Direct Payments For Health Care

A consultation on proposals for regulations and guidance

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Contents

Contents 4

Introduction 5
- The Government's approach 5
- Structure of this document and terminology 7
- Timetable and questions for consultation 8

Executive summary 9

Part One: Making direct payments 11
- Section 1: Circumstances, persons and services for which a direct payment may be made 11
- Section 2: Paying direct payments to a person nominated by an individual 14
- Section 3: Conditions that PCTs would be required to meet 17
- Section 4: Conditions that patients or payees would be required to meet 24
- Section 5: Setting the budget for direct payments 25
- Section 6: Terminating direct payments 26
- Section 7: Reclaiming direct payments 27
- Section 8: Review and monitoring 28
- Section 9: Information, advice and support 29
- Section 10: Treating direct payment services as NHS services 31

Part Two: Direct payment pilot schemes and evaluation 32
- Section 11: Selection of pilot schemes 32
- Section 12: The geographical scope of the pilot 33
- Section 13: Revoking or amending a pilot scheme 33
- Section 14: Extension of a pilot scheme 34
- Section 15: Evaluation 34

Annex 1: References 37

Annex 2: Glossary 38

Annex 3: Schedule 1 of the Social Care Regulations 39

Annex 4: The Consultation Process 40

Introduction

Background

1. This document seeks views on the Government's proposals for piloting direct payments for health care. This is part of the wider pilot programme to explore personal health budgets announced in *High Quality Care For All*.

2. In January, the Government published a policy framework for the pilot programme: *Personal health budgets: first steps*. Following expressions of interest from over half of the Primary Care Trusts (PCTs) in the country, 70 provisional pilot sites were announced in May. Pilot sites intend to test out personal health budgets for a range of different conditions and services, including long term conditions, mental health needs, learning disabilities, NHS continuing healthcare and end of life care. The first sites were confirmed as full pilots in early October. Details of the focus of each pilot site will be available on the Department of Health (DH) website[1] once sites achieve full pilot status.

3. Personal health budgets are intended to help create a more personalised NHS, by giving people more control over their care. PCTs are already able to offer personal budgets that do not involve giving money directly to individuals. The Health Bill, which has now completed its main Parliamentary stages, would extend these options by providing power to allow direct payments – where individuals receive money to arrange and pay for their own services. This document describes how we intend to use the powers in the Bill to make regulations to enable pilot sites to test direct payments.

4. We anticipate that the first sites would be able to offer direct payments in summer 2010. Initially, direct payments would only be allowed in authorised pilot schemes (we will shortly publish details of the process for authorising pilots for direct payments). After the pilot sites are reviewed, and with the explicit approval of Parliament, the power to make direct payments could be extended more widely.

The Government's approach

5. In line with the principle of co-production, our policy has been heavily informed by input from the provisional pilot sites and other stakeholders. It also reflects debates on the Health Bill in Parliament.

6. Our approach is based on three key messages:

[1] http://www.dh.gov.uk/en/Healthcare/Highqualitycareforall/DH_090018

- **Avoid being over-prescriptive**. Personal health budgets and health care direct payments are at a very early stage. Developing the policy, and overcoming the challenges involved, depends on the energy and enthusiasm of local pilot sites. While there are important safeguards that the regulations must include, we want to allow freedom to innovate and test different models – especially during this pilot stage. The regulations and guidance will be designed for the pilot period; we expect they will be reviewed and revised in light of the evaluation of the pilots if direct payments are extended more widely in future.

- **Build on the experience of social care direct payments**. Direct payments in social care were first introduced in 1997, following the Community Care (Direct Payments) Act 1996, and have been developed subsequently. Where appropriate, we have tried to mirror the principles and arrangements underlying social care direct payments. This should promote the integration of care, and greatly benefit those individuals who receive direct payments in both systems or move from one system to the other. Where we think there is a need to diverge from social care direct payments, we make this clear.

- **Develop guidance as well as regulations**. A consistent theme we have heard from pilots is that the Department should publish guidance to support the regulations and address issues that regulations do not cover. We intend to develop guidance over the next few months in partnership with pilot sites and other stakeholders. However, this document indicates the areas we expect the guidance to address.

7. There is sometimes a question of what should be in regulations and what should be in guidance. The regulations set out the formal legal requirements and powers – what a PCT must do, may do or must not do. Guidance is not binding, and is primarily designed to provide recommendations and describe good practice.

8. The regulations and guidance are only part of the piloting process. This consultation is specifically about the direct payment method of giving a personal health budget. However, many of the proposals here will be equally relevant to other forms of personal health budgets[2], and the policy has been developed as part of a wider pilot programme. It is supported by a structured learning network where PCTs and their partners (including local authorities and third sector organisations) can share ideas and develop solutions.

9. The proposals in this consultation document would apply to all conditions where direct payments are used, including for children, people with learning difficulties and people

[2] Such as notional budgets or budgets held by third parties. For more information, see *Personal health budgets, first steps* (DH Guidance, 2009)

with mental health conditions. Different sites will be looking at different patient groups during the pilot phase.

10. Direct payments, and personal health budgets more widely, should not be seen in isolation. They should align with the wider NHS system, including other policies such as care planning, choice, practice based commissioning, self-care and self-management.

Structure of this document and terminology

11. This document is in two sections:
    - Part one deals with the rules for making direct payments.
    - Part two is a much shorter section, specifically about setting up and evaluating the direct payment pilots.

12. The document largely follows the structure of the direct payment powers in the Health Bill (we have changed the order in a couple of places in order to group together related themes). The regulation-making powers themselves are in four new sections that the Health Bill would insert into the National Health Service Act 2006; we refer to them here as "the new legislation". For each of the provisions in turn, this document describes how we intend to use regulations, and what we propose to cover in guidance.

13. For convenience, the social care direct payment regulations[3] are referred to as the "social care regulations", while the "social care guidance" means the *Social Care Guidance on Direct Payments*[4].

14. The Secretary of State's powers to make direct payments would be delegated to PCTs that have been approved by Secretary of State as DH direct payment pilot sites – from here on referred to simply as PCTs. The document talks about PCTs administering direct payments, since they would be generally responsible under the regulations. However, the precise division of responsibilities within a PCT for delivering direct payments would depend on local circumstances and structures, and we do not intend to specify this in regulations. In practice, PCTs' functions might often be carried out by different people (for example, care co-ordinators or GPs), or by third party organisations.

15. When we refer to an individual or a patient we mean someone who has been offered and has accepted a direct payment as part of the pilot programme. When we refer to

[3] The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009 – see http://www.opsi.gov.uk/si/si2009/uksi_20091887_en_1

[4] Guidance on direct payments for community care, services for carers and children's services (DH Guidance, 2009) – see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104840

people who lack capacity[5], we mean people who lack capacity to consent to receive a direct payment.

Timetable and questions for consultation

16. The consultation will start on **23 October 2009** and run until **8 January 2010**. An easy read version will be available in early November 2009. If you would like to respond, the response form published alongside this document may help you, but please do not feel you have to use it. You can email us at personalhealthbudgets@dh.gsi.gov.uk or write to:

    The Personal Health Budgets Team,
    Room 601,
    Richmond House,
    79 Whitehall,
    London,
    SW1A 2NS.

17. Rather than ask a series of successive questions, there are four overarching questions we would like people to consider as they read through each section of the document:

Question 1: Do you agree with the substance of the proposal?

Question 2: Is the level of detail proposed for the regulations right?

Question 3: Is the balance right between regulations and guidance? Is there anything that should be in guidance rather than regulations, or vice versa?

Question 4: Is there anything else we should include?

[5] Capacity is defined by reference to the Mental Health Act 2005. The Act creates a presumption that someone has capacity unless there is evidence to the contrary, and requires capacity to be assessed on a decision-by-decision basis.

Executive summary

1. Subject to the passage through Parliament of the Health Bill, direct payments will be one way of delivering a personal health budget. They would involve giving money to individuals to allow them to buy their own health care in line with an agreed care plan. Direct payments would be piloted in PCTs as part of a wider DH personal health budget pilot programme. They would only be lawful in pilot schemes approved by the Secretary of State – though the Bill allows the possibility of extending them more widely in future. Regulations would govern how direct payments work, and how pilot schemes would operate. This consultation document sets out what we propose to include in regulations and guidance. It has two parts.

2. The first part outlines how we propose direct payments should work – the "rules". Wherever appropriate, we have mirrored the approach already taken for direct payments in social care. *Our key proposals are that:*

    - everyone in a pilot area who is capable of managing a direct payment (either on their own or with assistance), including people with learning disabilities or mental health needs, should be able to have one if they want one and if the PCT believe their condition and circumstances are suitable and meet the criteria set out in the PCT's pilot proposal (section 1.1);

    - direct payments could be used in flexible, innovative ways to meet agreed health outcomes; they would not need to be spent on traditional NHS services. They could be spent on any services, as long as they are legal and appropriate for government to fund, and agreed in a care plan as meeting the patient's health needs (section 1.2);

    - if an individual wants a direct payment but does not want to manage one themselves, a nominated person could do this for them. In cases where an individual lacks capacity (within the meaning of the Mental Capacity Act) to consent to receive a direct payment, a representative could manage the budget on their behalf (section 2);

    - before receiving a direct payment, the individual would have to agree a care plan with their care co-ordinator. This would set out the desired health outcomes, how they would be met (the services to be purchased) and the resources available (the budget) (section 3.1);

    - all the information, advice, guidance and support an individual may need should be made available to enable them to make an informed decision on whether to have a direct payment (or other type of personal health budget)

and to help them manage the budget (section 9). This would include advice on being an employer if they wanted to employ someone directly (section 3.2);

- any service that people purchase through a direct payment should meet all the regulatory requirements that it would need to meet if it was procured by traditional means; for example, staff should be vetted where necessary in line with existing legal requirements. PCTs would also be expected to consider the need for service providers to have indemnity cover, and discuss this with patients as part of the care planning process (sections 3.3 and 3.4);

- the individual or their nominated person/representative would need to have a dedicated bank account or other distinct and secure means of receiving a direct payment. People receiving other forms of direct payments, for example for social care, would be allowed to use a single account for all their direct payments as long as the PCT was confident that adequate monitoring and auditing could take place (section 3.5);

- it should be up to PCTs to calculate the amount of money in a direct payment (or other form of personal health budget). The amount allocated should meet the cost of all parts of the agreed care plan which are being met by the direct payment (section 5); and

- there would need to be regular reviews to ensure that the care plan was appropriate for meeting the individual's needs, and that the money was being spent in line with the care plan (section 8).

3. The second part of the consultation document is shorter and deals with setting up and evaluating the direct payment pilots. It proposes that:

    - the Secretary of State should explicitly approve sites before they can offer direct payments (section 11);

    - the pilots should run until 2012, but it would be possible to extend this if necessary (section 11); and

    - an independent review should be commissioned to assess the effect of direct payments. In practice, this will be part of the wider evaluation of personal health budgets, which is now under way (section 15).

Part One: Making direct payments

Section 1: Circumstances, persons and services for which a direct payment may be made

1. Section 12B(2)(a) of the new legislation would enable regulations to provide for the:
    - description of persons;
    - circumstances; and
    - services;

   for which a direct payment may be made.

Section 1.1: Persons for whom direct payments may be made

2. Mirroring social care regulations, our guiding principle here is for direct payments to be available to anyone who might benefit from them, if they are located in a pilot PCT and they meet the criteria set out in the pilot proposal.

3. *We propose that the regulations should allow:*
    - anyone in the area of a pilot PCT who is capable of managing a direct payment (on their own or with assistance) to have one if they want one, their conditions and circumstances are suitable and they meet the criteria set out in the pilot proposal. This would include people with learning disabilities and mental health needs; and
    - people with parental responsibility to hold a direct payment on their children's behalf, if the parent/ guardian agrees (see section 2.2).

4. In line with *Personal health budgets: first steps*, and as required by the primary legislation proposed by the Health Bill, having a direct payment would be voluntary.

5. During the pilot phase, the PCT would not be obliged to offer a direct payment (though, as signalled in *Building Britain's Future* (2009), the Government would be interested in exploring the idea of creating a right to a personal health budget in future, in light of the evaluation).

6. *We propose that the regulations should exclude from receiving a direct payment:*
    - people subject to certain criminal justice system requirements around alcohol or substance misuse (using the same definition as the social care regulations[6]).

[6] Schedule 1 of the Social Care Regulations, see Annex 3.

7. *We propose the guidance would mirror social care guidance and would:*

    - provide detail on how to assess whether someone is capable of managing a direct payment, with or without assistance. As our legislation requires and as is the case in the social care guidance, we would use the definition of 'capacity' from the Mental Capacity Act 2005;
    - remind PCTs of their obligation to act in accordance with legislation such as the Disability Discrimination Act, other equality legislation, and, subject to Royal Assent of the Health Bill, the duty to have regard to the NHS Constitution; and
    - give PCTs more advice to help them decide whether an individual is unable to manage a direct payment, with or without assistance. PCTs would be expected to use their discretion, but the guidance would recommend that they record and explain their reasoning. For example, unless the risk could be reduced to an acceptable level, a direct payment might be refused if:
        - the person had been unable to manage a direct payment in the past;
        - there had been past fraudulent use of a direct payment; or
        - the person's personal circumstances made it likely that a direct payment would be abused.

Section 1.2: Circumstances and services for which a direct payment could be made

8. We intend to heed the lessons learned from experiences in social care, where direct payments worked best where people had the flexibility to use their resources in a range of innovative ways, including using services and options not normally commissioned through traditional mechanisms.

9. We propose that PCTs should decide which services are suitable for funding through direct payments; allowing local flexibility is particularly important at this pilot stage.

10. *We propose that the regulations should include provision to allow:*

    - a direct payment to be used in respect of services intended to improve or maintain the "physical and mental health" of the individual;[7] or
    - a direct payment to be spent on a service, an item of equipment, maintenance of equipment, respite care, or on employing a member of staff as agreed as part of a care plan (see section 3.1).

11. *We propose that the regulations should include provision to exclude direct payments being spent on:*

[7] Section 1(a) of the NHS Act 2006

- alcohol, tobacco, gambling or debt repayment;
- primary medical services, as we do not wish to undermine the holistic, registration-based service provided by GPs; or
- emergency or urgent care[8], given its immediacy.

12. *We propose the guidance would:*

- encourage commissioners and clinicians to consider innovative and flexible approaches to meeting health and well-being outcomes. We will be offering some examples of best practice, including experience from social care direct payments.
- emphasise that direct payments do not supersede other policies and guidance. For example:
    - NICE guidance will still apply where relevant;
    - normal exception processes for drugs not approved by NICE will still have to be followed;
    - people would not be allowed to "top up" a direct payment from their own resources. In line with wider government policy, if individuals wished to purchase additional care privately, this could only take place separately, with clear accountability.
- offer more advice to PCTs around excluding specific conditions or services.
- encourage PCTs to publish their reasoning where they decide locally not to make any services, or parts of services available through a direct payment. For example, this could be on grounds that the PCT considers that to do so would be too expensive. If they do this they should consider in each case allowing exceptions based on an individual's need.

Examples of things a direct payment could be spent on, when agreed in the care plan:

- a course of physiotherapy or hydrotherapy for people suffering from long-term chronic pain
- an air conditioner for someone suffering respiratory conditions exacerbated by heat or poor air quality
- a personal assistant to provide health care
- a complementary therapy, for example acupuncture
- services that would indirectly improve health outcomes, e.g. the provision of transport to attend treatment
- respite care

[8] unplanned in- or out- patient admissions to hospital

Section 2: Paying direct payments to a person nominated by an individual

13. The new legislation would allow for two sets of circumstances where a direct payment could be paid to a third party on the patient's behalf:

    - New section 12B(2)(b) would enable regulations to make provision in relation to individuals with capacity to consent to receive a direct payment[9], but who would prefer to appoint a "nominated person" to receive and manage a direct payment on their behalf;
    - New section 12B(2)(c) would enable regulations to make provision in relation to people who lack capacity, where the direct payment could be paid to a "representative" on their behalf.

14. The new legislation also allows regulations to be made in situations where someone has fluctuating capacity – section 12B(3).

Section 2.1 Nominated person for individuals with capacity to consent

15. Section 12B(2)(b) of the new legislation would provide for regulations to govern the circumstances in which a direct payment could be made to a person nominated by a individual with the capacity to consent to receive it. This goes further than the social care regulations, as we think it is right to allow people to benefit from a direct payment even if they do not wish to manage it themselves.

16. *We propose that the regulations should:*

    - allow individuals with capacity to appoint a nominated person to hold a direct payment on their behalf. The nominated person should be competent and capable of managing the direct payment;
    - require that the PCT, the person receiving care and the nominated person give consent before the direct payment can be made. If any of them withdrew their consent, the direct payment would cease; and
    - require that PCTs and the nominated person agree that the nominated person will:
        - provide any information to the PCT that it considers necessary in connection with the direct payment;
        - undergo a Criminal Records Bureau (CRB) check when required under the Safeguarding Vulnerable Groups Act 2006. Under the Act, family members or close friends would not necessarily be required to undergo a CRB check; and

[9] In this document, references to people "with capacity" mean those with capacity (as defined in the Mental Capacity Act 2005) to consent to receive a direct payment.

  - use the direct payment to secure the provision of the services for which the payment was made, in accordance with the care plan.

17. *We propose the guidance would mirror social care guidance on suitable persons, and would set out more detail on:*

- who might be a suitable nominated person;
- the role of the nominated person and what is meant by acting in the 'best interests' of the person receiving care;
- the PCT's expectations of the nominated person, such as the provision of information for monitoring and review; and
- the process for discontinuing direct payments to a nominated person. PCTs would be encouraged, as far as possible, to ensure continuity of care.

Section 2.2: Representatives for people who lack capacity to consent

18. Where someone lacks capacity to consent to receive direct payments, we intend to allow a representative to receive a direct payment on their behalf, in line with arrangements for suitable persons in social care.

19. While the role of a person who represents someone with capacity (as set out in section 2.1 above) and one who represents someone who lacks capacity are similar, there is a distinction. A person who represents someone with capacity to consent to receive direct payments is referred to in this document as a nominated person, while a person who represents someone who lacks capacity to do so is referred to as a representative. In line with the social care guidance (and as required by the Mental Capacity Act 2005), there will be additional safeguards for people who lack capacity.

20. *We propose that the regulations should:*

- allow a person who lacks capacity to have a 'suitable person' acting as a representative on their behalf to receive a direct payment. This is a similar approach to that taken in the *Social Care Direct Payments Regulations*. Representatives usually, but not always would be:
  - court-appointed deputies, as set out in the Mental Capacity Act section 19(1);
  - donees of lasting powers of attorney made by the person now lacking capacity; or
  - parents or guardians acting on their child's behalf;
- set out the role of the representative; and
- specify the conditions which must be met by the representative.

21. *We propose the guidance would mirror the social care guidance and would explain:*

- the importance of representatives acting, as far as possible, in line with the individual's past and present wishes and feelings (and, in particular, any relevant written statement made when they had capacity);
- the procedures to appoint a representative, and the things the PCT should consider;
- the people whose views should be considered before making the decision to make direct payments to a representative;
- what is meant by acting in the best interests of someone who lacks capacity; and
- what should be done when disputes arise between the representative and others involved with the care of the person who lacks capacity.

Section 2.3: Patients with fluctuating capacity to consent to receive direct payments

22. Mirroring social care regulations, the new legislation would provide for regulations under new section 12B(3) to enable provision for people who have previously lacked capacity to consent to receive direct payments and who subsequently regain it. This would allow people with fluctuating capacity to receive continuity of care. When someone loses the capacity to consent, we intend that a representative would be required to receive direct payments on their behalf (see section 2.2).

23. If a person regains capacity after a representative has been receiving direct payments on his or her behalf, *we propose that regulations would require:*

- a full review as soon as possible of the person's condition, care plan and direct payment. In the period between gaining capacity and the review, the following can occur, if the individual wishes:
    - the agreed care plan and payment may continue;
    - the representative who had been receiving direct payments while the person lacked capacity may continue to receive direct payments;
    - the direct payment may continue to be made into the bank account held by the representative; and
    - all contracts for services agreed while the individual did not have capacity would remain intact.
- an end to the direct payment if the person receiving care withdraws consent after regaining capacity.

24. *We propose the guidance would mirror social care guidance, and would:*

- expand on what is meant by fluctuating capacity and regaining capacity, and give examples of when this may occur;
- advise PCTs to ensure that there is a regular review in cases where a person's capacity may fluctuate, to assess whether they have regained capacity, and if so, whether they wish to take greater control over managing their direct payment;
- encourage PCTs to enable people to always have as much control and input as possible into decisions that affect their care;
- highlight the potential benefits of advanced directives[10] and forward planning when the person has capacity to plan their care to aid representatives and PCTs, in the event the person loses capacity; and
- encourage PCTs to provide continuity of care even if a direct payment is no longer suitable.

Section 3: Conditions that PCTs would be required to meet

25. Section 12B(2)(d) of the new legislation would provide for regulations placing requirements on PCTs before they could make direct payments. We intend for regulations to provide for a number of different issues, including:
    - care plans;
    - employment;
    - registration and safeguarding;
    - indemnity;
    - distinct and secure means of receiving a direct payment; and
    - frequency of direct payments;

Section 3.1 Care plans

26. Before the direct payment could be given, the person receiving care, their representative or nominated person, and the PCT would need to agree a care plan,[11] which sets out the desired outcomes and how they will be met. The care plan could cover the person's whole health care needs, whether they are met through a direct payment or through other means.

27. There is already DH guidance on care planning, for example: *Supporting People with Long Term Conditions: Commissioning Personalised Care Planning* (2009) and *The National Framework for NHS Continuing Healthcare* (2007). However, knowing the

[10] Also referred to as a living will, advanced directives give instructions about future healthcare and treatment the person wants in the event that they no longer able to make decisions due to illness or incapacity.
[11] Also known as a support plan, personal health plan, or a care and support plan, but for ease here referred to as a care plan

amount of money to be spent on health care to address the agreed need is likely to change the discussions and alter the planning process. It is envisaged that PCTs' precise care planning processes will develop during the pilot period, guided by learning at local and national level.

28. *We propose that the regulations should require the PCT to:*

- agree a care plan with the individual before giving a direct payment. This would set out:
    - the intended health outcomes;
    - the resources to be used (see section 5); and
    - the services to be purchased to meet those outcomes (see section 1.2).
- have given reasonable consideration, before agreeing the care plan, to:
    - an agreed procedure for managing clinical risk;
    - if the individual wants to employ someone directly, whether they or their representative is able to properly meet their obligations as employers, if necessary with support or assistance (see section 3.1);
    - whether the services and employees, where required, are registered with the relevant organisations, for example the Care Quality Commission (CQC) (see section 3.3); and
    - whether there is appropriate indemnity cover (see section 3.4).

29. *We propose the guidance would:*

- advise PCTs to consider including other areas in the care plan, such as how to access information on:
    - support needed to manage the services in the care plan; or
    - future contingencies;
- advise PCTs to address the balance between choice and risk. This will be very similar to the social care guidance[12] and *Independence, Choice and Risk* (2007);
- PCTs would be advised to spend a proportionate amount of time considering whether services are safe, legal and properly indemnified before agreeing to a care plan;
- encourage PCTs to discuss with people ways to manage potential risks at an early stage;
- advise PCTs to put in place proportionate systems to adjust care plans once they are in operation: for example, if there are variations in the cost of a service, or the care plan needs further refinement, or the person's needs

[12] Social care guidance pg. 47

change. For some people this may happen frequently, or the care plan may have to change rapidly as the person's condition alters;

- highlight the core skills needed by staff for effective care planning and budget setting; and
- emphasise the importance of combining health and social care planning, where relevant. Many PCTs and local authorities are already working together to develop more co-ordinated care plans. The guidance would outline good practice for PCTs and local authorities working together to deliver more integrated care.

Section 3.2: Employment

30. In some circumstances, people will wish to use their direct payment to employ staff. PCTs should support them to do so, while ensuring that there are proportionate safeguards in place. (This issue is not so relevant to other models of personal health budget, where recipients would not employ staff directly.)

31. Employers' responsibilities are already well defined in employment law. We believe the main priority is for PCTs to support people in fulfilling those responsibilities. Therefore we do not propose to introduce extensive new legal requirements through regulations.

32. We intend to support staff and their employers to ensure that direct payments are successful, including ensuring that staff receive terms of employment which are safe, legal and fair. We are working with the Social Partnership Forum and Skills for Health to explore the implications for staff of personal health budgets more generally. This work will inform future policy development.

33. *We propose that the regulations should:*

- prohibit people from employing members of their family who live in the same house, except in exceptional circumstances and with the agreement of the PCT. This is in line with the social care regulations, and would apply for all forms of personal health budget; and
- require that PCTs inform people where they may obtain information and advice about employing staff and the obligations of an employer.

34. *We propose the guidance would mirror the social care guidance; and would:*

- set out the roles and responsibilities of individuals and PCTs towards staff employed directly by people with a direct payment. For example, this could include information on:
    - contracts and providing details about possible terms of service;
    - minimum wage legislation;
    - working time directives;

- health and safety regulations;
- leave entitlements, including dependency and maternity leave;
- sick pay;
- training and development;
- pension scheme provision (where appropriate); and
- notice requirements.

Section 3.3: Registration and safeguarding

35. The service that people purchase through a direct payment should meet all the regulatory requirements that it would need to meet if it was procured by more traditional means. As in social care, and in line with other legislation and practice, providers and staff should be vetted and checked to ensure that the services people receive are safe.

36. *We propose the regulations should:*

- require PCTs to satisfy themselves that the person or service named in the care plan has the necessary professional qualifications and is appropriately registered. They could either:
  - gather this information themselves; or
  - request that this information is gathered by the person receiving the direct payment, in this case we would expect the PCT to satisfy themselves that the results are satisfactory .

37. *We propose the guidance would mirror existing health and social care guidance, including:*

- recommending that PCTs record how they have satisfied themselves that the necessary checks have been undertaken and the results are satisfactory;
- highlighting existing safeguarding legislation, such as the Safeguarding Vulnerable Groups Act 2006 which:
  - requires providers, or people providing services as employees of organisations, to be vetted and checked;
  - would give the patient or their nominated person, if that nominated person is known to the patient (eg a friend or parent), discretion about whether they want the PCT to carry out a CRB check on an employee living in the same household as them, or a family member or friend involved in the provision of their care; and
  - would require the PCT to carry out a CRB check on anyone else involved in managing or delivering care, and tell the patient the results.

- highlighting that, where an employee or independent service provider is required to be registered with a professional body (eg the Nursing and Midwifery Council), they will continue to be required to be so;
- advising PCTs to consider before agreeing the care plan whether:
    - providers and staff are registered with a professional body and vetted where required;
    - services are required to be registered with the relevant governance organisation, for example the CQC;
    - a provider is required to be registered with the Independent Safeguarding Authority; and
    - it would be appropriate to require vetting of friends or family members providing care.

Section 3.4: Indemnity

38. There is indemnity cover when purchasing services from traditional NHS providers. Our intention is to help ensure that people are properly protected when buying services from non-NHS providers, with appropriate indemnity cover for the services they are receiving, while avoiding imposing undue burdens either on people receiving direct payments or PCTs. Our approach differs from the approach in social care direct payments due to the different types of treatment involved.

39. *We propose that the regulations should:*

- require PCTs to consider whether there is appropriate indemnity cover before they agree to the making of a direct payment and to explain the potential impact of inappropriate cover to the person receiving the direct payment. We believe it would be too prescriptive to insist that indemnity cover is always in place, but it is reasonable to expect PCTs to consider the need for indemnity when they agree a care plan.

40. *We propose the guidance would:*

- set out what is meant by appropriate indemnity cover - we would expect this to be proportionate, and in line with similar, traditionally commissioned services;
- explain what cover different services would be expected to have, and provide examples of good practice;
- emphasise that where indemnity is required as a condition of professional regulation, it would continue to be so;
- highlight other policy and practice in this area, including the forthcoming *Review of Policy for Indemnity Cover for Health Professionals*;
- discuss what information might be needed to help PCTs ensure there was the right level of indemnity cover;

- highlight that PCTs could gather this information directly, or request that this information is gathered by the person receiving the direct payment;
- highlight that PCTs should make reasonable efforts to ascertain that the necessary cover is in place; and
- explain that it would be the PCT's responsibility to check indemnity cover if an individual does not want to or is unable to check it.

Section 3.5: Distinct and secure means of receiving a direct payment

41. In line with practice in social care, we propose that direct payments should be made into a "distinct and secure means" of receiving them: for example, a bank account or a pre-paid card.

42. *We propose that the regulations should:*

- require PCTs to be satisfied, before they make a direct payment, that the means of receiving it are "distinct and secure".

43. *We propose the guidance would*:

- explain what is meant by "distinct and secure means" and give examples such as a separate bank account held by the individual or a prepaid card;
- explain that the "distinct and secure means" would:
    - allow direct payments to be held separately from the individual's other income;
    - only be accessible by authorised persons agreed with the PCT; and
    - be capable of being audited through statements of income and expenditure;
- mirror practice in social care (and we plan to make similar arrangements to those between DH and the British Banking Association for social care direct payments);
- offer more advice about supporting people to open bank accounts;
- explain that other forms of publicly funded direct payments (e.g. for social care or from the Independent Living Fund) could be paid into the same distinct and secure bank account, on the condition that the PCT believes that adequate monitoring and review procedures are in place to ensure that the direct payment will be used only for services agreed in the care plan; and
- highlight the importance of working in close co-operation with local authorities to develop a joint approach for people receiving direct payments.

Section 3.6: Frequency of payments

44. We do not intend to use regulations to set the frequency at which direct payments should be made. Instead, we propose that regulations should provide for PCTs to have the flexibility to agree this with individuals in light of their circumstances and needs.

45. *We propose the guidance would mirror the social care guidance, and would:*

- emphasise that the payment frequency should be jointly agreed between the person receiving the direct payment and the PCT- PCTs should consider the effects of the frequency of payment on the individual when developing the care plan;
- encourage PCTs to put in place reliable systems to pay direct payments at agreed dates, as well as having procedures to make additional payments in emergencies;
- encourage PCTs to pay the direct payment before the person purchases a service;
- advise PCTs that individuals could adjust the amount they use across a set period, where this flexibility is agreed in the care plan;
- advise PCTs to allow spare money to be 'banked' for use when a need arises, so long as the outcomes agreed in the care plan are met; and
- explain that, while it is anticipated that the majority of payments would be paid monthly, payments could also be made weekly, or as a one-off (probably to be used for large investments or single items).

Section 3.7: Complaints

46. Under the NHS complaints procedures people will have a means of complaint if something goes wrong with NHS services. However this may not always be the case with direct payments, although there would always be a right of complaint about any decision made by the PCT. Where a provider does not have a complaints procedure the PCT should make the implications of this clear to the individual. We do not anticipate that the regulations will say anything about complaints.

47. *We propose the guidance would:*

- encourage PCTs to make people aware of the relevant complaints procedure;
- make PCTs aware that there will be new regulations which sets out requirements for CQC registered providers;
- recommend that PCTs record how they have satisfied themselves that providers who are not CQC registered have a complaints procedure before they agree a care plan. If the provider does not have a complaints procedure, the implications of this should be made clear to the individual; and

- explain the role of the Parliamentary and Health Service Ombudsman and the Independent Complaints Advocacy Service.

Section 4: Conditions that patients or payees would be required to meet

48. Section 12B(2)(e) of the new legislation would enable regulations to set conditions that the person receiving the direct payment must comply with. Our proposals here differ from those for the conditions that apply in relation to social care, because health care involves greater risks. We propose to be more prescriptive in requiring patients to provide information to the PCT. This should help ensure direct payments are used effectively, while giving individuals as much choice and control as possible.

49. We propose that the regulations should require recipients, as a condition of receiving a direct payment, to:

- provide information on their condition and expected health outcomes;
- tell their PCT if their conditions or circumstances change sufficiently to require a re-assessment of their condition or their package of care;
- provide a distinct and secure means of receiving a direct payment (see section 3.5);
- provide evidence of and information about their spending, through the provision of receipts or any other information as required; and
- agree to ongoing review to ensure that the care plan is meeting their care needs (see section 8).

50. *We propose the guidance would:*

- give more detail about the kind of information that people receiving direct payments should provide, both about their condition and the expenditure of the direct payment;
- mirror social care in encouraging PCTs to discuss requirements with individuals at an early stage, before setting up the direct payment. PCTs should also agree the notice period that will be given if their requirements change. We anticipate that this would be no less than one month but would vary depending on frequency of payment; and
- set out examples of best practice for PCTs to ensure that audit arrangements are as simple and easy to understand as possible and are not needlessly intrusive, but are sufficiently robust to allow proper audit.

Section 5: Setting the budget for direct payments

51. Section 12B(2)(f) of the new legislation would enable regulations to set out how the amount of a direct payment could be calculated. While there may be some overlaps with resource allocations in social care, setting a budget in health care will be more complex. As resource allocation at the level of the individual is new to the NHS, we intend to develop the policy in light of experience gained through piloting.

52. *We propose that regulations should:*

- require direct payments to meet in full the assessed needs for which they have been given, as set out in the care plan;
- provide for the amount of the direct payment to be subject to the discretion of the PCTs- we do not intend use the regulations to set a minimum or maximum amount; and
- require that if a direct payment runs out within the time period it was intended for, the care plan should be reviewed.

53. *We propose the guidance would:*

- explain that developing and testing processes for allocating resources will be a key part of the overall pilot programme. The thinking around this will develop throughout the pilot process and pilots should keep informed of latest advice through the learning network. The guidance would differ from social care, in part due to the greater complexity of calculating budgets in health, and also because NHS care is not means tested;
- offer information to PCTs on different approaches for setting budgets, including references to the developing pricing framework for community services and the payment by results development programme[13];
- remind PCTs that the level of the direct payment should take into account any tax or National Insurance liabilities;
- explain that a direct payment could be used to purchase information, advice and support, and support needs should be taken into account when setting the budget;
- recommend that if the agreed care cannot be funded from the original sum allocated, additional resources may be required;
- advise PCTs to maintain a proportionate contingency fund, to ensure that if a person's condition changes unexpectedly, this can be accommodated by the direct payment;
- remind PCTs that they will continue to be responsible for providing a person's care, even if the direct payment runs out;

[13] *Transforming Community Services: Currency and Pricing Options for Community Services*, DH Guidance 2009.

- emphasise that people should not be allowed to "top up" their direct payment budgets with their own money. Direct payments need to support the core principle, enshrined in the NHS Constitution, that NHS care is based on clinical need not ability to pay (see section 1.2)
- advise that, where significant surpluses are developing, this may be offset against future direct payments, or may trigger a review of the care plan examining why the money has not been spent. We envisage that the individual's condition and size of the direct payment would influence when a review was triggered, but that this may be around 10% of direct payment.

Section 6: Terminating direct payments

54. New section 12B(2)(g), of the new legislation would enable regulations to allow PCTs to stop paying direct payments. The conditions under which this may be necessary are similar to the conditions under which a social care direct payment may be stopped.

55. *We propose that regulations should:*

- allow a PCT to terminate the whole or part of a direct payment, following a reasonable period of notice if:
    - an individual is no longer eligible for a direct payment;
    - the nominated or other person to whom payments are made is no longer suitable to receive direct payments under the regulations and an alternative nominated person cannot be found;
    - the person's need for the relevant service can no longer be met through a direct payment; or
    - fraud has occurred, or if the direct payment has been abused, or the patient or nominated person no longer consents to have a direct payment.
- enable immediate termination of a direct payment if necessary to safeguard public money, for example in cases of fraud; and
- provide for PCTs to be responsible for ensuring that liabilities incurred would be paid when a direct payment is terminated.

56. *We propose the guidance would mirror the guidance for social care direct payments and would cover:*

- how to discontinue direct payments, including how to calculate an appropriate period of notice and transitional arrangements;
- when to stop direct payments for people whose capacity to consent changes;
- providing continuity of care, for example if a person moves from holding one form of personal health budget to another; and
- examples of what would constitute abuse of a direct payment, for example a person purchasing services not agreed in the care plan.

Section 7: Reclaiming direct payments

57. There are two powers in the new legislation relevant to reclaiming a direct payment:

- New section 12B(2)(h) would provide for regulations to be able to be set out the circumstances where a PCT could or should reclaim a direct payment.
- Section 12B(4) would enable regulations to provide for recovering a sum due as a civil debt.

Section 7.1: Circumstances where a PCT may reclaim a direct payment

58. We propose to follow a similar approach to that followed in the social care regulations – but we intend to provide in regulations for more circumstances where it might be reasonable to reclaim a direct payment. PCTs would have discretion whether or not to reclaim.

59. *We propose that regulations would:*

- allow a PCT to issue notice of its intention to reclaim, and then reclaim all or part of a direct payment, if:
    - the person receiving the direct payment dies;
    - fraud occurs;
    - an unplanned surplus develops;
    - the care plan changes;
    - the direct payment is used for any service not agreed in the care plan; or
    - the person's circumstances change so that a direct payment is no longer a viable mechanism for meeting their health needs.

60. *We propose the guidance would mirror practice in social care, and would set out:*

- what PCTs should consider when deciding whether to reclaim a direct payment;
- what alternatives are available, for example offsetting a surplus against the future direct payment; and
- that PCTs should consider how contractual arrangements would be meet when a direct payment is stopped, for example if the person holding the direct payment dies or the PCT decides the direct payment is not the best mechanism for meeting their health needs.

Section 7.2: Reclaiming money as a civil debt

61. Section 12B(4) of the new legislation would enable provision for recovery of some or all of a direct payment as a civil debt. This is similar to what can occur under the social care regulations.

62. *We propose that regulations would:*

- make such provision in respect of a sum due were:
    - it is suspected that fraud has occurred; or
    - a patient is unwilling to repay money after it has been requested by the PCT under regulations made in section 12B(2)(h).

63. *We propose the guidance would mirror the social care guidance and would:*

- explain that court proceedings could be initiated to enforce the debt and give examples where this may occur, for example if a person used their direct payment to pay off a dept, gamble or buy alcohol or tobacco; and
- explain that the decision about whether to initiate court proceedings would be made on an individual basis.

Section 8: Review and monitoring

64. Section 12B(2)(i) of the new legislation relates to monitoring and reviewing a direct payment. Our approach to monitoring and reviewing direct payments in health is largely the same as in social care, and is intended to help safeguard people's health and public money without being too burdensome on individuals or PCTs. We also propose to include additional provision around triggering a re-review.

65. *We propose that regulations would set out:*

- the minimum frequency at which the PCT giving the direct payment must review the care plan and financial spending. We expect this to be at least annually;
- what should trigger an additional review, for example, if someone raises concerns that the direct payment is not being used to secure services specified in the care plan, the individual is having difficulty finding a provider, it is apparent that the person's circumstances have changed significantly, if there are safeguarding concerns, or if an individual requests a review; and
- additional rules governing reviews for people who lack capacity to consent to receive direct payments (see section 2.2).

66. *We propose the guidance would mirror the social care guidance and would:*

- advise the PCT to consider and agree with the person how frequently the PCT should monitor:
    - their care plan; and
    - their financial spending.
- encourage the PCT to consider and agree with the person:
    - how frequently reviews of the person's care plan should take place;
    - the circumstances that should trigger additional reviews; and
    - who should be involved in these reviews;
- encourage PCTs to monitor the direct payment and care plan in such a way as to promote the individual's independence, choice, health and wellbeing;
- explain the difference between "monitoring" and "review" as it applies to direct payment; and
- encourage PCTs to consider working with local authorities to develop joint monitoring and review systems.

Section 9: Information, advice and support

Section 9.1: Requirement to provide support, information and advice

67. Section 12B(2)(j) of the new legislation would enable regulations to require the PCT to provide, or make arrangements for the provision of advice, information and support, both during the development of someone's care plan and while they are managing the direct payment. The experience of social care direct payments has shown that it is vital for people to be given suitable support. Because direct payments are a new concept in health, we propose to provide for this in regulations (this differentiates heath care direct payments from those for social care, where there is no requirement in regulations to provide information, advice and guidance).

68. *We propose that regulations would:*

- require PCTs to provide patients or payees with, or make arrangements for the provision of, the advice, information and support, in an accessible form, needed at each stage of the process, for example when:
    - deciding whether to have a direct payment;
    - deciding what care would best meet their health outcomes;
    - managing a direct payment;
    - buying services or being an employer; and
    - buying equipment (e.g. a computer) to enable a direct payment to be managed;

69. *We propose that regulations would leave to the discretion of the PCT:*

- what form the support, information and advice would take; and
- who should provide the support, information and advice.

70. *We propose the guidance would reflect best practice in health and social care and would:*

- give examples of different mechanisms of information, advice and support. For example, support services could take the form of:
    - advocacy provided by a third party organisation such as user led organisations;
    - a brokerage service offered by a dedicated service broker; or
    - information provided by the NHS;
- give examples of different models of service provision, including:
    - traditionally commissioned service offering support to a number of people;
    - services provided through a provider on an individual basis; or
    - an individual providing services;
- advise PCTs how to tailor support to individual or group needs: for example, to people with learning disabilities, to people with communication difficulties, or to people in transition between children's and adult services; and
- encourage PCTs to consider what advice, information and support is needed at every stage, from the beginning of the care planning process and throughout the period of receiving the direct payment.

Section 9.2 Purchasing information, advice and support

71. New section 12B(2)(k) of the new legislation would enable regulations to allow PCTs to include the cost of purchasing support services in an individual's direct payment, if this is appropriate.

72. *We propose that regulations would:*

- allow relevant forms of information, advice and support to be purchased through a direct payment.

73. We propose the guidance would:

- expand on the circumstances in which an individual may use a direct payment to purchase information, advice and support; and
- give examples of information, advice and support which may be purchased through a direct payment.

Section 10: Treating direct payment services as NHS services

74. Section 12B(5) of the new legislation would enable regulations to define the extent to which services provided by direct payments should be regarded as services provided by the NHS. For example, regulations could define circumstances where a PCT could fully discharge its legal obligations to a person by providing a direct payment. Conversely, the power could be used to make clear that, even though a person had received a direct payment, he or she was eligible for other health services.

75. This power was included as a precautionary measure. We do not intend to use it to make provision in regulations at this stage.

Part Two: Direct payment pilot schemes and evaluation

1. This part of the consultation sets out our proposals for designing the direct payment pilot programme, which would include a number of different local pilot schemes involving one or more PCTs.

2. This section relates only to piloting, and has no equivalent in social care. It covers:

    - selection of individual pilot schemes;
    - purchasing care outside a PCT's geographical area;
    - revoking or amending pilot schemes;
    - extending pilot schemes;
    - scope of the review of the pilot programme; and
    - areas to be included in the review of the pilot programme.

Section 11: Selection of pilot schemes

3. Section 12C(1)(a) of the new legislation would allow regulations to provide for the Secretary of State to be able to make pilot schemes, and set up the pilot programme. Pilot schemes are likely to be defined by geographical area and by the particular characteristics of the people who might receive direct payments.

4. The Secretary of State will select the PCTs involved in the pilot schemes. We plan to publish details shortly about this process. Our current thinking is that:

    - all existing personal health budget pilot sites could apply to become direct payment sites (they would have to pass the pilot "progress check", and might need to submit extra information about direct payments); and
    - additional PCTs who did not originally apply to become pilot sites would have another opportunity to do so and join the pilot programme (they would have to go through the same process as our existing pilots have gone through).

5. Section 12C(1)(b) of the new legislation would also allow for provision in regulations to impose additional conditions on particular pilot schemes. These could address issues covered by new section 12B(2), for example some or all of:

    - the services, groups or conditions a particular pilot scheme would cover. We expect pilot schemes will be limited to offering direct payments only to the people within the groups they set out in their pilot site applications;

- additional requirements for monitoring or review, for example for schemes working with particularly vulnerable groups, due to either their clinical condition, or their circumstances; and
- additional requirements around information, advice or support.

6. *Section 12C(2)(a)* of the new legislation *would allow regulations to set out:*

    - the geographical locations involved; and
    - the transitional arrangements for individuals receiving direct payments when the pilot programme ends.

7. Section 12C(3) of the new legislation requires regulations to set out the time period in which pilot schemes can make direct payments. Our intention is that the whole pilot programme will begin testing direct payments in summer 2010, and then run until 2012.

Section 12: The geographical scope of the pilot

8. Section 12C(2)(a) of the new legislation would allow regulations in particular to provide for the geographical area of a pilot scheme to be defined when it is set up. We intend to do this by reference to the PCTs involved and the geographical areas they would cover.

9. However, we do not intend to limit people to only purchasing services from the geographical area of the pilot scheme. *We propose that guidance would*:
    - explain that, in line with current practice around cross-region purchasing, people with direct payments could purchase services from companies, individuals and organisations based outside the geographical area of the pilot scheme.

Section 13: Revoking or amending a pilot scheme

10. Section 12C(2)(b) of the new legislation would allow provision for the Secretary of State to be able to revoke specific pilot schemes (preventing those PCTs from making direct payments) or alter the conditions under which these pilot schemes can make direct payments. We envisage this happening only in exceptional circumstances.

11. *We propose that the Secretary of State under regulations should be able to:*

    - revoke a pilot scheme at any time, ending it;
    - amend a pilot scheme at any time, for example by altering its geographical scope by incorporating or excluding PCTs, or by extending the time period for which it will run; and
    - expand or reduce additional requirements under section 12C(1)(b) (see section 11).

12. If we choose to revoke the whole direct payment pilot programme, the Secretary of State could use the power at section 12C(7) to repeal the power to grant direct payments entirely. This would be by order, and would require Parliamentary approval through the affirmative resolution procedure.

13. *We propose the guidance would:*

- describe in more detail the circumstances under which the Secretary of State may revoke a pilot scheme.
- set out the things PCTs will need to do if the pilot scheme is revoked: for example, ensure continuity of care for people already receiving a direct payment by offering another type of personal health budget.

Section 14: Extension of a pilot scheme

14. Section 12C(3) of the new legislation would allow for regulations to enable the Secretary of State to extend the end dates of pilot schemes.

15. *We propose the guidance would:*

- give examples of the circumstances under which the Secretary of State might decide to extend the end date of a pilot scheme, for example:
    - if there are insufficient numbers of direct payments offered by a pilot site; or
    - if a delay results in direct payments being offered for a shorter period of time than initially envisaged.

Section 15: Evaluation

Section 15.1: Purchasing information, advice and support

16. Section 12C(4) of the new legislation would provide for regulations to set the scope of the review of a pilot scheme. We intend that this would be done as a review of the whole pilot programme.

17. *We propose that regulations would:*

- require aspects of pilot sites' activity relating to direct payments to be subject to review; and
- make provision for a subset of the pilot schemes to be reviewed in more depth, so that the effects of direct payments upon different groups of people could be investigated in greater detail.

18. *We propose the guidance would:*

- outline what information pilot schemes would be expected to submit to the review team and to DH, and when they would be expected to do this; and
- encourage the pilot schemes to contribute and co-operate with the review and explain what this would entail.

Section 15.2: Areas to be included in the review of the pilot programme

19. Sections 12C(5) and (6) of the new legislation would enable regulations to require the Secretary of State to commission an independent evaluation team, which would publish their findings when the review was complete.

20. *We propose that regulations would require the Secretary of State to:*

- set out the areas to be covered by the review. We anticipate that the key areas for evaluation would be:
    - the health, well-being and satisfaction of people receiving care, care-worker, and carer health - including their variation across different groups by condition and background;
    - access to direct payments across different groups by condition and background;
    - financial impact across the health and social care system and cost-effectiveness of direct payments;
    - impact on provision of services that are covered by direct payments and those that are not;
    - impact on staff in NHS and partner organisations;
    - innovation and responsiveness in the provider market, including NHS providers; and
    - the administration, implementation, and processes of the scheme.
- publish the findings of the review once complete.

21. *We propose the guidance would:*

- set out the timetable for the review, and more detail about what the evaluation team would be investigating; and
- explain the topics to be covered by the review in more detail, for example:
    - evaluating the financial impact across the system will include examining double running costs, administrative cost, the cost of support and brokerage, and overall value for money;
    - evaluating the impact on staff will include exploring the impact on changing roles, skills development and training needs.

22. DH has already commissioned an evaluation programme for the personal health budget pilot programme, and we anticipate that the regulations would reflect this. A research team was announced in October 2009. Initially they will focus on the forms of personal budget that are possible under current legislation; but their work will extend to include the health care direct payment pilot programme as soon as regulations are in place.

Annex 1: References

Personal health budgets websites

Pilot programme learning network	www.personalhealthbudgets.org
Department of Health website	http://www.dh.gov.uk/en/Healthcare/Highqualitycareforall/DH_090018

Policy documents

Building Britain's Future (HMG, 2009)	http://www.hmg.gov.uk/buildingbritainsfuture.aspx
High Quality Care For All: NHS Next Stage Review final report (DH, 2008)	http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825
The NHS Constitution (DH, 2009)	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419

Legislation

Mental Capacity Act 2005	http://www.opsi.gov.uk/ACTS/acts2005/ukpga_20050009_en_1
National Health Service Act 2006	http://www.opsi.gov.uk/Acts/acts2006/ukpga_20060041_en_1
Safeguarding Vulnerable Groups Act 2006	http://www.opsi.gov.uk/ACTS/acts2006/ukpga_20060047_en_1
The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009	http://www.opsi.gov.uk/si/si2009/uksi_20091887_en_1
The Local Authorities, Social Services and National Health Service Complaints (England) Regulations 2009	http://www.opsi.gov.uk/si/si2009/uksi_20090309_en_1

Guidance

Guidance on direct payments for community care, services for carers and children's services (DH, 2009)	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104840
Independence, choice and risk: a guide to best practice in supported decision making (DH, 2007)	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074773
Transforming Community Services: Currency and Pricing Options for Community Services, (DH, 2009)	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093008

Organisations

Care Quality Commission	http://www.cqc.org.uk
Health Service Ombudsman	http://www.ombudsman.org.uk
Independent Complaints Advocacy Service	http://www.dh.gov.uk/en/Managingyourorganisation/Legalandcontractual/Complaintspolicy/NHSComplaintsProcedure/DH_4087428
Independent Safeguarding Authority	http://www.isa-gov.org.uk

Annex 2: Glossary

Care co-ordinator
A person who manages the assessment and care planning process where a person needs complex and/or multiple services to support them, and who takes overall responsibility for ensuring that the process is completed satisfactorily. Care co-ordinators are usually the central point of contact with the individual. Depending on the setting and services, the same or a similar role might be played by a care navigator or a case manager.

Care planning
A process based on an assessment of an individual's needs that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Capacity
The ability to make a decision about a particular matter at the time the decision needs to be made. Capacity is defined by reference to the Mental Capacity Act 2005.

Care worker
A paid worker who supports people with everyday tasks.

Direct payments
Payments given to individuals to choose, organise and pay for the services they need.

Emergency Care
Unplanned in-patient or out-patient admissions to hospital

Guidance
Guidance is primarily designed to provide recommendations and good practice.

Integrated care
Integrated care is when both health and social care services work together to ensure that individuals get co-ordinated treatment and support.

Regulations
The regulations set out the formal legal requirements and powers – what a PCT must do, may do or must not do.

Social care
Social care refers to the 'wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships' (*Our Health, Our Care, Our Say: A New Direction for Community Services* (2006), paragraph 1.29). It is provided by statutory and independent organisations and can be commissioned by a local authority's social services department on a means-tested basis, in a variety of settings.

Annex 3: Schedule 1 of the Social Care Regulations

PERSONS EXCLUDED FROM DIRECT PAYMENTS

This Schedule applies to a person if they are—

(a) subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003, 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;

(b) subject to an alcohol treatment requirement as defined by section 212 of the Criminal Justice Act 2003, 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, Chapter 6 of Part 12 of the Criminal Justice Act 2003 or Chapter 2 of the Crime (Sentences) Act 1997 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 or a community punishment and rehabilitation order within the meaning of section 51 of that Act;

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

(f) required to submit to treatment for their drug or alcohol dependency by virtue of a requirement of a probation order within the meaning of sections 228 to 230 of the Criminal Procedure (Scotland) Act 1995 or subject to a drug treatment and testing order within the meaning of section 234B of that Act; or

(g) released on licence under section 22 or 26 of the Prisons (Scotland) Act 1989 or under section 1 or 1AA of the Prisoners and Criminal Proceedings (Scotland) Act 1993 and subject to a condition that they submit to treatment for their drug or alcohol dependency.

Annex 4: The Consultation Process

Criteria for consultation

This consultation follows the 'Government Code of Practice'. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

Link to consultation Code of Practice

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact
Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm