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Guidance on direct payments for healthcare: Understanding the regulations

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Updates to the previous version of this guidance (version 1, published 20 March 2014) are highlighted in yellow.

This guidance document is linked to statutory regulations on direct payments for healthcare and will be reviewed and updated annually.

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1. Aim of this guidance

This guidance is intended to support integrated care boards (ICBs) to understand and apply the direct payments for healthcare regulations.

This guidance will also be of interest to:

- people providing support to commissioners
- people providing health and care services
- voluntary sector groups and user led organisations who have an interest in personal health budgets
- NHS England nationally and regionally
- people receiving NHS care who are considering or are receiving direct payments for healthcare, and their carers.

Any inconsistency between this guidance and the legislation is to be interpreted in favour of the legislation. It is the responsibility of each ICB to ensure they act within the scope of relevant legislation and comply with their statutory duties.

2. Introduction

Direct payments for healthcare are one way of managing a personal health budget. Although these regulations only apply to direct payments, much of the information in this guidance is relevant to all types of personal health budgets (see section 2.2 for more information on how personal health budgets can be deployed).

ICBs may delegate delivery of direct payments for healthcare to a third-party (for example, a local authority or commissioning support unit). However, they must retain overall responsibility and remain legally responsible for all decisions made under the regulations.

This guidance is not intended to be a comprehensive 'how to' guide covering everything someone needs to know about direct payments – it is intended to explain the regulatory requirements.

Equality and diversity are at the heart of the NHS strategy. Due regard to eliminate discrimination, harassment and victimisation, to advance equality of opportunity,

and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it, has therefore been given throughout the development of the policies and processes cited in this document.

2.1 Personal health budgets explained

A personal health budget uses NHS funding to create an individually agreed personalised care and support plan that offers people of all ages greater choice and flexibility over how their assessed health and wellbeing needs are met.

The personalised care and support planning conversation identifies the care, support and services the personal health budget will be spent on. This can include a range of things to give people access to care, support and services that are holistic, innovative and build on their strengths.

Personal health budgets are flexible. They can be used to meet a variety of needs:

- For ongoing care and support to meet people's assessed health and wellbeing needs, eg NHS Continuing Healthcare, children and young people's continuing care, aftercare services under section 117 of the Mental Health Act.
- For one-off budgets to support people to achieve specific goals or outcomes enabling supported self-management eg hospital discharge, mental health recovery.
- To support children and young people with education, health and care plans aligned to expectations in the SEND Code of Practice.

And they can be:

- pooled to support several individuals to come together to achieve a common health and wellbeing goal, eg a group health weight management programme for people with a learning disability and/or autism
- integrated with social care and/or education personal budgets
- used to target and address wider system priorities such as identified health inequalities.

The following groups have a legal right to have a personal health budget – adults in receipt of NHS Continuing Healthcare, children and young people eligible for

continuing care, people eligible for aftercare services under section 117 of the Mental Health Act and people eligible for an NHS wheelchair.

The rollout of personal health budgets is not confined to these ‘right to have’ groups. Ensuring more people can benefit from personalised care is one of the key practical changes set out in the NHS Long Term Plan, which sets the ambition to increase the uptake of personal health budgets to 200,000 people by 2023/24.

In line with the NHS Long Term Plan and Universal Personalised Care, personal health budgets are part of the wider drive to give people more choice and control. They have real potential to improve outcomes, quality of care and reduce people’s reliance on unplanned acute care by enabling people living with long term conditions and disabilities to manage their health in ways that work for them.

2.2 Direct payments and personal health budgets

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

1. Direct payments for healthcare are monetary payments in lieu of services – made by ICBs to people (or to a representative or nominee on their behalf) to allow them to purchase the care and support they need.

2. Direct payments for healthcare are one way of providing all or part of a personal health budget. A personal health budget can be managed in three ways, or a combination of these:

   - Notional budget
     - where the commissioner (for example the ICB) holds the budget and uses it to secure services based on the outcome of discussions with the person, their representative, or, in the case of children, their families or carers.
   - Third-party budget
     - an organisation independent of the person, and the NHS commissioner, manages the budget on the person’s behalf and arranges support by purchasing services in line with the agreed personalised care and support plan.

- Direct payment
  - where money is transferred to the person, their representative or nominee, or, in the case of children, their families or carers, who contracts for the necessary services.

3. The introduction of notional budgets and third-party budgets into the NHS did not need changes to legislation or regulations; however, new regulations were required to enable the NHS to deliver direct payments.

   While the requirements in the regulations only apply to direct payments for healthcare, most of the steps, such as personalised care and support planning, budget setting, and the principles around empowering people to make decisions about their own care, will be the same irrespective of the way the personal health budget is provided. Wherever personal health budgets are being provided, the use of direct payments should be considered.

4. People eligible for NHS Continuing Healthcare and children and young people's continuing care have had a legal right to a personal health budget since 1 October 2014.

   Following a consultation in 2018, the right to have a personal health budget was extended to people eligible for aftercare services under section 117 of the Mental Health Act 1983 and people eligible for an NHS wheelchair (personal wheelchair budgets). This extension came into force on 2 December 2019.

2.3 Integrated working: health, social care and education

People with a personal health budget will benefit from health and social care and, where appropriate, education working well together and, for some, an integrated personal budget will also be beneficial.

The government's Integration White Paper identifies integrated personal budgets as part of the wider commitment to integrate services across health, social care and education, offering more holistic care and support to meet people's needs, improving their outcomes and experience, and reducing health inequalities – driving the integration of services at an individual level.

Furthermore, the legislative framework underpinning the Health and Care Act 2022 supports collaboration and partnership working to integrate services for people and families through the formalisation of integrated care systems.

5. In addition to this guidance document on direct payments for healthcare, personal budgets and integrated personal budgets in education, health and social care are governed by regulations as set out in the following guidance:

   - Special Educational Needs and Disability Code of Practice: 0 to 25 years, includes guidance on the right to request a personal budget for children and young people with education, health and care plans.
   - Care and support statutory guidance, includes guidance on personal budgets in adult social care.
   - Guidance on the legal rights to have personal health budgets and personal wheelchair budgets.

2.4 Additional information available

More information on personal health budgets is available on the NHS England webpages, including:

- an easy read document which explains what personal health budgets are
- practical information
- personal stories.

For further support from NHS England, organisations can sign up to the Personalised Care Collaborative Network on the Future NHS Platform (log in required).

National and regional support teams are also in place to provide support to ICBs as they continue to increase the availability of personal health budgets.

3. Scope of direct payments in healthcare

3.1 Who can receive a direct payment?

6. A direct payment can be made to, or in respect of, anyone who is eligible for NHS care [under the National Health Service Act 2006] and any other enactment relevant to an ICB. Direct payments can be made:

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

And where:

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

7. People aged 16 or over who have capacity, representatives of people aged 16 or over who lack capacity, and representatives of children can request that the direct payment is received and managed by a 'nominee' (see section 4.8).

8. Decisions about providing direct payments for healthcare should be based around need rather than being based around a particular medical condition or severity of condition or clinical pathway. The personal health budgets evaluation (2012) suggests that people with higher levels of need can experience greater levels of benefit regardless of their diagnosis.

9. The regulations do not go into detail about specific groups to whom a direct payment for healthcare should be offered, as this will be determined by government commitments, the Mandate to NHS England and local priorities.

ICBs will need to ensure that they keep abreast of national policy developments and commitments.

The personal health budget webpages will contain details of any announcements on who should be offered, or have a 'right to have' a personal health budget.

10. Direct payments for healthcare and personal health budgets more widely do not alter NHS eligibility policy. Only those people who are eligible to receive NHS services will be able to have a personal health budget, including a direct payment.

11. In addition to the requirements above, ICBs will want to be transparent in the way they decide whether a person could benefit from a direct payment for healthcare. They may want to consult relevant people (see section 4.5) and request information (see section 4.6). They will want to develop a consistent approach which considers a range of things, for example:

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

    This list is not intended to be exhaustive.

3.2 Services that direct payments cannot be used for

12. Direct payments for healthcare will not be appropriate for all aspects of NHS care a person may need.

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

    - vaccination or immunisation, including population-wide immunisation programmes
    - screening
    - the national child measurement programme
    - NHS health checks: for example, those which screen for heart disease, stroke, diabetes, kidney disease, certain types of dementia and also learning disability or autism annual health checks.

    Most GP services are already funded through such contracts, which means GPs have already been paid for these services. We would not want to disrupt the holistic care provided to people by their local family GP.

14. A direct payment cannot be used for urgent or emergency treatment services, such as unplanned in-patient admissions to hospital or accident and emergency.

    While ICBs should not include services which require unplanned emergency access they may want to develop advance care plans, contingency or crisis plans with people and include these in their personalised care and support plans. This will help to ensure their wishes are taken into account when a crisis happens or that they have increased support or services available to prevent the need for emergency care or hospital admission.

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

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

17. A direct payment cannot be used:

    - to purchase alcohol or tobacco
    - for gambling

- to repay a debt (with the exception of debts relating to services specified in the personalised care and support plan).

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

3.3 What can a direct payment be spent on

18. In principle, other than the services listed in section 3.2, a direct payment can be spent on a broad range of things that will enable the person to meet their health and wellbeing needs. A direct payment may only be spent on services agreed in the personalised care and support plan (see section 5).

    For brevity, the term 'services' is used throughout this document, although it refers to anything that can be bought, and which will meet someone's health needs. The personalised care and support plan must be agreed by both the ICB and the person receiving care, or their representative.

    Before signing off the personalised care and support plan, the ICB must be reasonably satisfied that the health needs of the person can be met by the services specified in the personalised care and support plan.

19. As far as possible, the person, with support from professionals, carers and others, should make the choices about how their needs are met. It may also be helpful to involve independent brokerage services, peer support and advocates in these discussions.

    People need the right information to make informed decisions about their care. This would include any evidence available about the effectiveness of potential services or treatments.

    In some cases people will have a statutory right to an independent advocate, which may be available under the Mental Capacity Act 2005, Mental Health Act 1983 and the Care Act 2014.

20. ICBs should be careful not to exclude different requests without examining each proposal on a case-by-case basis as there may be significant benefits for people's health and wellbeing. Personal health budgets work best where people have real flexibility over how they use their budgets.

21. In some cases, it may be sensible for an ICB to agree a service which would normally be funded by social care, or another funding stream if that service is

likely to meet someone's agreed health and wellbeing outcomes. ICBs should not refuse to purchase this because it has been traditionally commissioned elsewhere. In the case of NHS Continuing Healthcare the NHS is responsible for funding all the care and support a person is assessed as needing.

22. The person receiving the direct payment (whether it is the individual requiring support, their nominee or a representative) is responsible for ensuring that it is only used as agreed in the personalised care and support plan.

3.4 Deciding not to offer a direct payment

23. An ICB may decide not to provide someone with direct payments if, for example, it considers:
    - that the person (or their representative) would not be able to manage them
    - that it is inappropriate for that person given their condition or the impact on that person of their particular condition
    - that the benefit to that person 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.

    This is not intended to be an exhaustive list.

24. If an ICB decides not to give someone a direct payment they must inform the person, and any nominee or representative, in writing, and give their reasons. This should be in an appropriate and accessible format.

25. The person, their nominee or representative may request that the ICB reconsiders its decision not to give a direct payment. They may also provide additional evidence or relevant information to inform that decision. The ICB must reconsider their decision in the light of any new evidence, and then notify and explain the outcome of their deliberation in writing. ICBs only need to reconsider the decision not to give a direct payment once in any six-month period unless a new assessment is required due to changing needs.

26. Even if someone is not suitable to receive a direct payment, they may still benefit from more personalised care. The ICB should, where possible,

consider whether other forms of personal health budget, such as a notional budget or a third-party budget, might be suitable, or how else the person's care could be personalised.

27. To ensure equal access to a direct payment it will be useful for ICBs to monitor local activity to identify any groups where uptake seems to be low. This will identify where local processes and decision making may need to be reviewed. Such activity, that identifies and removes barriers to direct payments, will also help ICBs meet the requirements of the Public Sector Equality Duty.

3.5 Information governance

28. It is essential to understand the information sharing aspects of delivering direct payments to ensure that the privacy and confidentiality of the person is considered at all times. ICBs should carefully assess what personal data needs to be shared and with whom, keeping in mind that this should be minimised wherever possible to meet the relevant purpose.

29. Consideration should also be given to any support needed for people who may be using direct payments to employ staff directly, so that they also understand their responsibilities in protecting their employees' personal information.

4. Consent, capacity, ability to manage and support to manage

4.1 Consent

30. Direct payments can only be made where appropriate consent has been given by:

    - a person aged 16 or over who has the capacity to consent to the making of direct payments to them
    - the representative (see sections 4.10 to 4.13) of a person aged 16 or over who lacks the relevant capacity to consent
    - the representative of a child under 16.

31. The direct payment can be received and managed by the person who gives their consent, or that person can identify a nominee (see Section 4.8) to receive and manage it for them. Where a person lacks the capacity to consent, direct payments can be given to their authorised representative (see Section 4.10) if they consent to receiving the payment on the person's behalf. In the case of children, direct payments can be received by their parents or those with parental responsibility for that child.

32. As well as giving people more control and independence, direct payments carry with them greater responsibilities for people than traditionally commissioned healthcare.

    The person receiving direct payments (the person themselves if direct payments are made to them, or their nominee or representative) will be responsible for ensuring that the money is spent in line with the personalised care and support plan.

    People may also be taking on additional responsibilities as employers or by entering into contracts with people to provide services (see Section 7).

33. When providing direct payments, ICBs must be satisfied that the person receiving the direct payment understands what is involved, and has given informed consent. Where necessary, obtaining this consent might be a process involving a number of discussions, rather than a single event, and should be part of the wider personalised care and support planning process.

This is an area where people may need additional support, which can be provided by the ICB directly, or by another organisation working in partnership with the ICB. This support might include information about how people using direct payments are supported, the different options for managing a personal health budget, what to expect when receiving direct payments, and/or access to advocacy services.

34. These discussions should also provide information on how people's, representative's or nominee's personal information may be shared as part of managing direct payments, eg sharing their contact and bank details with another organisation who is managing their direct payments.

    People should be fully informed of what information will be shared, with whom and for what purposes, and be informed of their ability to limit this information sharing and the potential implications of this for receiving direct payments. See section 3.5 for further information.

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

4.2 Capacity to consent

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

37. Under the Mental Capacity Act 2005 when assessing someone's capacity to make a decision for themselves, people should use a two stage test of capacity:

    - does the person have an impairment of the mind or brain, or is there some disturbance in the functioning of their mind or brain? (It does not matter whether this is temporary or permanent)
    - if so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

38. Where there is reasonable belief that a person is unable to make a decision about the making of direct payments to them, ICBs must assess the person's capacity to consent.

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

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

4.3 Fluctuating capacity

41. Where a person who has consented to the making of direct payments to them subsequently loses their capacity to consent, the ICB may, where it is satisfied that the loss of capacity is temporary, allow a representative to be appointed to receive direct payments on their behalf, or an existing nominee to continue to receive them, until they regain capacity.

    In these circumstances, the role will be similar to that of a representative for someone who has been assessed to lack capacity on an ongoing basis.

42. Where someone's capacity to consent to the making of direct payments fluctuates (in that it impairs their capacity to make decisions at certain times but not others) it is important that there should be continuity of care, and any disruption should be as minimal as possible.

    It may be helpful to work with people with fluctuating conditions to draw up advance care plans under the Mental Capacity Act or include advance decisions within their personalised care and support plans for the times they lack capacity.

    Contingency plans within personalised care and support plans can also help to ensure that people's care in a crisis better meets their wishes, including the

identification of a nominee or representative who may take control of the direct payment at such times.

43. When a person with fluctuating capacity gains or regains their capacity to consent, their consent is needed to continue the direct payments.

44. Where a person without capacity gains or regains capacity to consent to the making of a direct payment to them:

a) if the person and their representative or nominee consents, the health body may continue to make direct payments to the representative or nominee of the person in accordance with the personalised care and support plan; or
b) if the person does not consent to the continued making of direct payments to the representative or nominee, the health body must stop making the direct payments; and
c) the health body must, as soon as is reasonably possible, review the making of the direct payments (see Section 8 for monitoring and review).

4.4 Ability to manage direct payments

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

- whether they would be able to make choices about, and manage, the services they wish to purchase
- whether they have been unable to manage either a healthcare or social care direct payment in the past, and if their circumstances have changed
- whether they can take reasonable steps to prevent fraudulent use of the direct payment or identify a safeguarding risk and if they understand what to do and how to report it if necessary.

46. If a representative (see section 4.10) receives direct payments on someone's behalf, or the person receiving care appoints a nominee (see section 4.8) to manage the direct payments on their behalf then the ICB needs to be confident that the representative or nominee can manage direct payments on the person's behalf.

47. Where an ICB is concerned that a person who wishes to receive direct payments may not be able to manage them, they should additionally consider:

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

48. A judgement by an ICB that someone is unable to manage direct payments should be on an individual basis, taking into account the views of the person, and the help available to them. Assumptions should not be made due to the existence of a particular condition, or that whole groups of people will or will not be capable of managing direct payments.

49. When considering whether someone is capable of managing direct payments, the ICB should take into account the support available to that person and should consider whether providing additional support would enable them to receive direct payments (see section 4.7).

50. If the ICB concludes that someone would not, even with assistance, be able to manage direct payments, it is important to discuss this with them, and if appropriate with family and friends. They should also consider whether a nominee (see section 4.8) could manage the budget.

51. If an ICB decides that someone is not suitable for direct payments, the organisation should inform them in writing of their decision, giving their reasons and as set out in section 3.4, the person, their representative or a nominee can ask for a review of this decision.

    The ICB should also consider other means of supporting the person to personalise their care and support, including through a notional budget held by the organisation, or through a third-party budget. People should not be disadvantaged by not being able to manage direct payments.

4.5 Who should the ICB consult when considering whether to make a direct payment?

52. Where there are questions about whether or not a person is suitable to receive direct payments and would be able to manage them, there are a range of people that an ICB may consult if they believe they may have information relevant to the decision to make direct payments.

    Where carers, or people with professional duties of confidentiality are being contacted, the ICB should seek the person’s consent for this information to be shared. This consultation process is for information gathering only to help the ICB make a decision. The ICB may consult one or more of the following:

    - anyone identified by the person involved as someone to be consulted for these purposes
    - if the person is aged between 16 and 18, the person with parental responsibility for them
    - the individual primarily involved in the person's care
    - anyone else who provides care for the person
    - an independent mental capacity advocate or an independent mental health advocate appointed for the person
    - any health professional or other professional who provides healthcare to the person
    - the person's social care team
    - if the person has one, a deputy appointed by the Court of Protection in relation to matters in respect of which direct payments may be made
    - a donee of a lasting power of attorney with the power to make the relevant decisions (see section 9 of the Mental Capacity Act (2005))
    - a person vested with an enduring power of attorney with the power to make the relevant decisions (see schedule 4 of the Mental Capacity Act (2005))
    - where relevant, anyone named by the person for whom direct payments are to be made, when they had capacity, as a person to be consulted for this purpose
    - anyone who the ICB considers is able to provide relevant information about the person. ICBs should be particularly aware that carers will have particular insights and should be seen as partners in care wherever possible.

53. If the person lacks capacity, the ICB may consult people listed above to establish whether or not that person would want to receive direct payments if they had capacity to consent.

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

54. The ICB may ask the person receiving care, their nominee or representative to provide information about:

- their overall health
- the details of the condition(s) in respect of which they would receive direct payments
- any bank, building society, post office or other account into which direct payments would be paid.

The ICB should ensure that only the necessary information needed to make this judgement is requested and that as far as possible, the privacy and confidentiality of the person is protected.

4.7 Information, advice and support

55. Having the right information and support is key to successful outcomes with personal health budgets. ICBs must make arrangements to provide the person to whom direct payments are made (including representatives or nominees) with information, advice and other support. This can be provided either directly or by another organisation working in partnership with the ICB.

    The ICB should ensure that the person receives adequate information and support at every stage of the process, including during the discussion about whether to receive direct payments, during personalised care and support planning discussions and in managing and accounting for them correctly.

    Information and support for people, representatives or nominees using their direct payments for healthcare to employ staff is included in section 7.

56. It is important to ensure that whatever support arrangements are made available, they are adequate to meet the full range of requirements that people receiving direct payments will have. The regulations do not specify either the type of support or the information that ICBs must provide, as there are a

number of possible options available. Examples given in the regulations to assist ICBs to meet this obligation are:

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

This is not intended to be an exhaustive list.

57. ICBs should ensure that the support they give is comprehensive, relevant, up-to-date, and accessible. This may include using different forms of media, and different formats or languages, depending on the groups they are aimed at.

    ICBs should ensure they adhere to the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support

needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

58. Many local authorities have already commissioned support services for people with social care direct payments, and ICBs may find it helpful to work with them to develop joint or integrated support services.

    ICBs may also want to consider consulting with and using the expertise of voluntary, user led, community, carers or peer support organisations when discussing or developing their ideas. This will give useful insight and expertise locally on a range of issues including how to meet the needs of people with protected characteristics and those at risk of health inequalities.

59. While support may be provided directly by the ICB, it may also be appropriate for people to purchase their own support, for example purchasing a payroll service to help when employing personal assistants.

    This should be discussed within the personalised care and support planning process and the personalised care and support plan should specify any requirement for information, advice or other support. This can then be funded as part of the personalised care and support plan, within which it must be costed and agreed in the same way as for any other service to be purchased by the person.

4.8 Nominees for people with capacity

60. 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 (see section 4.10).

61. It is important that the identified nominee understands that when agreeing to accept the direct payment on a person's behalf they are responsible for fulfilling all the responsibilities of someone receiving direct payments, as described below in Box 1 (below). People aged 16 or over with capacity and representatives receiving direct payments for healthcare, and those who act as their nominees need to be made fully aware of this.

Box 1: What is a nominee?

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

a) acting as the principal person for all contracts and agreements with care providers, employees, etc

b) using the direct payment in line with the agreed personalised care and support plan; and

c) complying with any other requirement that would normally be undertaken by the person receiving care as set out in this guidance (eg review, providing financial information).

62. The ICB must be satisfied that a person agreeing to act as a nominee understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. This is an area where people may particularly welcome advice, support and information around what they should expect when managing direct payments on someone else's behalf.

63. The ICB must satisfy itself of the person's suitability for the role, including, where appropriate, requiring the nominee to apply for an enhanced Disclosure and Barring Service (DBS) check with a check of the barred list for the relevant group (adult's or children's) including suitability information relating to vulnerable adults. The ICB should then make a suitability decision in relation to the information in the response.

64. Before the nominee receives the direct payment, the ICB must agree that the direct payments can be made in this way. ICBs should, in particular, consider whether the person is competent and able to manage direct payments, on their own or with whatever assistance is available to them (see section 4.4). In reaching their decision, the ICB may also:

- consult with relevant people (see section 4.5)
- require information from the person for whom the direct payments will be made on their state of health or any health condition they have which is included in the services for which direct payments are being considered

- require the nominee to provide information relating to the account into which direct payments will be made.

65. The people whom the ICB may consult in deciding whether or not to make direct payments to a nominee are the same as those they may consult before deciding to give a direct payment (see section 4.5).

66. If a proposed nominee in respect of a person aged 18 or over is barred the ICB 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. Such activities fall into "the provision of assistance in relation to general household matters to an adult who is in need of it by reason of age, illness or disability", which is a regulated activating relating to vulnerable adults under Part 2 of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006.

67. A named person in an organisation (including one such as a trust established for the purpose) may agree to act as nominee. Where a trust is established to act as a nominee, the trust must appoint a person to have overall responsibility for the day-to-day management of the direct payments and section 4.5 will apply to that person.

68. A person who has chosen to appoint a nominee may withdraw or change that nomination by writing to the ICB. If this occurs, the ICB must consider whether to stop paying the direct payment, consider paying it to the person directly, or paying it to another nominee; and they should review the direct payment and personalised care and support plan as soon as is reasonably possible.

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

4.9 The status of support organisations and managed account providers regarding the role of nominee

70. A managed account is where a third-party, which can be a named person (eg a solicitor or accountant) or an organisation (eg a direct payment support service), holds the money in a dedicated account for the person but does not

take any responsibility for the ways in which it is spent or enter into any contractual arrangements on behalf of the person.

The person, their representative or nominee gives all the direction as to how the budget should be managed, as agreed in the personalised care and support plan, and where it should be spent, thus maintaining the control that direct payments are designed to allow.

71. A managed account provider does not have the status of a nominee or representative and provides financial management and support services only to a person, their representative or nominee. In this situation the person, their representative or nominee remain fully responsible for the direct payment, including acting as the employer (where appropriate) and making all decisions about their direct payment.

    The managed account provider may offer advice and support around a number of elements including being an employer, in addition to co-ordinating the financial element of the direct payment but they do not take on full responsibility for the person's care and budget.

4.10 Representatives

72. If a person does not have capacity and so may not receive direct payments personally, the ICB 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 ICB 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 (ie no-one falling into categories a-to-f in paragraph 77).

73. 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.

74. Before someone can be a representative, they must give their consent to managing the direct payment. Like all decisions involving consent, ICBs should ensure that people are fully informed and provided with sufficient advice and support when making their decision.

    In a similar way to the process for appointing nominees, the ICB should also consider whether the person is competent and able to manage direct payments, on their own or with whatever assistance is available to them.

75. A representative may identify a nominee (see section 4.8) to receive and manage direct payments on their behalf, subject to the nominee's agreement and the approval of the ICB.

76. An appointed representative could be anyone deemed suitable by the ICB. However, it will be important for ICBs to take into account previously expressed wishes of the person, and as far as possible their current wishes and feelings.

    Where possible, ICBs should consider appointing someone with a close relationship to the person, for example a close family member or a friend. As far as is reasonably practicable, the ICB should also take into account the views of the people in paragraph 52 before appointing someone as a representative.

77. A representative can be:

    a) the person with parental responsibility, if the person is a child (under 16)
    b) a deputy appointed by the Court of Protection (under section 16(2)(b) of the Mental Capacity Act (2005)) to make decisions relevant to healthcare and direct payments ("the relevant decisions")
    c) a donee of a lasting power of attorney with the power to make the relevant decisions (see section 9 of the Mental Capacity Act (2005))
    d) a person vested with an enduring power of attorney with the power to make the relevant decisions (See schedule 4 of the Mental Capacity Act (2005))
    e) someone appointed by the ICB to receive and manage direct payments on behalf of a person, other than a child, who lacks capacity.

78. When considering whether a representative is suitable, the ICB should be aware of the terms under which someone has been appointed under a Lasting Power of Attorney made by the person or by the Court of Protection as the person's deputy. The attorney or deputy may only make decisions about the person's healthcare and securing services on the person's behalf to meet their care needs if they have been appointed to deal with these matters – a Lasting Power of Attorney can cover matters relating to the person's personal welfare as well as property and financial affairs but can be subject to a range of exclusions and restrictions.

    If an attorney or deputy lacks suitable powers, the ICB should consider whether, if they were to manage the direct payment, this would undermine the decision made by the person when they had capacity to give identified individuals the authority over specific aspects of their life only. In such circumstances, the ICB may appoint another person as a representative (under regulation 5(4)).

4.11 The role of the representative

79. 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, eg to help develop personalised care and support plans and to hold the direct payment. Further guidance about making decisions in the person's best interests is in Chapter 5 of the Mental Capacity Act 2005: Code of Practice
    - act in the best interests of the person when securing the provision of services
    - be the principal person for all contracts and agreements, eg as an employer
    - use the direct payment in line with the agreed personalised care and support plan
    - comply with any other requirement that would normally be undertaken by the person as set out in this guidance (eg review, providing information).

80. If a representative believes that the person for whom they are acting has regained capacity, they should notify the ICB as soon as possible (see section 4.3 on fluctuating capacity).

4.12 Deciding whether to make direct payments to a representative

81. When deciding whether or not to make direct payments to a representative, the ICB is required to act in the best interests of the person receiving care in accordance with section 4 of the Mental Capacity Act 2005 and should, in particular, consider:

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

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

82. When considering whether to appoint a representative, the ICB may also consult the person receiving care and all or any of those people identified in section 4.5.

83. The ICB must satisfy itself of the person's suitability for the role, including, where appropriate, requiring the representative to apply for an enhanced Disclosure and Barring Service (DBS) check, with a check of the barred list for the relevant group (adult's or children's).

4.13 When a child reaches the age of 16

84. When a child on whose behalf a representative has consented to direct payments reaches 16, the ICB may continue to make direct payments to the representative or their nominee in accordance with the personalised care and support plan, providing the child who has reached 16 and the representative and, where applicable the nominee, consent.

    If the child who has reached 16 does not consent, the ICB must stop making direct payments. In either case, the ICB must as soon as reasonably possible review the making of direct payments.

5. Personalised care and support planning and direct payments for healthcare

5.1 Personalised care and support planning

85. Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and wellbeing within the context of their whole life and family situation.

    This process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that are not working in the person's life and identifies outcomes and actions to resolve these.

86. The personalised care and support plan is at the heart of a personal health budget. Drawing up a personalised care and support plan should involve discussions between the person receiving the care, their nominee or representative, their care co-ordinator (see section 5.6), the appropriate health and social care professionals and any others the person would like involved in their care. The personalised care and support planning webpage includes additional information.

87. Wherever possible, ICBs should work with local authorities and other healthcare providers to ensure that the person has a single personalised care and support plan covering their health and wellbeing needs across both the NHS and social care. This could include all the services and support provided, whether traditionally commissioned or through notional or third-party budgets, as well as direct payments.

    For children with special educational needs and disabilities, who have a single education, health and care plan, this could also include their educational needs.

88. The personalised care and support plan is the basis of an agreement between the ICB and the person receiving direct payments and includes responsibilities on both sides. It is therefore vital that people are supported throughout the

personalised care and support planning process. This will help ensure that they are able to make informed decisions in their best interests, and that they do not find the process overly burdensome or overwhelming.

This support could take many forms – it may be from their healthcare professional, but some people may prefer an independent person to guide them through the process and liaise with the relevant parties. As with each aspect of personal health budgets, the best approach is to enable choice and not assume that the same option suits everyone.

89. As a result of the personalised care and support planning discussion, the personalised care and support plan should clearly set out the health needs that the direct payment is to address. These may be reasonably broad, but it should be clear to both the ICB and the people involved what the direct payments are meant to achieve.

90. Having set out the health needs, the personalised care and support plan should also set out the outcomes that are intended to be achieved. These may relate to both health and wellbeing outcomes. ICBs have broad powers to address people's health and wellbeing needs; and a good personalised care and support plan should address people’s needs holistically and include outcomes that may be met in ways that do not involve the use of the personal health budget.

91. Having set out the health needs and intended outcomes, the personalised care and support plan must specify the services to be secured by the direct payment in order to achieve these. This should be done in such a way to enable the ICB to be satisfied that the health needs and identified outcomes are likely to be met and should enable as much choice and control as appropriate while delivering value for money for the system.

92. The ICB must make arrangements for the person, their representative or nominee to obtain information, advice or support in connection with the direct payments. These arrangements should be specified in the personalised care and support plan and could be a service for which direct payments may be made.

5.2 What must be included in the personalised care and support plan for direct payments to be made

93. Before a direct payment can be made, a personalised care and support plan must be agreed between the ICB and the person, their nominee or representative. This must set out:

- the health needs of the person and desired outcomes to be achieved through purchase of services in the personalised care and support plan (the term 'services' is used throughout this document to refer to anything that can be bought and which will meet someone's health needs)
- what the direct payment will be used to purchase (see section 3.3)
- the size of the direct payment, and how often it will be paid (see section 6.1)
- the name of the care co-ordinator responsible for managing the personalised care and support plan (see section 5.6)
- who will be responsible for monitoring the health condition of the person receiving care
- the anticipated date of the first review, and how it will be carried out (see section 8)
- where necessary, an agreed procedure for discussing and managing any significant potential risks (see section 5.5)
- the plan should consider safeguarding and promoting liberty, especially where people lack capacity or are more vulnerable
- the period of notice required if the ICB decides to reduce the amount of the direct payment.

5.3 Agreeing the personalised care and support plan

94. When agreeing the personalised care and support plan, the ICB must be satisfied that:

- the health needs of the person can be met through the purchase of services in the personalised care and support plan (see section 3.3 for more information on what direct payments can be spent on)
- the amount of money in the personalised care and support plan will be sufficient to cover the full cost of each of the specific services in the plan

- the personalised care and support plan will be reviewed as required (see section 8)
- any significant potential risks have been discussed with the person, their representative or nominee and appropriate procedures to eliminate, reduce or manage these risks have been included in the personalised care and support plan (see section 5.5)
- where people lack capacity or are more vulnerable, procedures such as safeguarding, promoting liberty have been included appropriately in the personalised care and support plan.

95. The person or their representative must also agree that:
    - the person's care needs will be met by the services agreed in the personalised care and support plan
    - the amount of direct payment is sufficient to cover the full cost of the personalised care and support plan
    - the personalised care and support plan will be reviewed (see section 8) and their needs may be re-assessed as part of that review.

96. No service should be included in the personalised care and support plan if the ICB considers that the benefits are outweighed by the possible damage to health.

97. Where the National Institute for Health and Care Excellence (NICE) has concluded that a treatment is not cost effective, ICBs 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, ICBs should not use this as a barrier to people purchasing the service if it could meet the person'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, people 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.

98. ICBs should consider all proposals where it can be demonstrated that the use of the budget is a reasonable way to meet the person's health and wellbeing needs.

99. The sign-off of a personalised care and support plan should be a joint process between the person and the professional in which all requests have been discussed and any risks and issues identified.

100. If an ICB decides to refuse a service as part of the personalised care and support plan, the person, representative or nominee may request an explanation from the ICB. The person can also ask the ICB to reconsider their decision and provide additional evidence or relevant information to inform that decision.

    The ICB must reconsider their decision in the light of the new evidence, and then notify and explain the outcome of their deliberation in writing. If the dispute persists, the ICB should refer the person to the complaints procedure (see section 8.2).

5.4 Reviewing and revising the personalised care and support plan

101. The personalised care and support plan should be open to review and revision as necessary and should be reviewed at clinically appropriate intervals. It must be initially reviewed within the first three months, and then at least annually (see section 8 for more information on monitoring and review).

    In case of a change in a person's condition, it is important that the personalised care and support plan is reviewed, adapted to meet their changing needs and agreed as soon as possible.

5.5 Managing risk

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

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

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

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

105. Any discussion about risk should be realistic and aimed at enabling people to make decisions that are right for them. This may require balancing potential risks and consequences with the benefits associated with any decisions. There is a delicate balance between empowerment and safeguarding and providing choice whilst managing risk.

106. The balance between risks and benefits will be different for each person and will depend on their individual circumstances and health condition. ICBs should ensure that they do not impose blanket prohibitions and are sufficiently flexible to tailor their risk management processes to the needs of each person.

107. During the process of discussing risk with people, ICBs should ensure that all relevant others can contribute. ICBs should ensure that their family or carers, if they want to be involved, are included in these discussions if appropriate. It is also important to get the input of healthcare professionals who have the knowledge of the identified risks, and other people involved in the person's care, for example, social workers or care workers.

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

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

5.6 Named care co-ordinator

109. For each person receiving a direct payment, the ICB must name a care co-ordinator, and this must be recorded in the personalised care and support plan. The care co-ordinator is responsible for:

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

110. The care co-ordinator should normally be someone who has regular contact with both the person receiving care, and their representative or nominee if they have one. They do not need to have 'care co-ordinator' in their job title – the important thing is that they fulfil the responsibilities above and that the direct payment recipient is aware of who they are and their role.

While they can arrange with others to undertake actions, such as monitoring or review, the care co-ordinator should be the primary point of contact between the person and the ICB. This is a similar role to the care co-ordinator in many mental health services and case managers in NHS Continuing Healthcare.

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

6. Managing the money

6.1 Setting the amount of a direct payment

112. ICBs must set direct payments at a level sufficient to cover the full cost of each of the services agreed in the personalised care and support plan. NHS services, including personal health budgets, are free at the point of delivery. Contributing to the cost of their care by people is only permissible in a limited number of NHS areas such as wheelchair provision.

113. When calculating the budget, ICBs should ensure that they recognise the additional 'hidden' costs.

     For example, if someone is employing personal assistants, they must ensure that there is sufficient funding available to cover the additional necessary costs of employment such as tax, National Insurance, training and development, pension contributions, redundancy payments, any necessary insurance such as public liability, emergency cover and so on.

     If the direct payment includes agreement to purchase equipment, then any insurance or maintenance costs should be included in the budget.

114. ICBs must ensure direct payments cover the full cost of the care agreed in the personalised care and support plan. However, they do not circumvent existing government policy around additional private care. In no circumstances should the budget be set at a level where someone is expected to pay for care privately to meet their agreed health needs.

     If someone wishes to purchase additional care privately, they may do so, so long as it is additional to their assessed needs, and it is a separate episode of care, with clearly separate lines of clinical accountability and governance.

115. If the amount of a direct payment is not set at a suitable level, it must be reviewed and adjusted.

116. ICBs should consider including a contingency fund in the direct payment, either for the person or as part of a collective risk pool, to ensure that the budget is available to fully fund the personalised care and support plan.

6.2 Receiving a direct payment

117. NHS services are free at the point of delivery. ICBs must pay direct payments in advance. Under no circumstances, should people have to pay for services themselves and be reimbursed, even if receipts are available, for services agreed in the personalised care and support plan.

118. With the exception of one-off direct payments (see paragraph 120), ICBs must pay direct payments into a separate bank account used specifically for this purpose and held by the person receiving them (or held by a managed account provider). That person may be the person receiving care, or a nominee or representative. This account may also be used to receive money provided by the government for other care or services.

    These include direct payments for social care, direct payments for children with special educational needs and disabilities and other money paid to disabled people to secure relevant services. The bank account should only be accessible to people agreed to by the ICB, which should normally be limited to the person purchasing services.

119. When receiving direct payments, the person holding the account should keep a record of both the money going in and where it is spent, for example, through keeping bank statements and receipts. Where different funding streams are paid into a single account, this may require taking copies of statements, as there may be different monitoring and review processes.

    As far as possible, ICBs should endeavour to join up with other statutory services, to ensure that monitoring is not onerous and to limit the amount of duplication. These processes and conditions should be included in the ICB's own local personal health budget policies as well as the person's own direct payment agreement.

120. Where someone is receiving a one-off direct payment, it can be paid into the person's ordinary bank account (or that of a nominee or representative). A one-off payment is used to buy a single item or service, or a single payment made for no more than five items or services, where the person is not expected to receive another direct payment in the same financial year.

    People will need to provide evidence that the direct payment was used as agreed in the personalised care and support plan. However, for one-off direct

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

6.3 Stopping or reducing a direct payment

121. See section 8 for requirements on monitoring and review of direct payments. The ICB may increase or decrease the size of the direct payment at any time, if they are satisfied that the new amount is sufficient to cover the full cost of the services required to meet the person's needs in the current personalised care and support plan.

122. Before making a decision to stop or reduce a direct payment, wherever possible and appropriate, the ICB should consult with the person receiving it to enable any misunderstandings or inadvertent errors to be addressed and enable any alternative arrangements to be made.

123. Whenever a direct payment is reduced or stopped, the ICB must ensure that the person receiving the direct payment is given reasonable notice, and an explanation regarding the reasons for the organisation's decision. This must be done in writing, and it should be accessible and understandable to the person involved.

124. Direct payments may be reduced:
    - where the ICB is satisfied that a reduced amount is sufficient to cover the full cost of the current personalised care and support plan
    - if a surplus payment has accumulated that has remained unused. A surplus may indicate that the person is not receiving the care they need or too much money has been allocated. As part of the review process, the ICB should establish why the surplus has built up. Under these circumstances, a reduction in direct payment in any given period cannot be more than the amount that would have been paid to them in the same period.

125. There may be occasions when a person receiving care and support via a direct payment requires a stay in hospital. However, this should not necessarily mean that the direct payment must be suspended while the individual is in hospital.

    Consideration should be given to how the direct payment may be used in hospital to meet the person's support needs or to ensure employment

arrangements are maintained. For example, the person may prefer the personal assistant to visit hospital to help with personal care matters. This should not interfere with the medical duties of hospital personnel, but be tailored to work alongside health provision.

Suspending or even terminating the payment could result in the person having to break the employment contract with a trusted personal assistant, causing distress and a lack of continuity of care when discharged from hospital.

126. If a direct payment is suspended or terminated, all rights and liabilities related to the care agreed in a person's personalised care and support plan pass back to the ICB and any period of notice required for staff and other contracts and costs incurred due to the stopping of the direct payment must be met by the ICB.

127. Where direct payments have been reduced, the person receiving care, a representative or nominee may request the ICB to reconsider the decision and may provide evidence or relevant information to be considered as part of that deliberation. Where this happens, the ICB must inform the person receiving care and any representative or nominee in writing of their decision after reconsideration and state the reasons for the decision.

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

128. An ICB must stop paying direct payments if:

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

129. An ICB may stop making a direct payment if they are satisfied that it is appropriate to do so. For example, where:

- the person no longer needs care

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

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

131. In some cases, it may be necessary to stop the direct payment immediately, for example if fraud or theft has occurred. In these cases, ‘reasonable notice’ may include immediate termination of the direct payment. In these circumstances, the ICB should endeavour to protect public money as far as possible, whilst being mindful that they are still under a duty to provide healthcare if the person requires it. No person should ever be denied the care they need.

    Where possible, ICBs should also endeavour to continue to provide a personalised service and maintain a continuity of care. For example, an independent user trust could be established to manage the budget or the ICB could directly commission the services agreed in the personalised care and support plan.

132. However, ICBs should be mindful that genuine errors can occur and also that circumstances beyond people’s control can result in, for example, surplus, unspent funds. In such situations ICBs should work with budget holders to

understand the situation and explore alternative options for using the direct payment to meet the person's health and wellbeing needs.

6.4 Repayment of a direct payment

133. In some circumstances, the ICB may ask for all, or part of, the direct payment to be repaid. The decision to seek repayment, and the amount of money to be reclaimed, is at the discretion of the ICB with consideration to be given to the duty to exercise their functions effectively, efficiently and economically (s14Z33 of the NHS Act 2006) and the duty to have regard to the efficiency and sustainability in relation to the use of resources (s14Z43(1)(c) of the Health and Care Act 2022).

134. The ICB may reclaim direct payments if:

- they have been used to purchase a service that was not agreed in the personalised care and support plan
- theft, fraud or other offences have occurred
- the person receiving care has died, leaving part of the direct payment unspent
- the personalised care and support plan has changed substantially resulting in surplus funds
- the person's circumstances have changed substantially, such as admission to hospital resulting in the person not using the direct payment to purchase their care
- a significant proportion of the direct payment has not been used to purchase the services specified in the personalised care and support plan resulting in money being accumulated.

135. Again, ICBs should be aware that genuine errors can occur. The power to reclaim direct payments should not be used to penalise people for making mistakes or when the person has been the victim of fraud.

136. If a substantial amount of money accumulates in the person's account due to an underspend for any reason, the ICB should consider whether it is appropriate to reclaim that money. In some circumstances, it may be more appropriate to simply reduce subsequent direct payments, factoring in the existing surplus.

ICBs should also assess the reasons for the build-up of the surplus as part of the review process – for example, if there are surplus funds associated with employing staff – either the person is not receiving the care they need or too much money was allocated.

137. When reclaiming money from someone with a representative or nominee, the ICB should approach the person holding the money, rather than the person receiving care. The ICB should also ensure that, as far as possible, the person receiving care is also aware of their intention, and the reasons for this.

138. When reclaiming money from the estate of someone who has died, the ICB must approach the personal representatives of the person to seek repayment. They should do so sensitively and may wish to leave a period of grace to allow the executors of the will to ensure the estate is in order.

    The ICB should bear in mind that if the person, their representative or nominee was an employer, their employees will have employment rights, which may include a paid period of notice or redundancy payment.

    These payments should be met immediately by the ICB and where there is accrued money from the direct payments, reimbursed by the estate at a later date. Where there is no accrued money from the direct payments the liabilities remain with the ICB.

139. In some cases, the person may also be approached by the local authority (LA) and other public body seeking to reclaim direct payments, for example in cases where someone has a joint personalised care and support plan. In these circumstances, the ICB should co-ordinate with the local authority and other bodies to agree a common approach.

    ICBs should be aware of their responsibilities under the Data Protection Act 2018 and General Data Protection Regulation 2016 and should inform the relevant people before contacting the LA or other bodies.

140. If the ICB has decided to seek repayment, they must give the relevant person reasonable notice in writing, stating:

    - the reasons for their decision
    - the amount to be repaid
    - the time in which the money must be repaid

- the name of the person responsible for making the repayment.

141. On receipt of notice from the ICB, the person, representative or nominee may request the ICB to reconsider their decision. They may also provide additional evidence or relevant information to inform that decision. The ICB must reconsider their decision in light of any new evidence, and then notify and explain the outcome of their deliberation in writing.

 The ICB can only be required to reconsider their decision once. If the person is still unhappy with the decision, they should be referred to the local NHS complaints procedure.

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

7. Using a direct payment to employ staff or buy services

7.1 Using a direct payment to buy services from a provider

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

144. Some people may wish to pay a third-party organisation (eg via a third-party budget arrangement) to employ a personal assistant on their behalf. The third-party organisation should allow the person to have as much choice and control in the recruitment and management of the personal assistant as appropriate. However, the ultimate accountability for meeting employer responsibilities remains with the third-party organisation.

7.2 Using a direct payment to employ staff

145. People may wish to use their direct payment to employ staff to provide them with care and support. ICBs should support them to do so whenever possible, while ensuring that there is appropriate practical support.

146. For some people who receive direct payments, it may be their first experience of being an employer, and it will be vital that there is good information, advice and support available to them.

     Supporting good employment practice and promoting positive working relationships between personal assistant employer and employee can help ensure a sustainable and successful package of care. It can contribute to the retention of staff and prevent a breakdown of care arrangements which could impact adversely on the person's health or in some instances lead to hospital admission.

147. This support offer should be available to all direct payment recipients, their representatives or nominees who want it and could include for example support with recruitment, provision for payroll, pensions, training, managing sickness, insurance advice or other employment related information and services.

To comply with this, many ICBs work with their local authorities who may have arrangements in place, often through voluntary or user-led organisations to provide support and advice to direct payment holders and their personal assistants, and to people interested in receiving direct payments.

148. Where direct payments are being used to employ one or more people, the person receiving care, the representative or the nominee, should be made aware of their legal responsibilities and obligations as employers. This should include information on HM Revenue & Customs (HMRC) requirements including in relation to registering as an employer and health and safety requirements.

149. There will also be costs associated with employing a member of staff directly, such as National Insurance, pension contributions, training, insurance costs, maternity leave, emergency cover and, at times, redundancy. When setting the budget and agreeing the personalised care and support plan, ICBs should ensure that the full cost of employing someone is included, and people must not be expected to bear any of these costs themselves.

150. Where it becomes clear that payments, or returns detailing employee information deductions, have not been made, or that the person is failing to meet their obligations as an employer generally, the direct payment scheme should be reviewed and consideration given to whether alternative arrangements that result in the direct payment recipient no longer acting as the employer need to be made.

Not doing so may result in the person building up arrears of tax and National Insurance due to HMRC, which may then lead to enforcement action to recover any debt.

This situation should be avoided by effective, proportionate monitoring, and by providing clear, accessible upfront information about the responsibilities of becoming an employer. Many ICBs work with local authority partners who

have commissioned voluntary and community organisations to provide support to direct payment holders on these matters.

151. Concern about becoming an employer should not discourage people who would otherwise be willing and able to manage a direct payment. People should be informed of the local support available in relation to being an employer and the different options in relation to taking on staff, such as use of agencies.

This should be done accurately and responsibly, making recipients aware of what is involved without overstating the extent and complexity of these responsibilities.

152. As one of a range of support services, direct payment recipients may wish to make use of payroll services, which will take responsibility for administering wages, tax, pensions and National Insurance on their behalf. Costs such as this should be factored in when setting the budget.

7.3 Paying staff living in the same household

153. A direct payment can only be used to pay a family member or friend living in the same household to deliver care agreed in the personalised care and support plan if the ICB is satisfied that this is necessary to 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. ICBs will need to make these judgements on a case-by-case basis.

154. These restrictions are not intended to prevent people from using their direct payments to employ a live-in personal assistant, provided that person is not someone who would usually be excluded by the regulations. The restriction applies where the relationship between the two people is primarily personal rather than contractual, for example if the people concerned would be living together in any case by virtue of a personal rather than professional relationship.

155. Consideration should be given to any impact it may have on a family member's health and wellbeing or family relationships if they are also an employee.

156. Where a family member is both the direct payment recipient and the potential employee, there could be a conflict of interest. ICBs will want to assure themselves that this is a suitable arrangement and could consider employment of the family member through an agency or third-party as an appropriate solution.

Box 2: A person's family members are described in the regulations as:

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

7.4 Safeguarding and employment

157. When deciding whether or not to employ someone, people should follow best practice in relation to safeguarding, including satisfying themselves of a person's identity, their right to work in the UK, their qualifications and professional registration if appropriate and taking up references and ensure the appropriate type of Disclosure and Barring Service (DBS) checks are carried out.

158. ICBs should ensure that there is readily available advice in relation to the provision of DBS checks in respect of people who direct payment recipients may wish to employ to undertake regulated activity as per the Safeguarding Vulnerable Groups Act 2006.

It is likely that most personal assistants' work would be classified as regulated activity under the Safeguarding Vulnerable Groups Act 2006 and this is what

makes them eligible for enhanced DBS checks and a check of the Adults' or Children's Barred List. A collection of documents that you can use to decide whether a role is eligible for a basic, standard or enhanced DBS check is also available.

159. A person or their nominee or representative cannot apply for a DBS check on another individual. However, they may ask the ICB or another DBS registered umbrella body for advice in relation to arranging for the prospective employee to apply for an enhanced DBS check with a check of the adult's (or children's if appropriate) barred lists. This would include when employing or contracting with people providing care to the person, such as:

- regulated health care professionals – for example, nurses or physiotherapists
- people providing healthcare under the direction or supervision of a health care professional
- people (including personal assistants) providing personal care or involved in other activities that constitute regulated activity under the Safeguarding Vulnerable Groups Act 2006. These are examples of regulated activity relating to vulnerable adults and children within the meaning of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006 ("regulated activity"). An enhanced DBS check including a barred list check may be obtained to assess a person's suitability to engage in regulated activity. Refer to sections 113B, 113BA and 113BB of the Police Act 1997 (c.50) and S.I. 2002/233 and 2009/1882.

160. A local authority or NHS organisation can apply for DBS checks themselves or decide to commission the processing of DBS checks through an umbrella body. The umbrella body will be responsible for processing a DBS application; however, unless the umbrella body employs someone to make the suitability decision in regard to DBS checks the responsibility for the suitability decision remains with the organisation requesting a check.

161. Based on the results of the DBS check, the person employed to make the suitability decision must make the decision in relation to the particular role under consideration. The person who assesses suitability should be checking against their local safeguarding policy and recruitment of ex-offenders policy

to reach a decision on suitability. The decision should be an objective one based on facts.

162. If the suitability decision maker considers that the information disclosed on the DBS check indicates that the person is not suitable for employment in the specific role they are being considered for, then the individual employer cannot employ that person using a direct payment.

The individual employer cannot be involved in making the suitability decision in relation to the DBS check. Only the final decision regarding suitability can and must be shared with them but not the content of the DBS check.

If the person is deemed suitable in relation to the DBS check, then the individual employer can make a further decision about their employment in relation to other aspects of their suitability.

163. The person on whom the DBS check was conducted may choose to show their DBS check to the person intending to employ them if they so wish. If they agree that the person making the suitability decision can, subsequent to making the decision, share the information with the individual employer then data protection rules as outlined in the Data Protection Act 2018 must be adhered to when they do so.

164. The DBS Update Service allows people to reuse their certificate for multiple roles. If a potential employee or contractor has subscribed to the Update Service and has a DBS check at the appropriate level and for the appropriate workforce, the ICB may, with the person's permission, see the person's original certificate and use the free online portal to check whether that certificate is still up to date.

If the Update Service indicates that the certificate is not up to date, the ICB should ask the potential employee or contractor to apply for a new DBS check.

165. If the potential employee is barred, they must not be used to supply services to the group with which they are barred from working with. Barred individuals are committing a criminal offence if they seek employment in regulated activity with the group they are barred from working with. Similarly, it is a criminal offence if a person permits an individual to engage in regulated activity if they know or have reason to believe they are barred from that activity.

7.5 Insurance, indemnity and accountability

166. Personal health budgets and direct payments do not release the NHS from their duty of care to people within their care. Where people employ their own staff, through the use of a personal health budget, ICBs are responsible for ensuring that everything necessary to deliver safe care is included in the care package and that any significant risks have been discussed with the person or their representative and appropriate procedures to manage these risks have been included. Direct payments increase the level of choice and control people have but they do not change the statutory duty of care that the NHS has to all individuals.

167. Direct payments for healthcare can be used to pay for a personal assistant to carry out certain healthcare tasks only where these are appropriately delegated.

     In such cases a healthcare professional who is occupationally competent in the task and is accountable in relation to that aspect of clinical care of the person, will need to be satisfied that the task is suitable for delegation, specify this in the personalised care and support plan and ensure that the personal assistant is provided with the appropriate training, assessment of competence and ongoing support and competence review.

     More information on this can be found in the Delegation of Healthcare Tasks to Personal Assistants document.

168. Providers of some services will need to conform with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014. The order amends the framework legislation in respect of regulated healthcare professionals to require regulated healthcare professionals who are practising to have indemnity or insurance cover which provides appropriate cover in respect of the risks that may arise in the course of their work to ensure that people are able to claim compensation they may be entitled to.

169. Personal assistants employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover unless they are a member of a regulated health profession, even if carrying out activities which might otherwise be performed by health professionals. However, if a personal assistant causes an injury to the person they are supporting, this may result in a clinical negligence claim against the personal assistant by or on behalf of

the person they are supporting. It is therefore advisable for them to have clinical indemnity insurance when employed to carry out tasks of a clinical nature.

170. ICBs should note that accidents to people whilst receiving personal care from personal assistants employed by a direct payment recipient cannot reasonably be predicted as part of a risk assessment and could occur in any situation. Insurance cover should therefore include cover for personal injury for the individual employer and not just liability cover in the event of injury to others.

171. Each situation should be considered upon its own facts, having regard to the nature of services provided. ICBs should discuss insurance directly with individual employers (and personal assistants where possible) as part of the personalised care and support planning process and ensure they have access to good information and advice about available insurance policies and necessary cover.

172. ICBs should include appropriate funding within the personal health budget so that the personal health budget holder and personal assistants are provided with a level of protection that reflects the risk associated with the care package. They should ensure there is enough money in the budget year on year to cover the annual cost of agreed insurance.

Box 3: Types of insurance

There are four main types of insurance that need to be considered for individual employers and their personal assistants:

1. Employers' liability – This is a legal requirement under the Employers' Liability (Compulsory Insurance) Act 1969.

   Employers are responsible for the health and safety of their employees while they are at work. Employers' liability insurance provides a level of insurance cover for a business or employer in the event that an employee is injured at work or becomes ill as a result of their work and seeks redress or compensation from a responsible employer.

   Employers' liability insurance enables the employer to meet the cost of a compensation claim arising out of, or in the course of, the employment.

Anyone who employs personal assistants through a direct payment must take out Employers' liability insurance and there are a number of companies that offer insurance at reasonable rates.

2. Public liability - Provides cover if a third-party (ie not an employee) suffers injury or damage to their person or property for which you are held legally responsible. If a personal assistant causes injury or damage to a third-party arising out of their employment with the individual employer, it is likely that the individual employer would be found vicariously liable for their actions. The employer therefore needs insurance cover against such liability.

   Public liability insurance covers claims made by members of the public or other businesses, but not for claims by employees.

3. Clinical indemnity – Some insurers will insure personal assistants to carry out a wide range of complex healthcare tasks, provided they have proof of appropriate training. If a personal assistant causes an injury to the person they are supporting, this may result in a clinical negligence claim against the personal assistant by or on behalf of the person they are supporting
4. Insurance for personal assistants – There are also specific policies designed to protect personal assistants from claims against them, for example where the personal assistant accidentally harms the employer (eg spilling a cup of hot tea on the employer).

All four types of insurance may be necessary, depending upon the circumstances, to provide adequate protection for the employer, the personal assistant and third parties who may be affected by the employment relationship in some adverse way. This will not be the case in every circumstance, however, and each situation should be considered upon its own facts, having regard to the nature of services provided.

173. Where people buy services from professionals who are required to be registered with the Health and Care Professions Council (HCPC), it will be important that they check their registration status. This will also act as assurance that professional indemnity cover is in place since this is a condition of registration.

Where people wish to buy services from providers who are not required to be HCPC registered and have limited or no indemnity or insurance cover, they may do so; however, the person buying the service should be made aware of the potential risks and implications of doing so. This should be included in the discussion around risks when developing the personalised care and support plan.

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

174. If the person buying the service asks the ICB to undertake these checks on their behalf, the ICB must do so. ICBs should also ensure that people are aware that this is an option and may wish to offer this as part of the risk assessment and personalised care and support planning process.

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

7.6 Registration and regulated activities

176. If someone wishes to buy a service which is a regulated activity as listed under the Regulated Activities in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, they will need to inquire as to whether their preferred provider is registered with the Care Quality Commission (CQC). A direct payment cannot be used to purchase a regulated activity from a non-registered service provider.

It should be noted that the definition of regulated activity in relation to the Care Act 2014 is not the same as the definition of regulated activity in the Safeguarding Vulnerable Groups Act.

177. Personal assistants who are directly employed by an individual, or related third-party, and self-employed personal assistants with an agreement to work directly for a person to meet that person’s own personal care requirements do not need to be CQC registered. This is only the case where the personal assistant is directly employed without the involvement of an employment

agency or employment business and working wholly under the direction and control of that individual or related third-party.

178. A related third-party means:

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

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

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

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

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

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

181. Registered nurses who are employed by individuals or a related third-party may need to register with the CQC, dependent upon the type of care they are delivering as part of that employment.

182. All healthcare professionals employed directly by an individual or related third-party (eg a personal health budget holder), should check whether they need to be registered as an individual provider with the CQC, particularly if they are being employed in their professional capacity to carry out clinical care or treatment that could fall under 'treatment of disease, disorder or injury'.

183. In some circumstances, the provider may also need to be a registered member of a professional body affiliated with the Professional Standards Authority for Health and Social Care. If the personalised care and support plan

specifies that a task or tasks require a registered professional to undertake it, only a professional who is thus registered may be employed to perform that task or tasks.

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

185. While some service providers, for example acupuncturists, counsellors and complementary therapists, are not statutorily required to be registered, there are professional associations with voluntary registers that practitioners can choose to join. The Professional Standards Authority assesses organisations such as these who register practitioners and are not regulated by law.

186. However, there is no legal requirement to join these registers, and practitioners can still offer unregulated services without being a member of any organisation. However, if a provider is not registered with an appropriate body this should not automatically be a bar to purchasing from that provider, but this should be included in the discussion around risks when developing the personalised care and support plan.

8. Monitoring and review

8.1 Monitoring and reviewing direct payments

187. It is essential to check at appropriate intervals how the direct payment is being used, the health condition of the person and, whether the personalised care and support plan is achieving the agreed outcomes. This forms part of the duties of the care coordinator. It should be ongoing and worked into best practice and local processes around delivering care.

188. Reviews that focus on outcomes rather than processes can be the most effective way of identifying what works well and what doesn't work well for the person. Depending on what is agreed at the review, changes can be made to the resources, support or controls described in the personalised care and

support plan. Reviews are a crucial part of personal health budgets and of safeguarding and need to be carried out effectively. The aim of review is to strengthen the person's ability to achieve the outcomes they want.

189. Reviews should be proportionate to the person's circumstances and should place as few burdens on people receiving care, representatives and nominees as possible.

     Some people will need more frequent monitoring and detailed review than others for example, people who lack mental capacity, are particularly isolated or have a degenerative or fluctuating condition or where other particular risks are identified at care and support planning that need regular monitoring.

     ICBs should consider working with local authorities, or other statutory services, to develop joint approaches to reviews, to minimise duplication and to reduce the burden on people.

190. As a minimum, all personalised care and support plans must be reviewed formally within three months of the person first receiving a direct payment. Following this, reviews should be at appropriate intervals, but at least yearly. A review should consider:

     - whether the personalised care and support plan adequately addresses the health needs of the person, and whether the agreed outcomes are being met. This includes considering whether their health needs have changed, and if so whether the personalised care and support plan is still appropriate
     - any change in the person's and or representative/nominee's circumstances
     - whether the direct payment has been used effectively
     - whether the direct payment is sufficient to cover the full cost of each of the services
     - whether the person, or their representative or nominee, has used the direct payment appropriately and fulfilled their obligations, including where relevant their obligations as an employer to pay employment tax and National Insurance
     - whether the risks have changed, and whether the risk management is still effective
     - if it is the first review, or if a service has been changed, reassesses indemnity and registration

- any safeguarding issues particularly if the person lacks capacity or is vulnerable. ICBs should also consider whether their liberty is being promoted by the personalised care and support plan.

191. When carrying out a review, the ICB may:
    - re-assess the health needs of the person
    - consult anyone mentioned in section 4.5, and where relevant paragraph 77
    - review receipts, bank statements and other information relating to the use of direct payments
    - consider evidence around whether direct payments have been effectively managed, including if the person or their representative/nominee are able to carry out their employer role effectively, and any evidence as to whether service providers have or had appropriate indemnity and registration.

192. Ideally any care or financial review of the direct payment should be done at the same time to reduce the burden on the person and their family.

193. During the personalised care and support planning discussion, there should be discussion about what the review will look at, and the information that will need to be provided by the person, the representative or the nominee. This information must be:
    - legible
    - accompanied with authorisation for the ICB to make copies or take extracts
    - if requested by the ICB, accompanied with an explanation of the information provided
    - if requested, accompanied with a statement informing the ICB where information is held which the person has been unable to provide.

194. If an ICB becomes aware, or is notified, that the health of the person has changed significantly, the ICB must consider whether it is appropriate to carry out a review of the personalised care and support plan to ensure the person's needs are still being met.

195. If the ICB becomes aware or is notified that the direct payment has been insufficient to purchase the services agreed in the care and support plan, they must carry out a review as soon as possible.

196. The person, the representative or nominee may request that the ICB undertakes a review at any time. If this happens, the ICB must decide whether or not to undertake this review, taking into account local practices and circumstances.

197. Following a review, the ICB may:

- amend the personalised care and support plan
- decide to pay the direct payment to the person receiving care, rather than the representative or nominee
- decide to pay the direct payment to a representative or nominee rather than the person
- increase, maintain or reduce the size of the direct payment
- require that a direct payment is not used to purchase a service from a particular individual
- require that the person, representative or nominee provide additional information
- take any other action the ICB considers appropriate including declining further payments or make a referral to any relevant agencies if any risks are identified. This should normally be to ensure the safe and effective running of the direct payment or personalised care and support plan, or to protect public money if there is a significant risk of abuse.

8.2 Complaints

198. In addition to informing a person of their right to request that an ICB reconsiders a decision it has made in relation to a direct payment, as part of the discussion around the personalised care and support plan, there should be a discussion around how people can make complaints if something goes wrong.

199. The NHS complaints procedure will continue to apply to any decision made by the ICB. ICBs should ensure that people are aware of the process for accessing that procedure.

200. For complaints relating to providers, people will need to use the provider’s complaints procedure. A complaints process is a requirement for services registered with CQC, and people should contact the provider to explore how to

use that process. ICBs should consider how best to support people who wish to make a complaint about their provider and may wish to work with both parties to resolve disputes.

201. In some circumstances, providers will not have a complaints procedure (for example, if they are a small organisation that is not registered with the CQC). This should not necessarily be a barrier for people to purchase services from them, though the implications should be discussed as part of the discussion around risk.

202. The Parliamentary and Health Service Ombudsman can also investigate complaints about any service purchased by a direct payment that is referred to them. The ICB should ensure that if someone has a complaint and wishes to escalate it to the Ombudsman, they should be informed of how to do so.

    Generally, other mechanisms to resolve complaints should be explored and exhausted before appealing to the Ombudsman. The Ombudsman will be concerned to ensure that the actions of ICBs and providers are reasonable, and ICBs should ensure that proper records of all decisions are kept, including explanations for those decisions.

203. If a person stops an employee from providing care (eg personal care or healthcare), because they have caused harm to that person, the ICB must refer that employee to the DBS. The DBS can then make a decision about whether that person should be barred from working with adults or children. There is information on making referrals on the DBS webpages.

9. Annex A: Persons excluded from direct payments

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

a) subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003 (drug rehabilitation requirement),[1] imposed by a community order within the meaning of section 177 (community orders) of that Act,[2] or by a suspended sentence of imprisonment within the meaning of section 189 of that Act (suspended sentences of imprisonment)[3]

b) subject to an alcohol treatment requirement as defined by section 212 of the Criminal Justice Act 2003 (alcohol treatment requirement), imposed by a community order, within the meaning of section 177 of that Act, or by a suspended sentence of imprisonment, within the meaning of section 189 of that Act

c) released on licence under Part 2 of the Criminal Justice Act 1991 (early release of prisoners),[4] Chapter 6 of Part 12 of the Criminal Justice Act 2003 (release on licence) or Chapter 2 of the Crime (Sentences) Act 1997 (life sentences)[5] subject to a non-standard licence condition requiring the offender to undertake offending behaviour work to address drug or alcohol related behaviour

d) required to submit to treatment for their drug or alcohol dependency by virtue of a community rehabilitation order within the meaning of section 41 of the Powers of Criminal Courts (Sentencing) Act 2000 (community rehabilitation orders) or a community punishment and rehabilitation order within the meaning of section 51 of that Act (community punishment and rehabilitation orders)[6]

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[1] 2003 c. 44. Section 209 was amended by paragraph 88 of Schedule 4 to the Criminal Justice and Immigration Act 2008 (c. 4) and by S.I. 2008/912)
[2] Section 177 was amended by paragraph 82 of Part 1 of Schedule 4 to the Criminal Justice and Immigration Act 2008 (c. 4).
[3] Section 189 was amended by S.I. 2005/643.
[4] 1991 c. 53.
[5] 1997 c. 43.
[6] 2000 c. 6. Sections 41 and 51 were repealed, with savings, by Schedule 37 to the Criminal Justice Act 2003 (c. 44) (“the 2003 Act”).

e) subject to a drug treatment and testing order imposed under section 52 of the Powers of Criminal Courts (Sentencing) Act 2000 (drug treatment and testing orders)[7]

f) subject to a youth rehabilitation order imposed in accordance with paragraph 22 (drug treatment requirement) of Schedule 1 to the Criminal Justice and Immigration Act 2008 ("the 2008 Act")[8] which requires the person to submit to treatment pursuant to a drug treatment requirement

g) subject to a youth rehabilitation order imposed in accordance with paragraph 23 of Schedule 1 to the 2008 Act (drug testing requirement) which includes a drug testing requirement

h) subject to a youth rehabilitation order imposed in accordance with paragraph 24 of Schedule 1 to the 2008 Act (intoxicating substance treatment requirement) which requires the person to submit to treatment pursuant to an intoxicating substance treatment requirement

i) either:

   i. subject to a drug treatment and testing order within the meaning of section 234B of the Criminal Procedure (Scotland) Act 1995 (drug treatment and testing order),[9] or

   ii. subject to a community payback order under section 227A of that Act[10] imposing requirements relating to drug or alcohol treatment

j) released on licence under section 22 (release on licence of persons serving determinate sentences) or section 26 of the Prisons (Scotland) Act 1989 (release on licence of persons sentenced to imprisonment for life, etc)[11] or under section 1 (release of short-term, long term and life prisoners) or section 1AA of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (release of certain sexual offenders)[12] and subject to a condition that they submit to treatment for their drug or alcohol dependency.

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[7] Section 52 was repealed, with savings, by Schedule 37 to the 2003 Act.
[8] 2008 c. 4
[9] 1995 c. 46. Section 234B was inserted by section 89 of the Crime and Disorder Act 1998 (c.37).
[10] Section 227A was inserted by section 14(1) of the Criminal Justice and Licensing (Scotland) Act 2010 (asp 13).
[11] 1989 c.45. Sections 22 and 26 were repealed, with savings, by Schedule 7 to the Prisoners and Criminal Proceedings (Scotland) Act 1993 (c.9).
[12] 1993 c.9. Section 1 was amended by paragraph 98 of Schedule 8 to the Crime and Disorder Act 1998, by section 1(2) of the Convention Rights (Compliance) (Scotland) Act 2001 (asp 7) and by section 15(2) of MOSA. Section 1AA was inserted by section 15(3) of MOSA.

10. Annex B: Legislation, guidance and statutory instruments

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

The National Health Service (Direct Payments) Regulations 2013

The National Health Service (Direct Payments) (Amendment) Regulations 2013

The National Health Service (Direct Payments) (Amendment) Regulations 2017

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No. 2) Regulations 2019

Mental Capacity Act 2005 (c.9)

Mental Health Act 1983 Code of Practice

Safeguarding Vulnerable Groups Act 2006 (c. 47) as amended by the Protection of Freedoms Act 2012 (c. 9)

Care Act 2014

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