on_Direct_Payments_for_Healthcare_Understanding_the_Regulations_March_2014.pdf

Although this guidance relates to requirements for the implementation of personal health budgets when taken as a direct payment, it is also in the main applicable to best practice in relation to personal health budgets in all forms as set out in **section 2.3** above. The term PHB as used in this document refers to all forms of personal health budget unless otherwise specified. The guidance clearly specifies in detail best practice in relation CCG duties to offer a PHB and sets out the following key points:

- Who can receive a PHB – including, for direct payments, how to manage consent, capacity and safeguarding. Patients should have capacity to consent to manage a direct payment. If they do not have capacity, direct payments can be given to their representative. Patients with capacity can appoint a nominee to receive their direct payment on their behalf. In the case of children, direct payments will be made to people with parental responsibility.

- Which services can be purchased with a PHB – primary care, public health, urgent or emergency treatment care services are excluded as well as any illegal or unlawful activity or purchasing of alcohol, tobacco, repaying debt or using funds for gambling.

  Further guidance issued in September 2014 clarified the following key points in relation to the 'right to have':

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

- A personal health budget is not new money, it is money that would normally have been spent by the NHS on that person's care but used in a more flexible way to meet their needs. This means that where the CCG is already commissioning a service that meets needs and it cannot release funds from that service it may reserve the right not to offer choice or a direct payment for that element of the care package. An example of this might be occupational therapy commissioned from a community provider. However, the CCG must still ensure that this element of this package of care is as personalized as possible. The CCG will always give reasons in writing when deciding not to award a direct payment or element of a care package as a direct payment (see **section 4.11**).

- The CCG should in general not award a direct payment where there is no additional value in doing so. Therefore, although the right to have applies to all eligible patients regardless of the type of package of care that they receive, CCGs should proceed with caution in agreeing direct payments for patients in residential care settings. Furthermore, direct payments to patients in residential settings were not evaluated as part of the pilot and so there is no guidance on implementation for this kind of care package.

- Therefore, this policy is targeted at eligible patients *living at home.* For patients requesting a personal health budget in residential care settings, a notional personal health budget will be allocated unless the CCG has evidence that providing a personal health budget as a direct payment will add additional benefit to the patient's care.

  This policy should be read in conjunction with the full guidance.

4. Haringey CCG Process for Personal Health Budgets

4.1 Making patients aware of their right to a PHB

When a patient is found to be eligible for Continuing HealthCare (CHC), it will be the responsibility of the nurse assessor/reviewer to discuss this option with the patient (or family) and to make them aware of the different options for taking a

PHB. Information will be provided to the patient verbally and/or in writing using accessible language. The CCG will also offer patients the opportunity to access independent advice in relation to their options and has commissioned the Mental Health Support Association to provide this advice.

4.2 The Care co-coordinator

For each person choosing to receive a PHB the patient will have a named care co-coordinator. They are responsible for:

Managing the assessment of the health needs of the person receiving care, for the care plan;

Ensuring that both the individual, representative or nominee and the CCG have agreed the Care and Support Plan;

Undertaking or arranging for the monitoring and review of the PHB, the care plan and the health of the person; and

Liaising between the CCG and the person receiving the PHB.

The care co-coordinator will normally be someone who has regular contact with the person, and a representative or nominee if they have one. While they may not have care co-coordinator in their job title, the important thing is that they are fulfilling the responsibilities above. While they are able to arrange with others to undertake actions, such as monitoring or review, the care co-coordinator will be the primary point of contact between the person and the CCG.

4.3. Allocation of a care co-ordinator

A CHC assessment or review should be undertaken by a Multi-Disciplinary Team (MDT) in accordance with national guidance. At the point of assessment or review, the MDT should agree which professional should be allocated as care co-ordinator to fulfil the functions as set out in section 3.. In some cases, the CCG nurse assessor/reviewer will be the professional who has most contact with the patient and they will therefore be best placed to act as the care co-ordinator. The capacity implications for this are as yet difficult to predict and the CCG will review the resource required as the level of take up for personal health budgets, in particular in the form of a direct payment, is established.

4.4 Nominees and representatives

Patients with capacity may wish to appoint a nominee to act on their behalf. Where a patient is assessed as having no capacity to manage a direct payment, the CCG should consider whether a representative can act on the patient's behalf. It is important to note that for patients in receipt of a direct payment, both

nominees and representatives take on *all the responsibilities for managing the direct payment that the patient themselves would have if they were in receipt of the payment.* Nominees and representatives therefore sign the Direct Payment Agreement on behalf of the patients for whom they have been appointed (see **appendix VI**). Representatives can appoint nominees.

All advice, information and support that would be provided by the CCG to a patient in receipt of direct payments will be offered to their nominee or representative. See also **section 5** for more information on safeguarding and Disclosure and Barring Service checks (DBS) requirements in relation to nominees and representatives.

4.5 Representatives for patients without capacity

Representatives can be:

- A person with parental responsibility for a child or under 16 or a child over 16 who lacks capacity.

- Someone given powers as an attorney or a deputy by a court to make decisions in specified areas on the person's behalf. Not all attorneys and deputies will have suitable powers and these individuals cannot act as representatives.

It is expected that in most cases, patients assessed as eligible for continuing healthcare will already have a representative. However, it is also possible for the CCG to appoint an individual as a representative. In most cases this would be a family member or a close friend. In these cases, the CCG may also decide if it is in the patient's best interests, to pay a direct payment to the representative. This will be done in consultation with all other professionals and carers involved in the person's care.

4.6 Completion of a care and support plan

The named coordinator will develop, in partnership with the patient or their nominee or representative, a Care and Support Plan (**see appendix III**). This must set out:

- The health and wellbeing needs and outcomes to be met by the services in the Care and Support Plan.

- A suggested timetable outlining how the care and support will be delivered

- The services that the PHB will be used to purchase - tied to the discussion around outcomes, there must be a discussion about the goods and

services the person wants to purchase. As far as possible, the person, with support from professionals, carers and others, should make these choices. It may also be helpful to involve advocates at this stage and the Mental Health Support Association can provide this.

- The amount of the PHB, and how often it will be paid - PHBs must be set at a level sufficient to cover the full cost of each of the services agreed in the Care and Support Plan.

- An agreed procedure for managing significant potential risk as identified in the risk assessment questionnaire (see below).

4.7 Risk assessment and management

At the start of the care planning process, the care co-coordinator will also complete a risk assessment and management questionnaire (**appendix II**) in partnership with the patient, representative or nominee about potential risks, and how these can be managed. This should be reviewed regularly throughout the process and as part of the 3 month and annual review process.

During the process of discussing risk with individuals or their nominees or representatives, care co-coordinators should ensure that everyone has the opportunity to contribute. Care co-coordinators should ensure the individual or representatives is always involved in these discussions, and if appropriate, their family or carers. It will also be important to gain the input of a range of healthcare professionals and the people involved in the person's care, for example social workers or care workers. Care co-coordinators should consider how best to strike a balance between the views of individuals and healthcare professionals, maximising choice and control as far as possible, while also ensuring clinical needs are met.

4.8 Setting an Indicative budget

Once a care and support plan has been developed with the patient this will then be used to set an indicative budget using Haringey's Budget Setting Tool (Health Resource Allocation System (HRAS) (**appendix II**). The indicative budget predicts the amount of money allocated to the individual following an assessment of their needs as part of the CHC eligibility assessment and care and support planning process. It is the responsibility of the care coordinator to inform the patient or their representative that the budget at this point is indicative and discuss the options for how the PHB payment will be made. The patient should be made aware that there is an approvals process before the final budget and form of payment can be agreed.

4.9 PHB approvals and sign off

The final personal health budget will be agreed and signed off by both the commissioning manager and CCG clinical team manager. Where there has been a request made for a direct payment or where the package of care is considered high risk or high cost (as detailed in Haringey continuing care policy), then the care coordinator will be required to present this to the personal health budget approval panel for agreement. The terms of reference for this panel are set out in **appendix V** of this policy.

4.10 Role of the Personal Health Budget Approval Panel

The care coordinator will be responsible for presenting a request for a PHB to the personal health budget approval panel in the following circumstances:

- Request for a Direct Payment
- If the personal health budget is high cost as defined in the continuing care policy
- High risk (as identified in the risk and management assessment process)

The care co-coordinator will need to submit the relevant paperwork, as a minimum, to the panel to enable it make a decision:

- Indicative Budget
- Completed Risk Assessment
- Completed care and support plan documentation.

4.11 Deciding when not to offer a direct payment

As outlined in the best practice guidance, Haringey CCG may decide not to provide someone with direct payments if for example, the CCG considers:

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

- that the direct payment will not be used for the agreed purposes.

In the event where Haringey CCG decides not to give someone a direct payment, the person and any nominee or representative, will be informed in writing outlining the reasons for this decision in appropriate format for the patient or their representative to understand.

In cases where direct payments have been refused, Haringey CCG will, where possible, also consider whether other forms of personal health budget, such as a notional budget or a budget held by a third party, might be suitable for their needs, or how else their care could be personalised.

The person, their nominee or representative may request that a reconsideration of the decision not to give a direct payment. They may also provide additional evidence or relevant information to inform that decision. Haringey CCG will reconsider their decision in the light of any new evidence, and then notify and explain the outcome of their deliberation in writing. In thee circumstances, Haringey CCG will reconsider the decision not to give to give a direct payment only once in any six month period.

4.12 Value for Money

Haringey CCG will ensure that personal health budgets offer value for money for patients and the CCG. This will be done through the way in which personal health budgets are set up, through robust support planning and through effective monitoring or direct payments.

Whilst Haringey CCG want to maximise flexibility, in the support planning process patients and care coordinators should avoid using personal health budgets to commission packages of care which are provided under existing NHS contracts as long as they can meet needs. The personal health budget should be used to get maximum benefit for the patient and also used in a way to ensure that the CCG is not paying twice for the same service. The CCG will always seek to ensure that packages of care are personalized as much as possible.

4.13 Agreement

Once the personal health budget has been agreed by the CCG the care coordinator will then inform the patient, representatives or their family of the final budget and how the personal health budget will be provided (i.e. notional, Direct Payment or Third Party). This decision will also be recorded in the patient's record on care track. If it has been agreed for the patient to receive a direct payment the patient must also then agree to sign the CCG's direct payment agreement. A copy of this is attached as **appendix V**.

The care coordinator is responsible for then supporting the patient in implementing the personal health budget in order to meet the outcomes identified in their care and support plan.

4.14 Third party organisations and independent brokerage

The patient or their representative/nominee may choose an external organisation to hold their direct payment and/or recruit staff for them.

The patient or their representative/nominee may also choose to use an independent broker to support them in deciding how to use their personal health budget in order to meet their health and wellbeing needs and outcomes as identified in their care and support plan. The broker may provide on-going assistance, where required, in supporting an individual in the management of their care.

Both third party organisations and those providing brokering functions will be financed as part of the patient's personal health budget. The CCG may make reasonable checks on these organisations before agreeing fund them as part of the personal health budget. These checks may include but are not limited to:

- CQC reports where applicable
- Registration e.g. with the charity commission
- Financial checks

4.15 Monitoring and Review

The care plan should be open to review and revision as necessary, and should be reviewed at clinically appropriate intervals. The care coordinator will ensure that the care plan is initially reviewed within the first three months, and then at least annually. In case of a change in an individual's condition, it is important that the care plan is reviewed, adapted to meet their changing needs and agreed as soon as possible. It is the responsibility of the care coordinator to inform the commissioning manager if services are not working.

4.16 CHC Fast Tracks and referrals from hospital

If a fast track referral has come to the CCG where a patient requests a personal health budget via direct payment then the CCG clinical team will assess the level risk as detailed in the risk assessment and management plan (**appendix IV**) to determine whether it is appropriate for that patient to receive a direct payment.

4.17 Young People – Transition to Adult services

There will be some instances where a young person family is in receipt of a personal health budget and who will be transitioning to adulthood. As part of the

transition process the care coordinator for the family will also be responsible for discussing personal health budgets.

5. Safeguarding and Disclosure and Barring Service (DBS) Checks:

5.1 Nominees and representatives

The CCG requires representatives and nominees to have been subject to a DBS check and this will be verified by the Personal Health Budgets Approval Panel (see terms of reference for the panel, **appendix V**) and reflected in the Direct Payment Agreement (see **appendix VI**).

The CCG will arrange and fund DBS checks for nominees and representatives and those who do not pass these checks will not be accepted as nominees or representatives.

Representatives and nominees that are close family members, living in the same household or a friend involved in the person's care are not required to have a DBS check and there is no legal power for the CCG to require this. However, any safeguarding risks from representatives or nominees identified by the care co-ordinator will be included within the risk assessment and management plan and reviewed by the Personal Health Budgets Approval Panel. The CCG may decide not to accept the proposed nominee or representative in these circumstances in which case the reason for this will be explained in writing.

5.2.1 Organisations commissioned by the CCG with a notional budget

Services commissioned by Haringey CCG will be subject to the CCG contractual requirements under safeguarding policies for both children and vulnerable adults as laid out by local and London wide safeguarding policies and the Independent Safeguarding Authority, including CQC registration where applicable. Links to local policies are as follows:

http://www.haringeyccg.nhs.uk/downloads/policies//App.%206.3c%20-%20Safeguarding%20Adults%20Policy.pdf

http://www.haringeyccg.nhs.uk/downloads/policies//Safeguarding%20children%20policy%20and%20procedure%20December%202013.pdf

5.3 Individuals employed by patients in receipt of a direct payment

Patients will be strongly advised to follow best practice in relation to safeguarding, vetting and barring when employing individuals. The CCG will ensure that accessible information is available to the patient in written form which sets out this best practice. The care co-ordinator is also required to give this advice to the patient or their representative/nominee verbally. The care co-

ordinator **must record** that written and verbal advice has been given in this regard and this will be confirmed by the Personal Health Budgets Approval Panel (see terms of reference for the panel, **appendix V**) before the budget and care and support plan is approved.

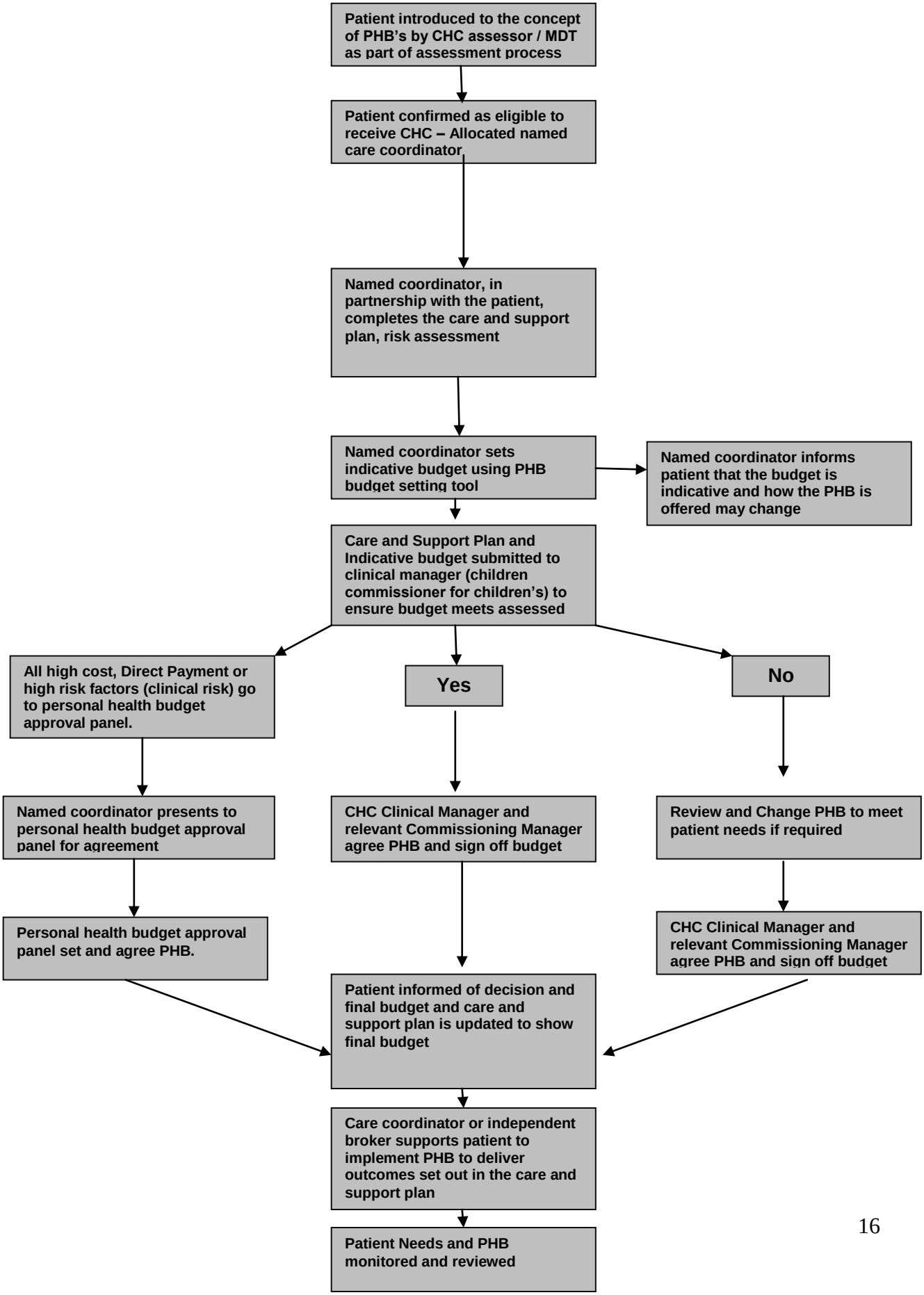
If a patient employs an individual then that individual must be subject to an enhanced Disclosure and Barring Service check and this will be reflected in the Direct Payments Agreement. The CCG will arrange and fund the DBS check.

The exception to this is where the person employed is a close family member, living in the same household or a friend involved in the person's care. However, any safeguarding risks from such proposed employees as identified by the care co-ordinator will be included within the risk assessment and management plan and reviewed by the Personal Health Budgets Approval Panel. The CCG may decide not to accept the proposed employee in these circumstances and reasons for this will be given in writing.

5.4 Complaints

As part of the discussion around the Care and Support Plan, there should be a discussion around how individuals can make complaints The NHS complaints procedure will continue to apply. A PALS Leaflet should be provided at the Care and Support Planning stage.

Appendix I – Personal Health Budget Flowchart



Appendix II – Health Resource Allocation System

NHS Haringey has developed a RAS to set the indicative and final personal health budget. This model to be adopted by Haringey is based on the successful model devised by NHS Oxfordshire as part of the PHB Pilot. This indicative budget setting model is based on developing an initial outline of the care and support needed to meet the health and wellbeing needs of the person which is part of the care planning process between the care coordinator and patient or family of the child. The elements of the package are then costed using the below spreadsheet to come to an indicative budget. A final budget will be agreed once the care and support plan has been developed more fully and outcomes identified.

The tool will use an *indicative* hourly rate to set the budget which has been developed through an analysis of existing spend so that we forecast likely costs of packages as accurately as possible. The tool also enables a indicative budget to be set if the patient or family choose to recruit their own carers and to enable the patient and the care coordinator to also identify and input any additional costs such as training, recruitment or insurance costs that may be required as part of someone's PHB. Through adopting this tool it enables us to be transparent and flexible when setting the budget. The tool has also been developed and will be used across both Adult's and Children's.

The PHB cost form below shows rates for standard care for adults – rates for children's and learning disabilities are available on request.

NHS
Haringey
Clinical Commissioning Group

INDICATIVE Personal Health Budget Cost Form

Please note, the indicative budget is an estimation of the costs required to meet your health and care needs. On completion of your support plan, a final budget will be authorised by the Commissioning Manager and the Continuing Healthcare Clinicla Manager, and if required the CCG's Risk and Enablement Panel where budgets are excess of £XXXX per week.

Client Name		**Date of Birth**	
Address		**Case Manager / Lead Nurse**	
CHC - date awarded		**Review Date**	

Care Package requirements (from Service Requisition)	Unit Measure (per day, per shift etc, per hour etc)	Unit Cost £	Units Per Week	Cost per week £	Care Agencies / Carers / Other Suppliers
Care Agencies (average rates):					
Standard Care Rate	per hour	£13.50	0.00	£0.00	
Sleeping Nights (9 hours)	per night	£00.00	0.00	£0.00	
Live-In Carer	per week	£800.00	0.00	£0.00	
Other (Please specify)					
Other (Please specify)					
Employed Staff:					
Live in Care	per week	£650.00	0.00	£0.00	
Weekday daytime rate	per hour	£11.14	0.00	£0.00	
Sleeping Night (9 hrs)	per night	£00.00	0.00	£0.00	
Other (Please specify)					
Other (Please specify)					
Other Charges:					
Transport		£0.00	0.00	£0.00	
Supplies	per week	£0.00	0.00	£0.00	
Equipment		£0.00	0.00	£0.00	
Day Centre (meals not included)	per day	£0.00	0.00	£0.00	
Other Charges:		£0.00	0.00	£0.00	
Other Charges:		£0.00	0.00	£0.00	
Total Cost Per Week				**£0.00**	

	Unit Measure (per day, per shift etc, per hour etc)	Unit Cost £	Units	Cost per year	
Annual charges/start-up costs					
Premier Care Personal Health Budget Insurance	per year	£149.00	1	£149.00	
Bank Holiday Supplements (Care Agency	per day	£0.00	0	£0.00	
Bank Holiday Supplements (Employer)	per day	£0.00	0	£0.00	
Training		£0.00	0	£0.00	

		£0.00	0	£0.00	
		£0.00	0	£0.00	
PA rate for training	per hour	£11.14	0	£0.00	
DBS Checks	per check	£68.00	0	£0.00	
Recruitment	per year	£0.00	0	£0.00	
Agency Costs (3rd party if used)		£0.00	0	£0.00	
Other (Please specify)		£0.00	0	£0.00	
Other (Please specify)		£0.00	0	£0.00	
Annual Charges				**£149.00**	

Respite Allocation	**Unit Measure**	**Unit Cost £**	**Per Year**	**Cost per Year**	
	per week	£0.00	0	£0.00	

Annual Indicative Budget	52 weeks			**£149.00**	

Indicative Care Package Costing Approved by:

CHC Clinical Manager
Name:

CHC Clinical Manager
Signature:

Date:

Comments:

NHS
Haringey
Clinical Commissioning Group

Personal Health Budget

Care and Support Plan

For

.....

Lead Nurse / Care Coordinator:

My Care and Support Plan Review Date:

3 Month review:

12 Month review:

Section 1: My Personal Contract information

My Name:[Type text]

My Home Address: [Type text]

My Date of Birth: [Type text]

NHS Number: [Type text]

My GP: [Type text]

My Telephone Number:[Type text]

My email:[Type text]

Would you like someone to act on your behalf? **Yes** **No**

Their Name: [Type text]

Their relationship to you: [Type text]

Their Address: [Type text]

Telephone Number: [Type text]

Section 2: About Me

Your Personal Background: Here is the opportunity to tell us about yourself, which may include, your family, childhood, schooling/education, any important relationships, any work/employment, your culture and religion

Use this section to outline what you feel is currently working and what is not working for you.

What is currently working for me in my life?	**What is not working for me in my life?**

Use this section to tell us your preferences around your care and support. For example, what support are you receiving from a family member, agency, a male or female carer, someone from your own culture, someone who is in your age group?

Use this section to outline what goals and outcomes you would like to achieve to improve your health and wellbeing over the next 12 months

My health and wellbeing needs	**My goals or outcomes (**What I want to achive)	**My ideas for achieving these outcomes?**	**Who will support me in achieving my outcomes?**

This is a suggested timetable around how you or your care and support to be delivered. Your or case manager may choose to record this information in a different way

Day	AM	Afternoon	Evening	Night
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Section 3: How will I spend my Personal Health Budget?

Please use this section to describe how you would like spend your Personal Health Budget to be used.

Use this section below to tell us how you would like to spend your Personal Health Budget

My Indicative Annual Budget is: £

What Will be purchased	How Much will it cost	How often (Hours / Days)	Total Per Year	Notes/ Details

You also need to decide how your Personal Health Budget will be managed. Listed below are some of the ways a budget can be managed. The Case Manager can discuss these options with you.

	Please tick
1) Notional budget	
This option means No money changes hands. You will be informed how much money is available and you will have the choice about the different ways to spend your money on meeting your needs. Your Case Manager will then arrange the agreed care and support.	
2) Personal Health Budget managed by a third party	
This is where a different organisation or trust holds your money and supports you to decide what you need. This organisation will then buy the identified care and support on your behalf.	
3) Direct payment	
You or your representative or nominee will receive the money directly as a direct payment. This would be paid directly into a separate bank account and you will manage it yourself, including all the purchasing of services.	

Section 4: Being in Control

Use this section is about how you will make decisions about your support plan.

Please use the following table to tell us how you will be involved in making decisions about your support plan and if anyone will be helping you

Important decisions in my life / planning	**How I must be involved?**	**Who makes the final decision?**

Section 5: How will I stay safe and well?

Think about the potential risks to you in regard to the support arrangements you have outlined in your support plan.
You need to consider how you would manage any risks associated with the service / item you intend to purchase.
Before purchasing services you need to carry out a number of checks to reduce the level of risk to yourself:

- Is the service provider registered with a professional body / obliged to be registered with a professional body such as the Care Quality Commission?
- Does the service provider hold public liability and personal accident insurance cover?
- Is the Care agency staff DBS checked?
- Does the provider have a complaints procedure?
- Are you satisfied they can meet your needs and outcomes you want to achieve?
- If you are buying equipment you need to ensure, for example, that its maintained, bought from a reputable supplier

If you are intending to employ your own staff you need to identify the risks associated with becoming an employer and how best to manage these risks.

You also need to think about any risk that might occur if these support arrangements were not put in place at all.

Use this space to record what steps you will take to ensure the care and support you receive is suitable and how you will manage any risks that have been identified.

For example: What will you do if your carer does not arrive for their shift or your condition worsens?

My area of concern	My contingency plan (what actions will I take)	By Whom (Who is to do this)

Section 6: Next Steps

Checklist – before returning your PHB Support Plan please make sure:

- you have answered all the questions
- you have signed the consent on the last page

Your PHB Support Plan will then need to be signed off by the Case Manager and the CCG's Financial lead

If the plan is not satisfactory it will be returned to the Personal Health Budget holder stating why and there will then be an opportunity to amend the plan. Only when a satisfactory plan has been completed and signed off will the money be released. When your PHB Support Plan has been agreed and signed a copy will be provided to you.

Data Protection Act 1998 

Under the Data Protection Act 1998, we have a legal duty to protect any personal information we collect from you. We need your agreement for us to share your PHB Support Plan with anyone who needs to see it. This could be someone who is organising your support or managing the money part of your budget.

- We will use the personal information you supply to us only for the reason that you provided it for.
- We will hold your information only for as long as it is necessary.
- We will not pass your information to anyone else unless this is made clear to you at the time you supplied it, or we are legally obliged to do so.

All employees and contractors who have access to your personal data or are associated with the handling of that data are obliged to respect your confidentiality.

Consent to share my care and support plan

I agree to share my care and support plan to enable me to receive the support required (please tick)			
Yes	Yes (but with limitations)	No	Unable to consent
If you have limitations about who you want your care and support plan to be shared with please specify who you DON'T want to share your plan with:			

Your Signature: [Type text]

Advocate or representatives signature: [Type text]

Date:[Type text]

Agreement of support plan and budget

We agree that the care and support plan and budget meet the needs of the patient.

	Patient , Representative or Nominee	Care Coordinator	Finance Professional for the CCG
Name			
Signature			
Date			

If the plan or budget is not agreed please give reasons below:

Case Manager Checklist:

Personal Health Budget Leaflet offered

Information on third party services (if an option) offered

Information on local advocacy and brokerage services offered

Risk Assessment completed

What makes a good Care Plan?

The plan must:

1) Show who the person is, with their strengths and skills, and their personal social context, as well as their health and wellbeing needs. If the person lacks capacity to make their own decisions the plan must show how this decision was reached and identify who will speak on their behalf.
2) Describe what is working and not working from their perspective.
3) Detail what is important to the person and what is important for their health and wellbeing
4) Identify and address any risks and how they will be mitigated to an acceptable level, including a contingency plan for if things go wrong, and a point of contact in health services
State the health and wellbeing outcomes to be achieved and how it is proposed that those outcomes will be achieved.
6) Describe in broad terms how the money will be held and managed and show how it will be used to achieve the outcomes.
7) Have an action plan that details who will do what and when to ensure that the plan is carried out.
8) Include the name of the person's care coordinator
9) State how and when the outcomes, and the money, will be monitored and reviewed. (This will include describing how people will know the plan is going well, and how people would know if things were going wrong.)
(From "Implementing Effective Care Planning" toolkit guide)

The Individual Care Planning Process
The central focus or personal health budget planning is on improving the dialogue between the person and health professionals to create a **synthesis** of **expert clinical knowledge with an individual's unique direct experience and capabilities, their preferences, creativity and motivation**. At the heart of a personal health budget is a care plan developed in partnership.

The following section of this paper outlines how this process may best take place. Whilst it is written as a number of stages, this does not imply a series of consultations, not will the process necessarily be linear. It is an iterative process, unique for each person. The stages do however; contain the essential steps towards building the finished plan.

Importantly, the stages mirror the criteria for sign off described in the strategic framework.This is because the strategic framework within which care planning is implemented is a dynamic part of the process, informing and shaping each person's individual conversation with their health team, and underpinning each health professional's decision-making. As such it does not remain separate from but is interwoven with every individual plan. The stages are as follows:

Stage one- Having the necessary information.
Stage two-What's working and not working.
Stage three-What's important to me and for my health, including risk enablement.
Stage four-Outcomes and priorities.
Stage five- Action planning.

Stage One: having the necessary information.
Before starting to plan, people will need to have been given clear accessible information about what a personal health budget is, what its purpose is and what the "deal" is around the money and the other important parts of the framework. That is: - all the elements of the strategic framework will need to be outlined, including information on- how much money, choice of ways to hold the money; choice of and range of support for planning; information about what could be possible; etc will each need to be discussed. Capacity issues will also be addressed at this stage.

This is a lot of information for someone to take in, and this first stage needs to be given sufficient time. Staff need to explore people's understanding, and give space for questions and clarification. Sending a leaflet or directing some-one to a web site is unlikely to be sufficient, though can be a helpful part of a broader approach. Linking people with others who have a personal health budget can be particularly helpful, both in person and through virtual links.

Stage two: what's working and not working.
Initially, the starting conversation seeks to build a trusting relationship and allow people space to explore what is working and not working in their life, related to their health. People may need to explore this with peers, to begin to move from a passive acceptance of everything the way it is, to a realisation that things could change. For example, if a parent carer has never been able to go out for the day with her child because the shift of agency staff who supports them happens every day at 2pm at home, they may not appreciate initially, that through using a personal health budget they could organise their days and the days of their child, very differently.

For people with long term health conditions – their health needs are woven through their life: - they are not a separate thing and so there is little need to worry that people will talk about random or irrelevant things when they identify what's working and not working well in their lives. This part of the planning process, and each of the next stages, gradually starts to build a picture not only of health needs, but of who the person is and how they want to shape their life by making the decisions about their health and wellbeing which matter most to them.

"Previously, the vital question of how the individual would like to live their life was never asked. There was little planning around the individual and often the debate would be around generic symptom management, and too often on the professional assumption that any other way would be too costly, too risky or too onerous" (personal health budget peer network member)

The stage at which a health professional's views are incorporated into the planning process is really important. The health professional's view is not put in at the very beginning *nor* at the

end .This second stage is exploratory discussion, active listening and respectful questioning and reflection- finding out the most important things which are working and not working.

Stage Three: What's important to me and important for my health, including risk enablement.
The next stage is to consider together, within those things which are working and not working, what is important to the person in terms of what matters most to them, and also what matters for their health. The person themselves is the only one who can know what matters to them; and the person themselves, (unless newly diagnosed), will also have a good idea of what's important for their health, to which the professional can add their expertise.

What matters most to some-one in their life can be accepted, - it simply does. It is then useful to understand a little more about the essence of what matters, in order to be able to write a specific outcome and an action plan linked to that.

In thinking together about what's important to and important for some-one, the health professional can helpfully contribute their expert knowledge about the specific "important for" information. - For example, the person may be aware that they need to keep their blood sugar or oxygen saturation at a certain level- the professional can give specific detail and advice about how to monitor and maintain the correct level for their particular illness, age and context. Health professionals also play a vital part in helping people explore really difficult issues around loss and adjustment to a different life after accidents or strokes, or following a life limiting diagnosis.
So it is at this third stage where the health professional can most usefully begin to input their knowledge, ideas and expertise.

A great planning process will lead to a plan which integrates what matters most to someone with what matters most for their health, because it's that interaction and joining together of best clinical practice with some-one's own motivations and creativity which leads to plans which are:

_ acted on not ignored;
_ a live participative process not a "prescription";
_ and which make best use of both professional and individual knowledge and ideas.

Risk enablement.
It is also at this stage that any risks can be identified and addressed. When planning with a personal health budget, risk and responsibility are openly discussed and can be shared. If a person wishes to have more power and control then there is an expectation that they will begin to share more responsibility for the management of their health condition. As stated before, it's a "deal", or a new contract.
However, everyone has different views of how much risk and responsibility they may want to take at different times, and so there should never be any compulsion to do things differently. Personal health budgets can be used, for all, some, or none of some-one's treatment, depending on what that person wants.

If a person is feeling vulnerable, scared and unwell, they may wish for health professionals to determine what is in their best interest. Alternatively, over time when they may feel more

confident, or if they feel that something vital to them is at risk of being lost or never achieved, they may want to take more control and more responsibility and they may view risk differently.

A more open, trusting and respectful dialogue can lead to better quality decision making and significant potential for improved outcomes, as some-one commits to carrying out the personal plan they have written. This “adherence” is seen as key to safety.

However, there are workforce development and cultural issues to be addressed: -
“Research in the UK suggests clinicians may take a “compliance approach” to self management and this is unlikely to be helpful” .... “The most promising way of supporting self management appears to involve approaches which empower and activate people so they feel more confident about managing their conditions and are more likely to alter their behaviours. There is strong evidence suggesting that improved self efficacy is associated with better clinical outcomes.”

“Whilst evidence is emerging, there is still a long way to go before we understand the education support necessary to optimise clinician’s attitudes, skills and behaviours towards self management. This also calls for a fundamental shift of power dynamics and the way both patients and professionals view their roles. “(“Helping people help themselves.”Health Foundation 2011.)

Supporting staff and people using personal health budgets to find personalised ways of managing risk

When developing the care planning process, it is helpful for both people with budgets and clinicians, commissioners and service providers to work together on how this part of the care plan will be discussed, agreed, and recorded. It can be helpful to have a separate sheet of the care plan specifically to address the issues of risk where the person and anyone supporting them to make their plan, records what might go wrong with the plan and how they plan to minimise the likelihood of this happening. On this sheet, it can be helpful to have a simple checklist of prompts such as:

• Is there is anything that the person or their clinician is worried about?
• Is there anything that has happened in the past that might arise again?
• Is there a possibility of harm or abuse?
• Is there adequate support in place if person wishes to use direct payments to employ their own personal assistant?

In their paper making the case for shared decision making in Health, Angel Coulter and Dr. Alf Collins argue that:- “There should be a formal process for documenting:

- The decision
- The agreed course of action
- The ongoing roles and responsibility of each party
- The risk- sharing agreement.

While all of the above is usually formalised in the process of consenting to a medical or surgical intervention, healthcare providers should ensure that they have documentation systems and processes in place when there has been a shared decision about any course of

action, such as adhering to a medication regime or undertaking a lifestyle or behaviour change. As well as providing a useful record for patients and other professionals they may encounter during their care, this practice could provide protection from legal challenge if clinicians can demonstrate that patients were offered choices and provided with reliable information about the options" (' Making Shared Decision Making A Reality' Angela Coulter and Alf Collins Kings Fund 2011)

Stage four: - priorities and outcomes
Having started with exploring what's working and not; and then going on to consider what's important to and for some-one; and how risks will be addressed; some clear priorities will begin to emerge. What needs to be ensured is that all of the priorities and the outcomes which flow from these, are the person's own outcomes. It is important not to add on professionals' "health outcomes" at the end just as they can't be imposed at the beginning.

"individual goals need to feel important to the patient....action planning may feel uncomfortable to the clinician where the patient is not willing to agree to something which the clinician sees as important....engaging with the process is essential to find out what the patient is prepared to do..."

"Patients and clinicians have similar aims to improve long term outcomes by increasing length of life and reducing morbidity-also in short term improving quality of life; but they often prioritise differently, with clinicians emphasising the former and people with long term conditions the latter. .....Accepting an individual's quality of life and their knowledge, skills and confidence to manage their own health and healthcare are important outcomes in their own right, poses newer and harder challenges..."

(Care planning- improving the lives of people with long term conditions" RCGP 2011)

If the outcomes are not recognised and owned by the person then it isn't their plan and something has gone wrong with the conversation. There needs to be further dialogue. The prioritising stage will pull together, from the conversation, what are the joint priorities agreed by the person and the health professional. There will have been a synthesis of ideas, and a clarification of top priorities for action, including risk enablement and contingency planning.

When developing outcomes, care needs to be taken against moving to thinking of services and therapies too soon. Outcomes are not services, treatments or therapy, nor attending places, - unless for a specific purposeful outcome. Outcomes are, broadly, changes in or sustaining of physical behaviours, or mental states/emotions. The care plan needs to describe clearly what is being aimed for- in specific terms. - What will be working better, be maintained or be avoided? This can include what is hoped for even in a deteriorating health condition, or at the end of life.
The health outcomes need to come from the person. The health professional's role is to help support the identification of the person's own outcomes and to contribute to making them as specific and individually relevant as possible. The actions which follow are then fully and clearly linked to the specific outcomes.

Stage five: Action planning.
The ideas about how to achieve the outcomes will be a bringing together of what some-one has thought of as their own solution, is willing to commit to and is motivated to do; with the

health professional's expertise about what might have proved useful for others and what research suggests too. The intention is that the plan produced is the person's own plan for their health outcomes, integrated with the other key parts of their day to day living. It is that personal ownership and control, together with the recognition of health as an interwoven part of some-one's whole life, which enhances the plan's effectiveness.

The actions in the plan should be specific and linked to the outcomes. As shown above, there must also be clear identification of potential likely risks and ways to address these.

Professionals need to trust people's own solutions-. This is at the heart of the shift in the relationship – people exploring what matters and finding their own ways to achieve change, actively and fully participating.

Appendix IV – Risk Assessment and Management Questionnaire

Personal Details

Name	
ID	
Address	

Involved Professionals

GP Name	
Allocated worker or care manager	

Other involved professionals – 1

Name of professional	
Role or designation	
Other information	

Other involved professionals – 2

Name of professional	
Role or designation	
Other information	

Other involved professionals – 3

Name of professional	
Role or designation	
Other information	

Other involved professionals – 4

Name of professional	
Role or designation	
Other information	

Risk Assessment & Management

Medical Condition & Physical Health (state of general health including pressure care)

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Taking Medication

Including information concerning diagnosis and adherence to advice around medication and including Polypharmacy e.g. confusion when taking 4 or more medicines.

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Mental Health & Emotional Well Being

Including risks from isolation/ self harm etc

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Personal Care (including self-neglect, continence issues

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Mobility and Transfer (including risk of falling)

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Cognitive Impairment/ including wandering & unsafe actions

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Communication

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Physical/Home Environment and Health & Safety (including domestic appliances)

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Food and diet (including malnourishment & dehydration

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Housing situation/ Finance & Debt

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Risk of Abuse

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Carer Stress (includes relationship breakdown)

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	

Any other identified problems/ needs/ conditions

Identified Risk or Hazard exacerbating factors	
Issues & Actions to be addressed in Support Plan including referrals to be made	
Areas of disagreement	
Other comments	
Summary of agreed Risk Management Actions	

Assessment date and Assessor details

Name and designation of the person completing form	
Name of person completing the assessment (if different to above)	
Date of Assessment	

Appendix V – Personal Health Budget Approval Panel Terms of Reference

Personal Health Budget Approval Panel
Terms of Reference

1. Personal Health Budget Approval Panel

1.1 Haringey CCG acknowledges that risk can be a consequence of people taking decision about their lives. Haringey CCG recognise that in undertaking the Health Resource Allocation System, there will be occasions where the indicative budget may not sufficiently cover the costs of services identified within the care and support plan aimed a meeting identified needs.

1.2 These terms of reference describe the arrangements Haringey CCG has put in place to:

- Consider and agree a personal health budget for our high risk and/or complex packages of care and
- Approve a personal health budget to be received as a direct payment.

1.3 Patients who are to receive their personal health budget by 3rd party or notional budget arrangement do not apply.

2. Purpose of the Panel

2.1 The purpose of the panel is to:

- Provide a multi-disciplinary/multi-agency forum to agree any personal health budget for high risk and/or complex packages of care
- Identify and monitor the clinical risks identified in the care and support plan
- Provide a forum to monitor and provide quality assurance for the Health Resource Allocation System

2.2 Confirm that the direct payment will be:

- Sufficient to meet the individuals identified needs
- Managed in accordance with Department of Health guidance
- Reviewed within three months

3. Patient Eligibility

3.1 The Panel will be responsible for agreeing personal health budgets for all eligible children and adults.

4. Duties and Responsibilities

4.1 In the consideration of high risk and/or complex packages of care the Panel will:

- Ensure that for any identified risks measures are put in place to reduce to an acceptable level prior to approval
- Establish and maintain a risk register
- Provide, upon request, management/activity reports

- Ensure updates are made to the Health Resource Allocation System based on decisions made by the Panel
- Record costs of the various provider services that have been agreed at the Panel

4.2 In the consideration of provision of personal health budget as a direct payment the Panel will:

- Ensure that there is clear evidence that there are up to date assessments and that a client centred approach has been used to maximise the possibility of the client accessing local services
- Ensure that there is clear evidence that a wide range of interventions have been explored with the client and family across agencies and that potential outcomes have, as far as possible, been measured against a baseline
- Ensure that the care and support plan for the client presented to the Panel includes expected outcomes of the purchased services and timetabled monitoring arrangements (including full review within three months)
- Ensure that regular reviews track progress towards expected outcomes, value for money and that there are annual reviews for all clients
- Ensure that Panel data is used to identify gaps in service provision, to assist long term planning and funding projections

5. Recording Panel decisions

5.1 The Panel administrator will keep a record of the discussion and any action points leading from this.

5.2 The Panel members will jointly sign documentation agreeing the outcome of the decision.

5.3 All personal health budgets are time limited with the expectation that cases will be reviewed and re-presented to the Panel, where appropriate, within agreed timeframes.

5.4 Applications/requests cannot be received directly from clients or their carers.

6. Post Panel

6.1 Decision summary sheets will be prepared in the week following the Panel and circulated to Panel members and client representatives (Panel attendees). These will include conditions of approval.

6.2 Where the Panel does not approve the request, written feedback will be given.

6.3 The Panel administrator will ensure an accurate audit trail of Panel decisions within CHC clinical and financial management systems e.g. Care Track.

7. Communicating Panel decisions to clients, family and carers

7.1 The named care co-ordinator will be responsible for communicating Panel decisions.

8. Meeting clients' needs prior to receiving Panel decisions

8.1 The Continuing Healthcare team are responsible for ensuring clients' needs are met until prior to a Panel decision and the process started with the client.

9. Membership of the Panel

- Director of Commissioning
- Assistant Director of Mental Health
- Deputy Chief Finance Officer
- Clinical Team Manager of the Continuing Healthcare Panel

10. Others invited when relevant may include representation from:

- Community health services
- Acute health services
- Safeguarding
- General Practice
- Continuing Healthcare
- CCG Commissioning
- Finance
- Children's & Adult Social Care
- Voluntary Sector

11. Presentation of Cases

- The named care co-ordinator is responsible for completing the relevant paperwork and submitting this to the Panel
- The named care co-ordinator will update the client on the progress of the case to Panel
- The named care co-ordinator will present the case to Panel

12. Frequency

12. Meetings are held monthly and diaried for year.

13. Professional Disagreement

13.1 All agencies acknowledge that there will be occasions where there may be differences of opinion about whether the care and support plan meets the identified needs. Every effort will be made within the meeting to resolve these differences. This may be by means of seeking a further assessment whether by a single agency or jointly. If this is not possible to resolve this issue at the meeting then the matter should be referred for review.

Appendix VI – Direct Payment Personal Health Budget Agreement

This document forms an agreement ("the Agreement") between:

NHS Haringey and (insert name of patient or their representative or nominee)

for the provision of continuing healthcare services through a direct payment from a personal health budget which is to be paid pursuant to Section 12A of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service (Direct Payments) Regulations 2013, as amended.

The purpose of the Agreement is to set out the responsibilities of both NHS Haringey and the patient or their representative or nominee receiving direct payments from NHS Haringey provided as part of a personal health budget. All Appendices form part of the Agreement and its terms and conditions.

Representatives and Nominees

Representatives

In certain circumstances, including where you, the patient, are under 16 or are otherwise unable to consent to your direct payment, someone else may legally receive and manage your direct payment on your behalf to procure support for you under your support plan. That person is called a **representative**.

If we consent to the appointment of that person being your representative, your representative will receive and manage the direct payment on your behalf, and will be required to sign and agree to the terms of this Agreement on your behalf.

Nominees

You or your representative is entitled to appoint (nominate) someone else to legally receive your direct payment on your behalf to procure support for you under your support plan. That person is called a **nominee**.

Where we consent to your nomination, your nominee will receive and manage the direct payment on your behalf, and will be required to sign and agree to the terms of this Agreement on your behalf.

Disclosure and Barring Service (DBS) certificate

If your proposed representative or nominee is not a close family member, a person living in the same household as you, or a friend involved in your care, your proposed representative or nominee must apply for an 'enhanced with list checks' DBS check. If your proposed representative or nominee is on either of the 'barred' lists, Haringey CCG will not provide its consent to their receiving and managing your direct payment.

Responsibilities of NHS Haringey

NHS Haringey will:

- ensure that the amount of the direct payment paid is sufficient to provide for the full cost of each of the services specified in the support plan (Appendix 2);

- inform you, your representative or nominee (as applicable) of the budget which has been set aside for your care by NHS Haringey's Resource Allocation System;

- make payments as agreed into your designated bank account to the agreed timescale (as set out under Appendix 3, as may be amended from time to time);

- provide you, your representative or nominee with support, advice and information to help you to manage your direct payment;

- undertake a periodic review of your health needs, at least once within the first three months, and subsequently at intervals not exceeding 12 months, and adjust your personal health budget accordingly, if required -in addition, such reviews will be to ensure your, your representative or nominee's compliance with your/ their obligations as set out below; and

- nominate a care co-ordinator ("**Care Co-ordinator**") to manage the assessment of your health needs for your care plan and to assist in the monitoring of the direct payments made to you, your representative or nominee for that care plan.

Your Responsibilities:

You, your representative or nominee will:

- only use the money from your direct payment to buy services or items as outlined in your Care and Support Plan (Appendix 2) in order to meet your needs and achieve your outcomes;

- only use the direct payments to procure services specified in your care plan, in accordance with your care plan and, in particular, to secure the provision of the whole of a service specified in your care plan;

- only purchase services from reputable agencies;

- only purchase a regulatory activity from a provider registered with the Care Quality Commission when purchasing services through an agency or employer;

- not purchase care from a healthcare professional who is unregistered, if they are required to be registered with a professional regulatory body;

- ensure that you have the appropriate care when you need it and have back up arrangements in the event that unforeseen events occur such as a carer caring for you becomes ill;

- ensure that staff are adequately skilled to support your needs safely when you, your representative or nominee employ them directly;

- take out a public liability insurance policy to the value of £20m and employee liability insurance to the value of £5m if employing staff. The cost of this can be met from your personal health budget and outlined within your Care and Support Plan (Appendix 2);

- complete a Disclosure and Barring Service(DBS) check on anyone you are intending to employ. If the prospective employee has a valid DBS check but it is 12-months old or over, NHS Haringey recommends that you obtain a new one. All DBS checks will be paid for by NHS Haringey;

- not employ staff/ personal assistants who live at the same address as you, family members or close friends unless you agree this with NHS Haringey in advance. NHS Haringey will review such requests on a case by case basis to determine whether securing a service from that particular person is necessary to meet the patient's need or to promote the welfare of the child;

- ensure that you, your representative or nominee obtain(s) the appropriate skills and resources allowing you (or them) to organise, and keep a proper record of, the way each direct payment is spent;

- open/ use a dedicated bank account to receive your direct payment. This account must only be used for monies to pay for your health care and should only be accessed by persons approved by the CCG;

- only spend the sum of each direct payment.- any overspend or any bank charges / legal charges or Inland Revenue costs will be your, your representative or nominee's responsibility (as applicable);

- produce a list of how you (or they) intend to spend the personal health budget on a monthly basis;

- keep evidence of all the money which is spent including till receipts, invoices, copies of staff wage slips, copies of staff timesheets/ hours worked - this evidence will need to be provided to NHS Haringey every 13 weeks to ensure that your personal Health Budget has been spent in line with the agreed care and support plan (in addition, NHS Haringey may request an explanation from you, your representative or nominee of any information provided if it requires such an explanation);

- allow NHS Haringey to see, upon request, copies of bank statements from your personal health budget bank account, for the purpose of audit and review, or any other information which NHS Haringey considers necessary to enable it to appropriately monitor this Agreement;

- co-operate with, and provide all information as reasonably required by, your Care Co-ordinator;

- use an accredited/ reputable Payroll Service to pay any personal assistants or employees and ensure that you, your representative or nominee (as applicable) comply with any employment law obligations if you or they directly employ a staff member;

- be responsible directly [and fully] for any claims, damages, liabilities, costs, expenses and demands arising from the support or care provided to you by those employed or engaged by you, your representative or nominee.

- notwithstanding that you, your representative or nominee will be responsible for meeting the cost of any overspend on your personal health budget, if you (or they) overspend or underspend on your personal health budget allocation, we will review

your needs to make sure they have not changed and that we have allocated the correct amount (in the event of any underspend at the time of your next review, any unused monies must be returned to NHS Haringey in the form of a cheque, made payable to NHS Haringey);

- inform NHS Haringey immediately of the following:
  - if the state of your health or other relevant circumstances change substantially;
  - if you change address or contact details;
  - if you leave the country for a period of more than 4 weeks; and/or
  - that you no longer require your direct payment if there is a change in your needs or circumstances;

- agree to the terms and conditions outlined in this Agreement.

General Terms and Conditions on the use of your direct payment personal health budget

NHS Haringey intends that your Personal Health Budget is the means by which you, your representative or nominee can meet your assessed needs in a flexible and creative way and this has been reflected in your care and support plan.

NHS Haringey reserves the right to increase or reduce the amount of the direct payments at any time where it considers it appropriate to do so. You, your representative or nominee will be given reasonable written notice of any decision to reduce the amount of direct payments to you (or them), and such notice shall state the reason(s) for that decision.

NHS Haringey will have the power to require the repayment of any funds:

- which have been used to buy items or services not outlined within your care and support Plan (including without limitation for the purchase of alcohol or tobacco, gambling services or facilities and/ or to repay a debt other than in respect of a service specified in the care plan);
- where the care plan or your circumstances have changed substantially;
- where money has accumulated;
- in the event of theft, fraud or another offence;
- in the event of your death; and/or
- where you, your representative or nominee are in breach of any of your or their obligations under this Agreement.

Where NHS Haringey requires a repayment, it shall provide you, your representative or nominee with reasonable written notice of the reasons for the repayment, the amount to be repaid, the timeframe in which you or they must make the repayment to NHS Haringey and confirm the person who must make the repayment.

If there is any misuse of your direct payment monies (including without limitation where you, your representative or nominee fail to use the money in accordance with the terms of this Agreement, your care and support plan or law), NHS Haringey reserves the right to:

- arrange for a 3rd Party or accountancy service to take over the management of your direct payment;

- withdraw your direct payment and transfer you onto a Notional Budget, managed directly by NHS Haringey; and/or

- recover any monies you, your representative or nominee have not spent in line with your approved care and support Plan. NHS Haringey may also use legal action to recover any misused funds.

In addition, NHS Haringey also reserves the right to suspend or withdraw your direct payment should:

- NHS Haringey not be able to contact you, your representative or nominee for a period of over 4 weeks or more;
- you lose the capacity to consent to receive direct payments (unless NHS Haringey can be satisfied that your loss of capacity is temporary and/or a representative or nominee can manage your direct payments on your behalf);
- the person in respect of whom the direct payment is made not be a patient of NHS Haringey's;
- NHS Haringey not consider any nominee to be a suitable person to receive direct payments on your behalf and/ or the nominee refuses to receive payment on your behalf and/ or you withdraw your nomination of that nominee;
- there be an event of theft, fraud or another offence;
- NHS Haringey consider that your health needs cannot be met, or are not being met, by services under the care plan or you cease to need the services;
- You, your representative or nominee be in breach of any of your (or their) responsibilities and obligations under this Agreement (including without limitation where you, your representative or nominee use your direct payment(s) to buy items or services not outlined within your care plan).

Where NHS Haringey determines to suspend or withdraw the making of direct payments, it shall provide you, your representative or nominee with reasonable written notice stating the reasons for its decision.

All patients or their representatives or nominees have the right to challenge the operation of this Agreement under NHS Haringey Complaints Procedure (this will be provided to you, your representative or nominee on request). In addition, either party may terminate this Agreement by giving the other party four weeks notice in writing, and you, your representative or nominee shall return any residual sum of the direct payment to NHS Haringey within one week of the end of such notice period.

NHS Haringey will not be liable for any injury, which does not arise from NHS Haringey's own negligence or other breach.

Variations to this Agreement may be made by the written consent of both parties. However, any variation in your healthcare needs will be determined by NHS Haringey and reflected in an amended care and support plan, and discussed with you, your representative or nominee.

If there is anything in this Agreement that you do not understand, please ask your Case Manager or Broker before you, your representative or nominee signs it. NHS Haringey would encourage you, your representative or nominee to get independent advice on the Agreement. Most local and national charities will be able to help you, your representative or nominee, or you (or they) can get legal advice from a solicitor.

NHS Haringey needs to use information about you (the patient) in order to manage your personal health budget and for related healthcare purposes. We may need to share information about you with other NHS organisations (such as [XYZ]) and health and social care providers,

such as your GP and [X] local authority. By entering into this agreement, you, your representative or nominee (as applicable) agree to our use of information in this way. We will handle information about you in a way which respects your rights and confidentiality, and in accordance with the Data Protection Act 1998.

For more information about how we use your information, please see the Haringey CCG website:

http://www.haringeyccg.nhs.uk/about-us/your-data.htm

NHS Haringey and the patient or patient's nominee or representative agree to the above responsibilities and terms and conditions with regard to the provision of this Direct Payment Personal Health Budget.

Signed by NHS Haringey**:**

Date	
Signed by Employee	
Print Name	
Job Title	

Signed by the patient or their representative or nominee:

Date	
Name of Patient	
Signed by Patient	
Signed by the representative or the nominee (the person who will manage the payments and arrange the services on behalf of the Patient)	(If not the patient, please state relationship to the patient)
Print Name	

Appendix 1: Useful Contact Details

Returned Monies	Cheques made payable to:

Appendix 2: Patient's Care and Support Plan

(Attach copy of the Patient's Care and Support Plan)

Appendix 3
Schedule of Payment

Personal Health Budgets
Schedule of Payment

Patient Name / Trust Fund _____

DOB _____

Details _____

_____

_____

Initial Payment £ _____

Date payment to be made _____
(1 months' notice required for processing)

Monthly Payment
(thereafter) £ _____

Patient's Bank Details

Account number _____

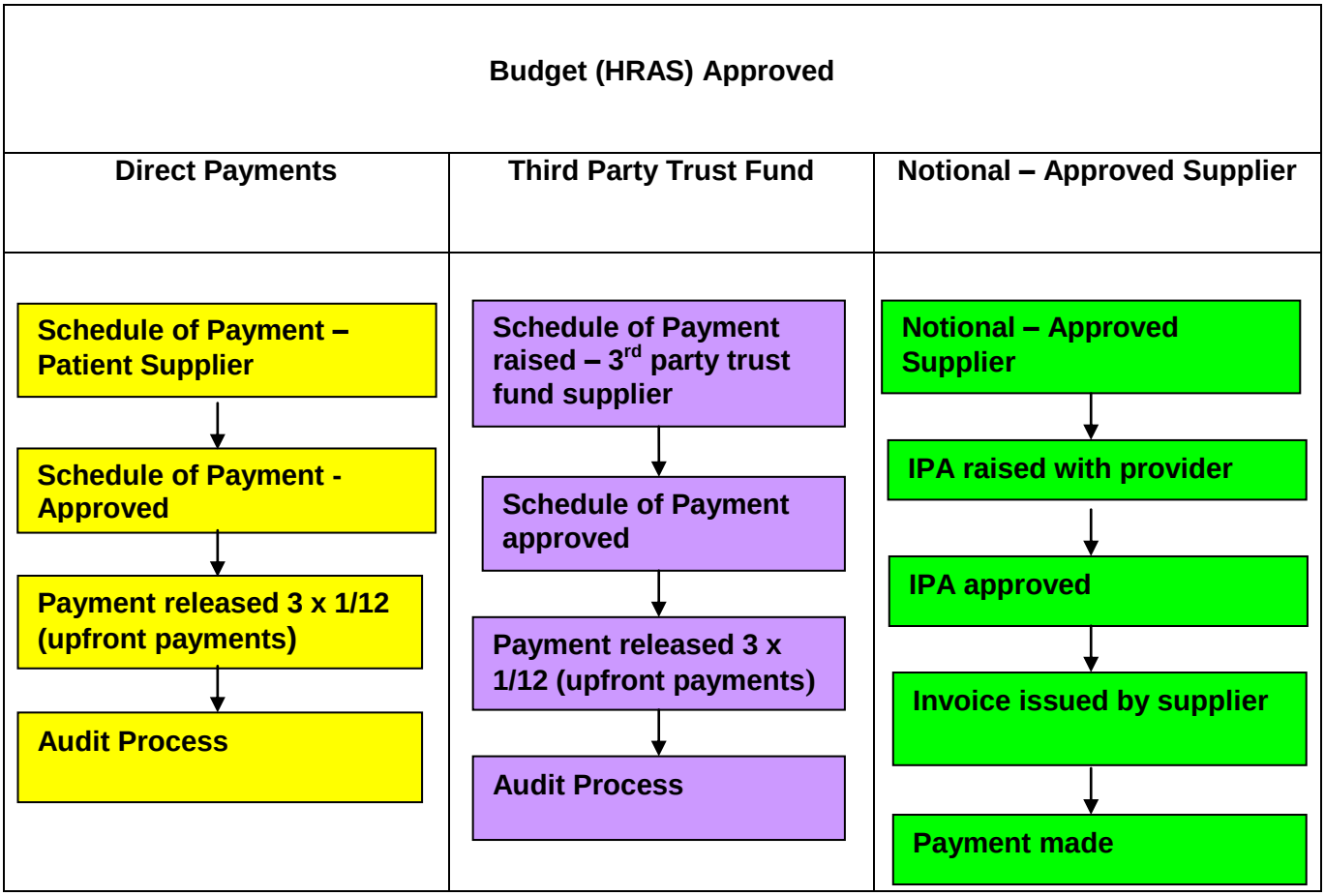
Sort Code	_____
Authorised	_____
Date	_____

Appendix VII – Finance Processes

Payment mechanisms and financial controls

Finance Systems

The management of the payment process is summarised in the table below.



Notional Budgets

These will be managed via the Haringey CCG SBS Payment System and will follow the current financial systems for purchasing of services and placement process for commissioning packages of care. The steps in the process are as follows:

1) Patient requesting notional budget identified in Care and Support Plan

2) Patient agrees to the Care and Support Plan and is informed of their notional budget

3) Providers identified in Care and Support Plan are approved by relevant commissioner (if using notional budget)

4) CHC commissioning team (or broker) approaches preferred provider to arrange for the patients care to be delivered.

5) Commissioning team issue Individual Placement Agreement issued to provider

6) Provider is paid through standard non PO approval on SBS by the CHC Finance administrator

Direct Payments

Direct Payments will be managed via a schedule of payments. Steps in the process are as follows:

1) Patient requesting direct payment identified in Care and Support Plan
2) Final PHBs budget (as calculated by the HRAS) agreed by CCG
3) Patient agrees to the Care and Support Plan and signs the CCG's Direct Payment agreement
4) For direct payment holders the patient is responsible for opening the bank accounts in order to set the payee up on Oracle, SBS requires a letter from PHB Holder (addressed to Haringey CCG) providing their bank account details
5) CCG Local finance officer will confirm bank account details
6) Payments to be authorized by named budget holders
7) Payments set up on SBS for three months then subject to review. CCG to inform the CSU of any changes to payments.
8) On 20th of each month Finance Administrator completes manual payment requisition form (scheduled payment) for an automatic payment for:
   - All *new* personal health budgets
   - Following a CHC 3 month or annual review
   - Changes to any existing PHB's
9) Director of commissioning and commissioning manger signs the manual payment requisition form.
10) CHC finance administrator inputs requisition form PHB amount into care details on Care track, updates notes and uploads manual requisition form for patient.
11) CHC Finance Administrator then submits the signed Manual Payment Requisition form to CCG Local Finance Officer
12) Local Finance Officer then sends Manual Payment Requisition form to CSU for Payment.
13) CSU to send list of payments to Borough on a monthly basis.
14) CCG to monitor payments made by patients on a monthly basis. This will be delivered by requiring the Patient or there representative to submit to the CCG their spend (through receipts / proof of payments) against the agreed personal health budget. Payments will be stopped in the event of any irregular activities.

Third Party Management

The process will run in a similar way to the Direct Payments Process. For clarity the steps are as follows:

1) Third party trust fund identified in Care and Support Plan and approved by CHC Commissioning Managers
2) Third party agrees and signs third party agreement
3) Third party sets up a separate bank account for payment
4) Schedule of payment is completed by Care Co-ordinator (Appendix 8)
5) Schedule of Payment is sent to Head of Continuing Healthcare for Approval
6) Schedule of Payment is sent to Head of Finance for agreement
7) Schedule of Payment is implemented by Accounts Payable
8) CCG to monitor payments made by patients on a monthly basis. This will be delivered by requiring the Patient or there representative to evidence to the CCG spend (through receipts / proof of payments) for the period against the agreed personal health budget. Payments will be stopped in the event of any irregular activities.

Financial Process for ending a personal health budget

1) Care coordinator informs CHC Finance administrator that personal health budget is longer required

2) If following eligibility panel, this is done by the CHC placement officer. Either update Care Track to show changes
3) CHC Finance administrator informs CCG Local Finance Officer as soon as information is received and closes **care details** onto 'Care Track' to ensure payments are stopped on system also
4) CCG Local Finance Officer informs CSU to cancel standing order

Ceasing Direct Payments

1. Care coordinator notifies patient or representative giving the reason for ceasing payments and giving notice period.

2. CHC Finance administrator cease package on Caretrack

Finance Audit and Controls of PHB's

The CCG will audit the delivery of PHB's and to manage any financial risk associated with personal health budgets. This audit will involve:

- Review of overall spend PHB's as part of the CHC Budget Management process
- As part of the finance payment process the CCG will review on an ongoing basis Direct Payment spends against their budget to ensure the money is being spent in accordance with their identified assessed needs.

Process for Recovering personal health budget money

- Care coordinator or CHC commissioning team, as part of the three monthly review, identifies unused funds in the individual's account and seek advice from the CCG Local Finance Officer.

- CCG Local Finance Officer will undertake a budget transfer following receipt of the money to return the unspent money to the correct budget.

- CHC Finance Administrator updates care track.