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**North East Lincolnshire Council**

**and**

**Humber and North Yorkshire Integrated Care Board (at North East Lincolnshire Place)**

Direct Payments Policy

for adult social care, mental health after-care, and continuing healthcare

 

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## 1 Introduction

This policy provides the framework within which direct payments are made available in North East Lincolnshire. It should be read in tandem with the policy entitled “Micro-Commissioning in Adult Social Care, Continuing Healthcare and Funded Nursing Care: principles of consistent, pragmatic, and ethical decision making” which can be found at <https://www.northeastlincolnshireccg.nhs.uk/> (‘the Micro-commissioning Policy’).

### 1.1 Integrated structures

An agreement under s75 of the National Health Service Act 2006 (‘the NHS Act’) enables North East Lincolnshire Council (‘the Council’) and the Humber and North Yorkshire Integrated Care Board at North East Lincolnshire Place (‘the ICB’), to have integrated and lead commissioning arrangements and pooling of budgets for those services detailed within the s75. The Council and ICB deliver some functions, and also commission providers to deliver health and social care functions. Via the s75, the ICB acts as host for adult social care.

Direct payment duties under the Care Act 2014 are primarily directed at local authorities. Related Continuing Healthcare (CHC) duties under the NHS Act are imposed on ICBs. Mental health aftercare duties deriving from s117 of the Mental Health Act 1983 (MHA) are shared. Given the integrated commissioning arrangements in North East Lincolnshire, and for ease of reference, where duties are referred to in this policy they will be referred to as duties imposed on the ICB (acting both on its own behalf and/ or as the Council’s delegate).

### 1.2 Key deliverers of direct payment functions

The ICB’s CHC team delivers assessment, micro-commissioning, personal health budget and direct payment functions for CHC eligible adults.

Both Focus Independent Adult Social Work (‘Focus’) and Navigo deliver adult social care assessment, micro-commissioning, personal budget and direct payment functions for those with a social care need. Focus also delivers direct payment audits, charging, financial assessment and collection functions. It maintains the direct payment card system for use by all eligible individuals, whether funded by CHC, adult social care and/ or s117.

Navigo also delivers mental health s117 after-care functions on behalf of the ICB and Council. Navigo identifies s117 entitlements, assesses s117 need, and working with other relevant partners, manages micro-commissioning, personal budget and direct payment functions to meet s117 needs.

## 2 Scope and definitions

### 2.1 Scope

This policy applies to all adults (those aged 18 and over). The term ‘adult’ is used to refer to those with needs for care and support, where a direct payment may be suitable to meet their needs – whether those needs are met via the Care Act, NHS Act or s117 of the MHA. This policy will be referenced and applied by all care practitioners supporting adults for whom a direct payment may be suitable, regardless of which organisation employs them.

Whilst health services are provided free at the point of delivery (and adult social care is not), the principles set out in this document are applicable when considering delivery of all direct payments. Public law principles apply to provision of both health and social care.

The micro-commissioning policy offers further information about the scope of adult social care, CHC and s117 mental-health aftercare.

### 2.2 Definitions

The micro-commissioning policy offers further definitions, such as in respect of micro-commissioning, CHC and ordinary residence. The following are the most pertinent to direct payments:

**Personal budgets**

While different regimes govern the use of health and social care funding and terminology can differ, the Department of Health and Social Care is clear that consistent principles should be applied within local policies for personal budget/ personal health budget expenditure, to support people to make decisions that are right for them. The term ‘personal budget’ will be used throughout whether the budget relates to adult social care, mental health after-care or CHC needs.

Everyone whose needs for care and support are met by the ICB must receive a personal budget. A personal budget is the amount of money allocated to meet the needs identified in the assessment and recorded in the care and support plan. The detail of how the personal budget will be used is set out in the care and support plan. A direct payment is one way of providing a personal budget to an adult.

**Direct payments**

Direct payments are monetary payments made to adults who request to receive one to meet some or all of their eligible care and support needs. Direct payment activity includes (but may not be limited to):

* providing information about direct payments
* considering whether a direct payment is a suitable way of meeting needs
* considering whether an adult is able to manage a direct payment, alone or with support
* considering whether another person is suitable to manage the direct payment on behalf of the adult, alone or with support
* entering into a direct payment agreement with the adult, or the person managing it for them, where a direct payment is a suitable way of meeting needs
* signposting to support for managing direct payments
* undertaking associated administrative tasks, such as arrangements for administering, monitoring, auditing and reviewing of direct payments
* ending direct payments and recovering funds where necessary.

**Care Practitioners**

The term ‘care practitioners’ is used throughout this policy to denote staff directly interfacing with members of the public: individuals with needs, carers, families and representatives. ‘Finance practitioners’ are staff in the Focus Finance Team.

**Care and support**

The term ‘care and support’ is used throughout this policy to describe the provision of services or other activity to adults in need of care and support, whether via the Care Act, NHS Act, or s117 of the MHA. It is also intended to include adult carers in need of support.

The term ‘eligible care and support needs’ is used throughout this policy to denote needs deemed eligible via the application of criteria within the Care Act, NHS Act, or s117 of the MHA and associated statutory guidance and regulations; again it is intended to include reference to the eligible support needs of adult carers of adults.

**Representatives**

An adult may have help with their direct payment from a representative. In the context of direct payments, a representative may indicate one of two types of person:

1. a ‘nominated person’ is a person nominated by an adult (with relevant mental capacity) to manage the direct payment on their behalf, and who agrees to do so
2. an ‘authorised person’ is someone who asks to manage a direct payment for an adult who lacks relevant mental capacity, as defined by the Mental Capacity Act 2005 (MCA). A person is authorised if:
3. they are a deputy appointed by the Court of Protection, or an attorney appointed under a Lasting Power of Attorney, with authority to make decisions about the adult’s needs for care and support; or
4. the appointed deputy or attorney consents to them acting as authorised person, in agreement with care practitioners; or
5. neither i nor ii above are relevant, but the care practitioner identifies that the person is suitable to act as authorised person.

Other than where it is necessary to identify the difference, the term ‘representative’ will be used throughout this policy to mean either a nominated or authorised person.

It should be noted that the above definitions of nominated and authorised persons are drawn from the Care Act, and there are some differences in expectation depending on whether the nominated person receives a direct payment under the Care Act or NHS Act. Those receiving a CHC direct payment as nominee are always responsible for fulfilling all responsibilities of someone receiving a direct payment (for example, acting as principle for contracts or employment or for care). Those receiving a Care Act direct payment as nominee may have agreed a variable and/ or lesser level of responsibility.

## 3 Purpose and aims

This policy’s aim is to produce a consistent and fair framework for provision and management of direct payments, applied on an equitable and transparent basis.

In particular, this policy is intended to recognise:

### 3.1 the financial context in which direct payment activity takes place

The adult social care budget is agreed annually by the Council’s cabinet and is limited. Similarly, the NHS is tasked with delivering better outcomes for patients within limited resources. Health and social care budgets are constrained and the ICB expects budgets to be managed with regard to National Audit Office (NAO) guidance.

The ICB expects care practitioners to:

* Meet the eligible needs of those for whom the ICB is responsible within the available budget (subject to considerations of exceeding the budget where the law compels it)
* Meet the eligible needs of those for whom the ICB is responsible, with regard to the NAO Successful Commissioning Guide (guidance on securing value for money in public spending - see below)
* Operationalise this policy in ways that are consistent with meeting the objectives contained herein, in compliance with the law.

The NAO defines value for money as ‘the optimal use of resources to achieve the intended outcomes’, and uses three criteria when assessing value for money:

* Economy: minimising the cost of resources used or required (inputs) – spending less
* Efficiency: the relationship between the output from goods or services and the resources to produce them – spending well; and
* Effectiveness: the relationship between the intended and actual results of public spending (outcomes) – spending wisely.

The NAO criteria should be applied to all adult care and support functions undertaken on the ICB’s behalf, including direct payment activity.

### 3.2 the legal context in which direct payment activity takes place

The legislative context for direct payments is set out in the Care Act 2014, NHS Act 2006, Mental Health Act 1983 (MHA) s117(2C), and the Care and Support (Direct Payments) Regulations 2014 (‘the Direct Payment Regulations’), the National Framework for NHS. CHC and NHS Funded Nursing Care (underpinned by the National Health Service Commissioning Board and Clinical Groups (Responsibilities and Standing Rules) Regulations 2012), Decisions about direct payments must also reflect public law principles.

This policy is not intended to give a full account of the legal position, but rather to offer highlights likely to be of particular relevance to care practitioners with responsibilities for direct payments.

All references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching to them.

### 3.2.1 Public law principles and decision making

Application of legislation (and local policy) is always subject to public law. Care practitioners are expected to take decisions in a way that is compliant with public law duties and principles. Care practitioners must ask themselves the following when making direct payment related decisions:

* Legality – is the proposed decision reflective of legislative obligations, and within the limits of the discretion allowed by law (taking into account all relevant considerations and ignoring irrelevant ones)? For example, have the exclusions within Schedule 3 of the Care Act’s Direct Payment Regulations been considered?
* Rationality – is the proposed decision reasonable and proportionate in all the circumstances? Does it maintain a proper balance between the interests of the adult to which the decision relates, and those of ‘the State’ (i.e. in this context, the ICB)?
* Procedural propriety – has the decision making process ensured that the adult affected by the decision (and/ or their representative) has had a fair opportunity to participate in it? Have any views expressed by the affected adult (and/ or their representative) been properly taken into account? Have any procedural rules in relevant legislation been complied with (advance notice, copies and involvement, for instance)?

The implications of not taking into account all relevant considerations (see ‘Legality’ above) when making public law decisions were helpfully summarised by the judge in R v London Borough of Merton [2017] EWHC 1519 (Admin), paragraphs 53 to 55:

* First, where there are specific factors *required by law*to be taken into account, a failure to take account of such factors will necessarily vitiate the decision
* Secondly, there are other factors which *may* be taken into account (or indeed which others or the court itself would have taken into account). In such a case, a failure to take such factors into account will not vitiate the decision
* Thirdly, there is a class of factors which *ought*to be taken into account. Here a failure to take account will vitiate. Such factors have variously been described as “relevant” or “clearly relevant” or “so obviously material” to the exercise of the particular discretion that they ought to be taken into account.

Whilst the Merton case relates to decision making under the Care Act, the way in which public law principles have been applied throughout the judgement may be equally pertinent for decisions made under the NHS Act or s117 of the MHA.

Care practitioners are reminded that as a matter of public law, a policy provides a starting point, and a framework for the application of professional decision making to each adult’s individual circumstances; this policy is not intended to fetter discretion.

### 3.2.2 Key legislative provisions include:

### 3.2.2.1 The Care Act 2014

Direct payments may represent an important aspect of choice and control for some adults, leading to better outcomes from their care provision. However, the gateway to receiving a direct payment must always be through a request. No one must be forced to take a direct payment – they are not appropriate for all.

Care practitioners have a key role in ensuring that adults are provided with relevant and timely information about direct payments, so that they can decide whether to request one to meet their care and support needs. Information will include:

* What direct payments are
* How to request a direct payment, including the use of nominated and’ or authorized persons to manage and/ or receive the payment
* Explanation of the direct payment agreement
* Making arrangements with social care providers
* The responsibilities involved in managing a direct payment and being an employer (where relevant)
* Signposting to local organisations, and support organisations who can offer advice and support about employing staff
* The requirements of keeping accurate records and monitoring arrangements.

The Care Act provides that as part of the care planning process, adults must be informed of which of their needs (if any) can be met via a direct payment. Where an adult requests a direct payment after the support planning stage or between care and support reviews, wherever possible the review will be brought forward to accommodate consideration of the request for a direct payment.

Care practitioners are reminded that they are required to consider whether the adult would experience substantial difficulty in being involved with Care Act processes; this includes consideration of direct payments. If it is thought that the adult would experience such difficulty, and that there is no appropriate individual to support and represent them for the purpose of facilitating their involvement, then the care practitioner must arrange for an independent advocate to support and represent the adult.

### 3.2.3.4 the NHS Act 2006/ the ‘Standing Rules’/ the National Framework for NHS CHC and NHS Funded Nursing Care (‘the Framework’)

A direct payment can be made to, or in respect of, anyone over 16 who is eligible for NHS care (under the NHS Act s12A, any other enactment relevant to an ICB, including aftercare services under s117 of the MHA). Direct payments should be an option for people who can benefit from one, subject to certain exclusions. This policy is focused on those aged 18 or over, and in so far as it relates to health spend, those in receipt of CHC or services under s117 of the MHA (see 3.2.3.6 below re the MHA).

CHC means a package of ongoing care that is arranged and funded solely by the NHS where the adult has been assessed and found to have a ‘primary health need’ as set out in the Standing Rules. Care is provided to meet health and associated social care needs arising as a result of disability, accident or illness.

Similar to duties under the Care Act, ICBs must provide information, advice and support in respect of direct payments. Everyone receiving CHC has the right to ask for a personal health budget, including a direct payment. Direct payments can be spent on a broad range of things to enable individuals to meet their health and wellbeing needs, in accordance with their agreed care and support plan. The ICB must be reasonably satisfied that the adult’s needs can be met by the services/ support specified in the care and support plan, using a direct payment. The adult (or their representative) is responsible for ensuring that if they are offered a direct payment, it is only used as specified in the care and support plan.

### 3.2.2.2 The Mental Capacity Act 2005 (MCA)

Although decisions regarding whether a direct payment is a suitable way of meeting needs are not decisions made by the adult seeking care and support, each adult’s consent to participate in direct payment activity, or their refusal, is subject to the principles of the MCA. As always it is important to support adults to make their own decisions wherever possible, and even where it is not possible for them to do so, to ensure that they are involved in decision making by others, in their best interests.

Local MCA policy requires that care practitioners proactively consider an individual’s capacity, and record whether they are acting in reliance on the statutory presumption of capacity, or where this is not appropriate, proceed to undertake a capacity assessment. Care practitioners must carefully identify the decision against which capacity is being assessed, and the factors relevant to it (i.e. what salient points the individual needs to understand, retain, use/ weigh and communicate in respect of that decision). Direct payment related decisions and associated capacity considerations may include (but are not limited to):

* Requesting a direct payment
* Selecting a nominated person
* Managing a direct payment, with or without help
* The responsibilities associated with having a direct payment
* Using a direct payment to employ someone/ contract for services, with or without help.

Capacity decisions relevant to direct payments (and other care and support matters) should be recorded in the assessment and care and support plan.

Where the adult lacks capacity in an area relevant to direct payments, care practitioners will seek to work with appointed others, where available, such as:

* An attorney appointed via an Enduring Power of Attorney (EPA)
* An attorney appointed via a Lasting Power of Attorney (LPA)
* A deputy appointed by the Court of Protection
* Any other relevant appointment (e.g. a person selected as ‘appointee’ by the Department for Work and Pensions (DWP) for the purpose of benefits payments).

Persons appointed via any of the above mechanisms will be asked to evidence it by providing a full copy of the document appointing them. Copy evidence will be lodged with the adult’s records.

Where there is no relevant person appointed to act on behalf of an incapacitous adult, care practitioners will seek to involve relevant others (in accordance with s4 of the MCA) such as family members, friends or advocates with the aim of:

1. Facilitating the involvement of the adult in direct payment activity
2. Making best interests decisions on behalf of the adult.

### 3.2.2.3 The Equality Act 2010 (EqA)

Anti-discriminatory practice is a fundamental part of ensuring an ethical basis for care provision, and critical to the protection of individual dignity. The EqA protects those receiving care from being treated unfairly on named grounds known as the ‘protected characteristics’. The protected characteristics are:

* + age
  + disability
  + gender reassignment
  + marriage and civil partnership
  + pregnancy and maternity
  + race (including ethnic or national origins, colour or nationality)
  + religion or belief (including lack of belief)
  + sex
  + sexual orientation.

Direct discrimination occurs when an individual is treated less favourably than another in similar circumstances on the grounds of a protected characteristic. Indirect discrimination occurs when a condition or requirement is applied equally to everyone but some are unable to comply because of a protected characteristic; this is unlawful unless the condition or requirement is objectively justifiable. The EqA also prohibits harassment and victimisation.

The EqA applies to all delivering public services; following the principles within the EqA will enable care practitioners to ensure that individuals receive support that is respectful, inclusive and effective, and that they are able to access help which meets their needs and takes into account any which may arise as a result of one or more protected characteristics.

The Local Government Ombudsman (LGO) has helpfully summarised key EqA’s requirements of care providers (and care practitioners) as being to:

* anticipate the needs of potential disabled service users; and
* make reasonable adjustments to enable disabled people to access services in a way that is as close as possible to the standard offered to the public at large.

(<https://www.lgo.org.uk/decisions/adult-care-services/assessment-and-care-plan/20-000-835>).

### 3.2.3.5 The Human Rights Act 1998 (HRA)

The HRA requires UK courts to give effect to a large part of the European Convention on Human Rights (ECHR). The HRA declares that it is unlawful for a public authority to act in a way which is incompatible with the ECHR. Convention rights include freedom from inhuman or degrading treatment (Art. 3), the right to freedom and security of person (Art. 5), the right to respect for private and family life (Art. 8) and freedom from discrimination (Art. 14). Interference with Convention rights must not be arbitrary or excessive, but must be necessary and proportionate to the legitimate aim pursued.

### 3.2.3.6 The Mental Health Act 1983 (MHA)

Much help and support provided by local authorities for people with mental health problems is delivered via the Care Act 2014. A small minority receive their services under s117 of the MHA. The Care Act direct payment regulations are broadly applicable to those eligible for support under s117. S117 imposes a duty for both local authorities and the NHS to provide (or arrange for provision of) services for people who have been detained under, and then discharged from, certain sections of the MHA. Aftercare services includes those provided via a direct payment under the Care Act, or regulations under the NHS Act 2006. Aftercare services are provided without charge.

The MHA Code of Practice provides guidance on provision of direct payments (33.17/ 33.19).

### 3.2.3.7 the NHS Constitution

The aim of the Constitution is to safeguard the principles and values of the NHS. The ICB is required by law to take account of the Constitution in its decisions and actions. The ICB must, in the exercise of its functions, act with a view to securing health services that are provided in a way which promotes the Constitution, and promotes awareness of it among patients, staff and members of the public.

The principles and values within the NHS Constitution are reflective of those within the Care Act, particularly within s1 (setting out the wellbeing principle). There are some obvious differences regarding the way NHS principles might apply to delivery of social care; for example, social care is not delivered free at the point of access but is means tested. However, many NHS principles are equally pertinent, such as ‘aspiring to the highest standards of excellence and professionalism’, and ‘providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources’.

The rights and responsibilities in the Constitution generally apply to everyone entitled to receive NHS services (including CHC and mental health after-care), and to NHS staff. Whilst the Constitution may not apply directly to local authorities in which social care functions are not delegated, in North East Lincolnshire it is expected that its principles and values will apply to delivery of direct payments. Equally, whilst not all staff to whom this policy applies are NHS employees, each staff member is expected to consider how the Constitution’s principles/ values might apply in their own setting.

## 3.3 The general principles against the backdrop of which the allocation of resources takes place

### 3.3.1 Meeting needs v providing services

The core purpose of care and support is to meet need in a way that helps adults to achieve the outcomes that matter to them. The concept of ‘meeting needs’ under the Care Act 2014 signifies a shift from previous duties to ‘provide services’ and recognises that everyone’s needs are different. Whilst the NHS is more likely to use the language of ‘services’, in the context of direct payments, this refers to anything that can be bought which will meet the individual’s care and support needs. NHS England (NHSE) guidance stipulates that personalised care planning should establish that needs and identified outcomes are likely to be met, enabling as much choice and control as appropriate. Direct payments can be an important mechanism for providing greater choice and flexibility to meet individual needs.

There is no duty to achieve the outcomes that matter to adults; rather the duty is to assess whether the provision of care and support can contribute to achievement of those outcomes (see Davey, R (On the Application Of) v Oxfordshire County Council [2017] EWHC 354 (Admin), at paragraph 21; this is a Care Act case, but its principles are likely to be broadly applicable to CHC provision, which stipulates ‘due regard’ for the individual’s preferred outcomes). Care practitioners are expected to take a strengths/ asset-based approach in supporting individuals to consider how to achieve the outcomes that matter to them. Care practitioners **must** consider what else, other than (or in addition to) the provision of commissioned care and support, might help an individual to achieve their outcomes. For some adults, direct payment options may better support the achievement of outcomes and offer an individually tailored, strengths/ asset-based approach to meeting need. Further guidance is available in the local Practice Framework which can be found here: [Health and Social Care Professionals (nelincs.gov.uk)](https://livewell.nelincs.gov.uk/health-and-social-care-professionals/)

### 3.3.2 Wellbeing and the whole family approach

Care practitioners are expected to consider how best to promote wellbeing when carrying out any of their care and support functions, including direct payment processes. The Care Act describes wellbeing as relating to a number of areas, including (for example) control by the individual over the care and support they receive. Direct payments may offer some adults an important mechanism for control.

The concept of wellbeing is not explored in detail in the Framework, although the importance of promoting it, and its impact on needs, is mentioned; the ‘key elements of a person-centred approach’ to CHC assessment and care planning are arguably less developed than, but not unlike, the Care Act’s key principles and standards. CHC models must maximise personalisation and individual control, and reflect individual preferences, as far as possible. This is reiterated in NHSE guidance, which describes personalised care planning as a series of facilitated conversations in which the person actively participates to explore management of their health and wellbeing in the context of their whole life and family situation.

A codified or defined concept of wellbeing does not feature in the MHA Code of Practice (which details expectations around mental health aftercare). However, the Code emphasises the importance of ensuring that the full range of each individual’s needs is reflected in after-care planning. Having regard to the Care Act’s concept of wellbeing when planning mental health aftercare is likely to support application of the MHA Code of Practice.

The care planning process – which includes consideration of direct payments - is an opportunity to consider holistically the individual’s needs and preferences in the context of their wider support network. Utilising the whole family approach necessitates consideration of how the individual’s needs impact on the wellbeing of those around them. Impact on wellbeing and interpersonal relationships are key matters to which care practitioners must have regard when considering direct payments – both in respect of the adult with needs and carers in need of support.

The Framework makes reference to being considerate of the impact of the adult’s needs on others (including the risks posed to others by the adult’s needs); involving the adult’s carer(s) and family in decisions about care and treatment is a core component of the Framework. Similarly, the MHA Code notes that mental health aftercare planning should not place undue reliance on carer contributions.

### 3.3.3 Balancing outcomes and best value

In determining how (rather than whether) to meet eligible needs, the law entitles the ICB to take into account its financial resources. It must also comply with its related public law duties, including ensuring that its available funding is sufficient to meet the needs of the entire local population i.e. the ICB must be cognisant of the impact that meeting individual needs has on the overall budget. The Care Act states that determination of how to meet need (rather than whether) may reasonably be balanced with consideration of budgetary requirements. Similarly, NHS Direct Payment Regulations 2013 impose an explicit requirement to consider value for money before agreeing to offer a direct payment (Regulation 3(2)(c) and 5(2)(c)). Budgetary considerations include promoting independence and preventative interventions to reduce and delay needs, which in turn, reduces future demand on the ICB’s budget.

When an individual requests a direct payment, whether this is appropriate to meet need must be determined with reference to the matters set out within this policy, including by reference to the impact of the adult’s needs on their life, their desired outcomes and value for money**.** Care Practitioners are expected to evidence:

* when considering direct payments under the Care Act, how they have *had regard to* the wellbeing factors set out at s1(3) of the Care Act when balancing outcomes and best value.
* when considering direct payments under the NHS Act, whether a direct payment is appropriate for the adult given their particular condition and its impact, how/ why the direct payment represents value for money, and where applicable, how any additional cost is outweighed by benefit to the adult.

Decisions should be taken on a case-by-case basis, weighing up the total costs of different potential options for meeting needs; cost is a relevant factor in deciding between suitable alternative options for meeting needs. This does not necessarily mean choosing the cheapest option, but the one which delivers the best outcomes for the best value in relation to the adult and the available budget at any given time. Consideration should also be given to treating similar cases in the same way in the interests of equity, within any one financial accounting period. Whilst not the sole, or necessarily primary consideration, financial matters are a key factor in reaching a conclusion on how to meet need, including whether to meet them via provision of a direct payment.

Where outcomes and value for money cannot be appropriately balanced, care practitioners are expected to make a reasoned and pragmatic choice, which may sometimes result in direct payments being refused.

## 4 Policy

### 4.1 the local approach to making direct payments

The ICB’s starting position is that it will pay all direct payments via a direct payment card account. This is because the ICB considers that this is the most effective and efficient way to make direct payments, which offers a good balance of positive outcomes for adults and best value for the public purse.

Alternatives to delivery of a direct payment via a card account will be considered on an individual basis, if there are sound, compelling reasons for doing so. The decision as to whether a direct payment card account or an alternative is appropriate for an adult is for care practitioners to determine in the first instance, taking account of individual circumstances.

If an individual requests that a direct payment is paid via an alternative to card accounts, the following (non-exhaustive) factors will be considered -

* Whether payment via an alternative is suitable to meet the adult’s needs
* Whether there are benefits to payment via an alternative, which could not be achieved from delivery via card account
* Whether the individual is or has been unable to manage alternatives, and/ or has not managed direct payment monies appropriately in the past
* Whether, if the card account currently appears unworkable for the individual, any action could reasonably be taken to ensure that it becomes workable for them
* Whether the individual encounters significant problems or barriers to using the card account which are unavoidable/ cannot be resolved. An example of a barrier might be a lack of access to the internet.

Disputes regarding delivery of direct payments via a card account will be resolved by reference to the Individual Commissioning, Approval & Advice Panel (ICAAP) and/ or the Appeals Panel and/ or the CHC Decision Forum, depending on individual circumstances.

Where it is agreed that a direct payment card account is not suitable for an adult, payments will be made to a separate bank account created solely for this purpose, and held by the person receiving the direct payment. No one beyond those agreed with the care practitioner should have access to this account.

Regardless of how the direct payment is made, adults/ their representatives are required to sign an agreement acknowledging their responsibilities as recipients of direct payments. The agreement includes such matters as appropriate record keeping on spend. Creating a card account also requires practitioners to undertake an identification check using the ‘Know Your Customer checklist’.

### 4.2 Making direct payments available

### 4.2.1 Adults with capacity to request a direct payment

Care practitioners must clarify at the earliest stage possible where the request for a direct payment originates. Direct payments may be made to the adult, or if they request it, to a nominated person acting on their behalf. Where the adult requests that a nominated person receive the direct payment, the nominated person should be involved in the care planning journey, unless the adult does not want this. The nominated person should receive the same information about direct payments processes as the adult. This is to ensure that the nominated person understands their legal obligations as the direct payment recipient to act in the best interests of the adult.

Where an adult has mental capacity to request a direct payment (payable to themselves or a nominated person), and where a direct payment relates in whole or in part to needs met via the Care Act/ duties discharged under s117 of the MHA, care practitioners must satisfy themselves that four statutory conditions are met in their entirety; the conditions are:

1. The adult has capacity to make the request, and where there is a nominated person, that person agrees to receive the payments
2. the Council/ ICB is not prohibited by regulations from meeting the adult’s needs by making direct payments to the adult or nominated person
3. the care practitioner is satisfied that the adult or nominated person is capable of managing direct payments either alone, or with whatever help the care practitioner thinks the adult or nominated person will be able to access
4. the care practitioner is satisfied that making direct payments to the adult or nominated person is an appropriate way to meet the needs in question/ discharge obligations under s117 of the MHA.

NHS (Direct Payment) Regulations 2013 10 and 11 also impose conditions on making direct payments, which taken as a whole, are broadly reflective of requirements in the Care Act.

### 4.2.2 Adults lacking capacity to request the direct payment

### 4.2.2.1 conditions

Where adults are assessed as lacking capacity to request a direct payment, an authorised person can receive the direct payment on the adult’s behalf. Care practitioners must satisfy themselves that where a direct payment relates in whole or in part to needs met via the Care Act/ duties discharged under s117 of the MHA, the authorised person meets five statutory conditions in their entirety; the conditions are:

1. where the person is not authorised under the MCA but there is at least one person who is so authorised, the person who is authorised supports the request
2. the ICB is not prohibited by regulations from meeting the adult’s needs by making direct payments to the authorised person
3. the care practitioner is satisfied that making payments to the authorised person is in the adult’s best interests (within the meaning of the MCA), and that the authorised person will act in the adult’s best interests in arranging for provision of the care and support for which the direct payments will be used
4. the care practitioner is satisfied that the authorised person is capable of managing the direct payment by himself or herself, or with whatever help the care practitioner thinks the authorised person will be able to access
5. the local authority is satisfied that making direct payments to the authorised person is an appropriate way to meet the needs in question/ discharge obligations under s117 of the MHA.

Where a direct payment is made in respect of an adult who lacks relevant mental capacity, such is made subject to a further condition (see regulation 3(5) of the Care and Support Direct Payment Regulations 2014) applied regarding application for an enhanced criminal record certificate. The requirement to obtain a certificate is broadly similar under CHC regulations. The cost of criminal record checks via the Disclosure and Baring Service (DBS) will not generally be met by the ICB or included in the direct payment amount.

### 4.2.3 All adults

When deciding whether to give a direct payment, the care practitioner must satisfy themselves that direct payments are an appropriate way of meeting needs/ discharging obligations under the relevant statutory framework. Appropriateness is for the care practitioner to determine, taking into account all relevant factors (including the law, this policy and the Micro-commissioning Policy). NHSE guidance suggests that where there are questions about whether an adult is suitable to receive direct payments and would be able to manage them, there are a range of people that care practitioners may consult if they believe they may have information relevant to the decision to make direct payments (with the adult’s consent). They include those involved in the adult’s care, their representative, or any other person identified by the adult as a person to consult for these purposes.

The direct payment amount should be a sum that represents the reasonable cost of meeting the eligible needs set out in the adult’s care and support plan, which the direct payment is intended to meet. The personal budget amount, and how this has been used to calculate the direct payment amount, should be made clear to adults/ their representative.

Consideration should be given to whether the direct payment is sufficient, for example where the individual requires support to manage the direct payment, or to ensure that the legal obligations associated with becoming an employer are complied with. Additional costs associated with direct payments are only justified on the basis that the direct payment is an appropriate way to meet the adult’s needs and in a way that incurs such costs. As NHSE guidance notes, direct payments must represent value for money and, where applicable, any additional cost outweighed by the benefits to the individual.

### 4.2.3.1 Support for managing direct payments

Where the care practitioner is satisfied that a direct payment is an appropriate way to meet need, they must also be satisfied that the individual requesting it is able to manage the direct payment themselves, or with whatever help they are able to access.

CHC guidance offers useful considerations for when deciding whether an individual is able to manage a direct payment, which the ICB considers equally pertinent for all types of direct payment:

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

Similarly, NHSE guidance offers direction of wider applicability; where care practitioners are concerned that an individual may be unable to manage, they should also consider:

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

Where an individual is not able to access appropriate support, care practitioners should take all reasonable steps to provide it or provide access to it, perhaps via referral to third party support organisations (subject to the following paragraph).

Those who need help to manage a direct payment should not automatically be excluded from having one without consideration of how they might access support. However, where the individual requesting the direct payment is able to manage that payment themselves without obvious difficulty but chooses not to, they will be expected to meet the costs of management support (e.g. via a third party support organisation) from their own funds.

### 4.2.3.2 Employment obligations

Where the care practitioner is satisfied that a direct payment is an appropriate way to meet need, and it is appropriate to meet that need by employing someone (and the adult and/ or their representative on their behalf wishes to employ someone), all genuinely unavoidable employment costs must be included in the personal budget (and so in the direct payment).

Genuine employment costs will include those which are legally necessary such as Employers’ National Insurance Contributions, pension costs (where the employee does not wish to opt out), employers’ liability insurance, public liability insurance and any other relevant insurance, mileage allowance whilst *at* work (as opposed to there and back to work) if the employee’s car is to be used for the adult’s transport, statutory sick pay – and wages at the minimum wage (subject to the next paragraph), correctly applying the Working Time Directive as to the counting of hours. Genuine employment costs may also include other costs such as recruitment or payroll. The direct payment must be sufficient to meet these costs if it is appropriate to meet the adult’s needs by incurring them.

Where a maternity/ paternity etc payment becomes relevant, this will be considered via application to ICAAP and/ or the CHC Decision Forum. With regard to potential redundancy payments, consideration will first be given to meeting these from surplus or unused funds in the direct payment account, recovery from insurance held by the adult or via insolvency processes. Where all other options have been explored without success, an application to meet redundancy costs may be made to ICAAP and/ or the CHC Decision Forum.

Where someone is being employed using a direct payment, it is generally expected that direct payments will include an amount to remunerate the employee(s) at minimum wages only. Higher rates may be payable where in the care practitioner’s reasonable opinion:

* paying a higher amount balances outcomes and best value in a way not possible if remuneration is only offered at the minimum wage;
* remuneration above minimum wage is required to secure a necessary, higher level of expertise than would otherwise be available at minimum wage.

In all cases where remuneration higher than the minimum wage is being considered, reference must be made to ICAAP and/ or the CHC Decision Forum before a final decision is made. Where payment of wages higher than the minimum wage is not approved by ICAAP/ the CHC Decision Forum, the adult may still choose to fund the additional remuneration from private funds.

As the employer, the adult or their representative on their behalf, will be responsible for the payment of employment costs. This means that the adult/ their representative will need to confirm with practitioners that all employment requirements are being met (for example, by providing a declaration of compliance with pension auto enrollment and/ or confirmation of appropriate insurances).

The care practitioner must be satisfied that the adult (or their representative) has the required knowledge and expertise to manage their own payroll obligations. If the care practitioner is not satisfied, the adult/ their representative must utilise a suitable reputable payroll provider to ensure that all appropriate matters are attended to. Suitability is for care practitioners to determine, taking into account all relevant factors. Where the adult (or their representative) is unable to manage the payroll, the reasonable and proportionate costs of a payroll provider will be included in the direct payment. Whether costs are reasonable and proportionate is for the care practitioner to determine taking account of all relevant factors (including for example, the value of the direct payment, the payroll support provided and the outcomes to be achieved); where costs appear to practitioners to be unreasonable or excessive, the adult may be expected to meet the costs of the excess from their own funds. The requirement to use a suitable reputable payroll provider and to pay them no more than is reasonable and proportionate is not intended to undermine the adult’s choice and control, but rather to ensure that arrangements offer an appropriate balance between outcomes and best value.

DBS checks are strongly recommended as part of any recruitment or contracting process (see below). However, the cost of DBS checks will not generally be met by the ICB or included in the adult’s direct payment amount.

Where a direct payment is being used to employ someone (or to contract for services; see below), care practitioners must also consider how the adult’s needs will be met in the absence of the person(s) employed/ contracted, for example whilst sick or on holiday. How such absences will be managed must be included in the care and support plan.

Adults/ their representatives will be asked to provide evidence of compliance with employment obligations.

### 4.2.3.3 Specific requirements when contracting a self-employed personal assistant

Many of the considerations applicable to employing a personal assistant are equally pertinent when contracting with a self-employed personal assistant.

Where a personal assistant is self-employed, great care should be taken to ensure that the personal assistant’s employment status has been properly understood. This can be complex.

When personal assistants identify as self-employed they must:

1. complete the form found via this link and provide a PDF copy to their adult/ their representative <https://www.gov.uk/guidance/check-employment-status-for-tax>
2. produce an insurance certificate to show they are self-employed
3. evidence their Unique Payable Tax Record Number
4. produce invoices for their fees/ agreed costs and submit these directly to the adult/ their representative for care received. If invoices are not produced/ submitted, the PA cannot be self-employed and will not be paying the correct tax and national insurance
5. complete form ***DPSSEFORM1*** (available from Focus) to acknowledge that they are responsible for their tax, national insurance etc.

Self-employed personal assistants will also need to provide evidence that appropriate insurance is in place. Care practitioners need to identify at the beginning of the direct payment if a personal assistant is going to be recruited on a self-employed basis and advise that the above requirements will be checked. Requirements will be checked by either:

1. A third party support provider, if one is in place
2. A finance practitioner at the initial direct payment audit.

If this process is not adhered to and the documentation is not received, the direct payment will be suspended and alternative arrangements to meet need must be put in place by the care practitioner.

If personal assistants change during the direct payment, the process will be checked at the audit review to ensure everything is in place. If not, the direct payment will be suspended and alternative provision made.

### 4.3 Refusing a direct payment

NHSE guidance provides non-exhaustive examples of where requests for direct payments may be refused, including where:

* the adult (or their representative) would not be able to manage them
* it is inappropriate for the adult, given their condition or the impact on them of their particular condition
* the benefit to the adult of having a direct payment does not represent value for money
* providing services in this way will not provide the same or improved outcomes
* the direct payment will not be used for the agreed purposes. Although not mentioned in NHSE guidance, this may include where there is previous evidence of mismanagement, or debts arising from non-payment of the adult’s financial contributions to the costs of social care.

A request for needs to be met via a direct payment does not mean there is no limit on the amount attributed to the personal budget, and so to the direct payment. There may be cases where it is more appropriate to meet needs via commissioned services, rather than by making a direct payment: for example, where the costs of an alternate provider arranged via a direct payment would be more than the ICB would be able to arrange the same support for (for example because of VAT impact or bulk purchase opportunities), whilst achieving the same outcomes for the adult. Where an adult or their representative simply wishes to replicate a commissioned offer by use of a direct payment – but at higher cost - this is unlikely to represent value for money, unless significantly better outcomes will be achieved via the direct payment route.

Considerations should be focused on the expected outcomes of each potential care-delivery route, including direct payments. In other words, decisions should be based on outcomes and value for money, rather than being purely financially motivated. Where a care practitioner feels that the test of outcomes and value for money does not justify use of a direct payment, their carefully reasoned decision must be recorded.

The consideration stage should be performed as quickly as is reasonably practicable. Interim arrangements will meet care and support needs whilst a decision is being made.

Any decision to refuse a direct payment should be provided in writing to the adult/ their representative, setting out the reasons for refusal by reference to the local or statutory conditions within the Care Act or CHC Framework which have not been met, and confirm what (if anything) the person requesting the direct payment could do to obtain a positive decision in future.

Where a direct payment is refused, care practitioners should consider other ways of personalising care, including (for example) through a third-party supported budget.

For further guidance, refer to the Care and Support (Direct Payments) Regulations 2014, the Care Act’s Statutory Guidance Chapters 11 and 12. See also the Micro-commissioning Policy.

### 4.4 Administering, monitoring, reviewing and reconciling direct payments

### 4.4.1 Setting up and paying direct payments

Before a direct payment can be made, care practitioners must agree a care and support plan with the adult/ their representative which sets out the adult’s needs and desired outcomes, and how the intended support will contribute to meeting them. The plan should reference which elements of the plan will be met via direct payments, and which via other mechanisms (if any) e.g. via support from a carer. The plan should also clearly set out:

* the direct payment amount
* how and when it will be paid
* the name of the practitioner responsible for monitoring the plan and direct payments
* dates or a timeframe for reviews
* procedures for managing risk (for example, back up arrangements required should support/ services arranged via the direct payment fail).

The recipient (the adult and/ or their representative) of a direct payment will also enter into a written agreement with the ICB (directly or acting via Focus) which will set out the terms on which the direct payment is provided. Direct payments will be administered in accordance with the terms of the agreement which is available from Focus, or CHC as applicable. Agreements are updated and resigned where necessary, at the adult’s annual review.

Adults will receive their personal budget amount as a ‘net’ payment into their direct payment account four weekly in advance. Where an adult has been financially assessed as able to make a financial contribution to the cost of their social care, the required contribution must be made to the direct payment account, so that when the personal budget amount and the adult’s contribution are added together, they provide enough money to meet the needs set out in the care and support plan. The adult’s social care contributions are always taken into account first (before monies contributed from the public budgets) when calculating spend on meeting the adult’s agreed need.

A direct payment may be suspended or terminated and commissioned services provided if the adult’s contributions to their social care costs are not made to the direct payment account. Non-payment of the adult’s contributions to the direct payment account may also result in the ICB instigating debt recovery processes.

### 4.4.2 Monitoring, reviewing and reconciling a direct payment

By accessing sufficient evidence (e.g. via bank statements), care practitioners in conjunction with finance practitioners, must be satisfied that the direct payment:

* is and continues to be an appropriate way to meet need
* is being used and continues to be used effectively to meet the eligible needs set out in the care and support plan
* terms and conditions, on the basis of which the direct payment is made, are being and continue to be met, and
* in offering an appropriate balance between outcomes and best value, remains an effective use of public money.

Management of any risks associated with the direct payment must also be considered.

Monitoring direct payment accounts will ensure that where the adult/ their representative has employment responsibility and liabilities such as tax and national insurance, these costs are being appropriately met using the direct payment.

All direct payment accounts (including third party supported accounts) will be monitored, reviewed and reconciled during regular financial audits. Care practitioners will carry out a light touch audit of direct payments at the initial 6-8 week care review (for social care) or 12 week care review (for CHC) to identify any early difficulties. Finance practitioners will undertake a more thorough audit within 6 months of starting the direct payment, and then at least annually thereafter. Direct payments will be monitored, audited or reviewed more regularly where care practitioners, in conjunction with finance practitioners, reasonably consider it necessary. Where practicable and appropriate, direct payment audits will be aligned with reviews of care and support. As a minimum, information from direct payment audits are fed into care reviews, and vice versa.

The purpose of reconciling the direct payment account is to ensure that there are sufficient funds available to meet the adult’s care and support needs and that the funds have been spent appropriately in meeting those needs. It is intended that monitoring, review and reconciliation of accounts should be proportionate to the level of needs being met and the value of the direct payment, and be as unobtrusive as possible.

Where funding from more than one public bodies is agreed (for example the adult receives contributions from the NHS and local authority), integrated budgets paid to and managed through a single account, will be monitored by Focus.

### 4.4.2.1 Reclaiming direct payment monies

The ICB reserves the right to reclaim direct payment monies in any and all of the following circumstances:

* Where direct payment monies have not been fully used, for example because the adult’s circumstances have changed
* Where services have been purchased to meet care and support needs at an advantageous cost (so creating a surplus in the direct payment account)
* Where direct payment monies have been spent in ways that are not in accordance with the care and support plan
* Where direct payment monies have been misused or misappropriated (including when theft, fraud or other offences have occurred)
* Where the terms and conditions on which the direct payment has been provided have not been complied with
* Monies have been paid to the direct payment account in error
* When direct payments are ended, any unused surplus or advance amounts provided are generally reclaimed (see further at 4.6.3 below).

Note: the above is not intended as an exhaustive list.

Whether a reclaim is reasonable will depend on the circumstances, such as the reason why monies have not been fully used or a surplus has been created. For example, some adults with fluctuating conditions may need to accumulate more money in times of lower need to enable them to cover the costs of meeting higher level needs when necessary. Working together, care and finance practitioners will decide whether to review the adult’s needs, to reclaim monies, to reduce subsequent direct payments to reduce any surplus, or to take into account the unused sums.

The adult/ their representative will be notified of any amount identified which will be reclaimed, or subject to an adjustment in the form of a lower direct payment amount in future. The adult/ their representative will be given reasons for the reclaim or adjustment and that timeframe within which action is required by them, or will be taken by the ICB.

### 4.5 Using direct payments

Direct payments are intended to be used flexibly and innovatively, and no unreasonable restriction should be placed on the use of the payment, as long as it is used safely and appropriately to meet the eligible needs detailed in the care and support plan, and managed in accordance with agreed terms and conditions. Choice and flexibility should be encouraged at the support planning stage but any significant variation in the services described in the plan should be agreed with the care practitioner in advance and in writing.

Direct payment monies must not be spent on paying for general living costs such as food, housing costs, household bills or other day to day expenses, and/ or buying food, drinks or gifts for the adult or anyone else (these exclusions are not intended as an exhaustive list).

Care practitioners and adults may find the following guidance from a Local Government Ombudsman decision useful clarification on use of direct payments (referred to as ‘DPs’), with local emphasis:

*“In my view DPs are public funds given to a service user under a quasi-trust arrangement to meet eligible needs and defined outcomes in a support plan. While acknowledging strong participation and consultation rights in assessing and planning needs in adult social care (including the right to self-assessment), and that decision making is to a significant degree a matter of partnership between service user and council, it is for the council to make a final decision on outcomes, the definition of eligible care and support needs, what may be provided to meet needs and the service user’s personal budget. While giving the service user flexibility and discretion about use of DPs – in particular in relation to who provides a service, the way in which the service is provided, and deciding pattern of use of a service - the service user is required to account for their use through the council’s review and monitoring process and the council is entitled to take a view on what constitutes their legitimate use and can in certain circumstances require repayment of money placed in the DP account” (*<http://www.lgo.org.uk/decisions/adult-care-services/direct-payments/16-017-296>).

### 4.5.1 Use of direct payments for residential stays

Social care direct payments can be used to purchase short stays in residential care providing that the stay does not exceed a period of four consecutive weeks (28 days) in any 12-month period. The need for short stays should be detailed in the care and support plan.

Care Act regulations specify that where direct payments are used to purchase short breaks in residential care, and where the interim period between two stays is less than four weeks, then these two stays should be added together. The total of these stays should also not exceed four weeks. In both cases, no further residential care can be purchased using direct payments until 12 months have elapsed since the start of the four week period. Alternative funding arrangements would need to be agreed at this time.

Care Act regulations do allow direct payments to be used to purchase short breaks in residential care where stays are four weeks and less, and are separated by four weeks, and do not exceed four weeks when added together. In this case, the adult can use their direct payment to purchase short breaks in residential care throughout the year.

Direct payments may be considered for adults that live permanently in a care home where they require non-residential care services. Similarly, an adult may have temporary access to direct payments to try independent living.

CHC rules are similar.

### 4.5.2 Using direct payments for care and support provided by the Council/ ICB

Direct payments cannot be used to pay for care and support provided by the Council/ ICB. There may be cases however, where an adult wishes to make a one-off purchase of care or support from the Council/ ICB (such as a short break). In these circumstances, it would be appropriate for the person to use their direct payment for this purpose.

### 4.5.3 Using direct payments to pay family members

In respect of both the adult and their representative, Care Act regulations (Care and Support Direct Payment Regulations, regulation 3(3)) and NHS regulations exclude direct payments from being used to pay:

1. their spouse/ civil partner (or someone living with them as if they are their spouse/ civil partner)
2. a close family member (as defined by the regulations) living in the same household as them
3. the spouse/ civil partner (or someone living with them as if they are their spouse/ civil partner) of a family member (as defined by the regulations) living in the same household as them

for either:

1. care and support, or
2. help with managing direct payments,

except where care practitioners determine this to be necessary.

Note: the test for deciding whether to pay persons falling in the categories at a) to c) above is not one of ‘exceptional circumstances’, but one of whether paying the person is this way is ‘necessary’. In determining necessity, care practitioners will have regard to the adult’s wellbeing, and to the arrangements most likely to provide an appropriate balance between outcomes and best value. NHSE guidance states that these judgements should be made on a case-by-case basis.

Regarding wellbeing, care practitioners may also consider the impact that a change of relationship may have on household dynamics, where a family member goes from offering informal support to being a formal, paid worker. Management of disputes or conflicts of interests in such situations may be particularly sensitive and difficult to manage. Careful thought should be given to the impact on existing community support networks and relationships in the home, perhaps particularly in respect of a spouse who may reasonably expect to provide some support to the adult without payment.  Care practitioners should also note that paragraph 12.38 of Care Act statutory guidance states that support is “not intended to be income replacement” (which results in tax, employment and benefits implications). Care practitioners and adults may find a useful example of a social care direct payment being refused for payment to a family member in this Local Government Ombudsman decision: <http://www.lgo.org.uk/decisions/adult-care-services/direct-payments/17-002-290>

Where a care practitioner does determine that such a payment is necessary, they will record it in the adult’s care and support plan. The care practitioner will record the circumstances and reason for the decision, along with the payment amount, payment frequency and activities covered by the payment, in agreement with the adult and the person being paid as well as any other relevant person (e.g. an advocate). The agreement will also include how disputes will be managed between all relevant parties where a family member is being paid to provide care and support or manage direct payments.

Care practitioners will be unlikely to deem such a payment to be necessary where:

* the proposed payments are unlikely to provide an appropriate balance between outcomes and best value
* there are other reasonable and available alternative ways of meeting the adult’s needs for care and support, or to manage a direct payment
* there is a risk of a conflict of interests, for example because the family member under consideration is also the adult’s representative
* there is a risk that the direct payment may be abused
* there are other sensitivities such as potential safeguarding issues.

Reference must be made to ICAAP and/ or the CHC Decision Forum before a final decision is made.

### 4. 6 Reducing, suspending or ending direct payments

### 4.6.1 Reducing a direct payment

Direct payments may be reduced where (by way of example):

* a needs assessment and/ or review identifies that the adult’s needs have reduced
* following assessment and/ or review, the care practitioner is satisfied that a reduced amount is sufficient to meet the needs set out in the care and support plan. This may be the case where, for example, the adult’s needs can be met more cost effectively than previously, whilst still ensuring that those needs are met
* a surplus has accumulated in the adult’s account. A surplus may be identified during review of a direct payment by a finance practitioner, as at 4.4.2.1 above. A surplus may indicate that the adult has not been receiving the care that they need, or that too much money has been allocated. Care practitioners will need to establish why the surplus has built up, before deciding if a reduced payment is reasonable.

Where a reduction is considered, it will be discussed with:

* the adult
* the adult’s carer (where applicable)
* the adult’s representative (where applicable)
* any person involved in administering or managing the direct payment
* anyone else the adult wishes to involve
* where the adult lacks relevant mental capacity, those that the MCA requires to be included in decision making.

Reasonable, written, notice will be given of any reduction, with reasons.

### 4.6.2 Suspending a direct payment

Adults entering hospital should consider how best to use the direct payment at that time, especially where they are an employer and suspension of the direct payment could necessitate a break in the employment contract. The adult should be helped to explore how their care and support needs, as well as their health needs, are met whilst in hospital. This may include discussing with hospital staff the possibility of the adult’s personal assistant visiting the hospital to help with the adult’s personal care matters. Plans to continue supporting the adult using a direct payment during their period of hospitalization must be discussed and agreed with the adult’s care practitioner.

Where the personal assistant is able to continue delivering relevant support during the period of hospitalization, they may continue to be paid at the level of their normal wages. Support during hospitalization may include, by way of example, checking on the adult’s empty property and watering plants, assisting with the adult’s communication needs at the hospital, taking clothing home for laundering and returning clean clothes to the hospital.

Where the personal assistant is unable to continue delivering relevant support during the period of hospitalization, a ‘retainer’ may be paid to the PA at 50% of their normal weekly wage. The retainer may be paid for a maximum of 6 weeks within a 12 month period.

Where the adult’s representative requires a hospital stay, the adult’s needs must continue to be met. This may be through a temporary nominated or authorised person, or through short term commissioned care and support.

A direct payment may also be suspended whilst care or finance practitioners consider whether to end the direct payment, for any of the reasons referred to at 4.6.3 (excepting death of the adult, which will certainly result in ending the direct payment). Where a suspension is being considered, care practitioners will discuss this with those listed at 4.6.1 above, in respect of reducing a direct payment.

Wherever possible, care practitioners will give the adult/ their representative reasonable notice before suspending the direct payment. What is reasonable will depend on the circumstances including (for example) the reasons for the suspension, the way in which the direct payment is being utilised and whether there are any resulting implications to be taken into account, such as employment obligations. Twenty-eight days’ notice will be provided wherever possible. Suspending a direct payment without notice is likely to be exceptional; however, there may be serious cases, such as where the representative is not using the direct payments in the adult’s best interests, where it will not be possible to give any notice.

### 4.6.3 Ending a direct payment

Direct payments will end where (by way of example):

1. the adult no longer has the eligible needs for which the direct payment was made available
2. care practitioners reasonably consider that the direct payment is no longer an appropriate way to meet the adult’s eligible needs. This includes (but may not be limited to) situations where the direct payment has ceased to offer an appropriate balance between outcomes and best value i.e. a direct payment is no longer an effective use of public money
3. the adult no longer wishes to receive the direct payment
4. the adult’s representative no longer wishes to receive the direct payment, and (where appropriate) no alternative arrangements can be made for another suitable person to receive the direct payment
5. care practitioners reasonably consider or are notified by any other person that:
6. the adult is or no longer appears capable of managing the direct payment with necessary support
7. the adult’s representative is or no longer appears capable of managing the direct payment with necessary support, and (where appropriate) no alternative arrangements can be made for another suitable person to receive the direct payment
8. the authorised person is not acting in the best interests of an adult who lacks relevant mental capacity, within the meaning of the MCA
9. there are serious concerns that the adult or their representative is misusing or misappropriating the direct payment, for example, the adult or their representative is not using the direct payments to meet the needs set out in the care and support plan. This could also include fraud, theft or other abuse in connection with the direct payment
10. the adult or their representative in some other way fails to comply with the direct payment’s terms and conditions, for example by failing to pay assessed financial contributions into the direct payment account, or failing to comply with reasonable request for information
11. care practitioners become aware that regulations prohibit the adult or their representative from receiving a direct payment
12. The adult’s representative dies and (where appropriate) no alternative arrangements can be made for another suitable person to receive and/ or manage the direct payment
13. The adult dies.

The direct payment will also end where:

* an adult or their representative loses relevant mental capacity. If the loss of mental capacity is considered temporary then direct payments may continue, providing someone suitable (suitability is for care practitioners to decide) is willing to continue managing the payment. The situation will be closely monitored by care practitioners and mental capacity will be reviewed before a decision is taken to either end the direct payment, or enter into a new direct payment agreement with another person
* an adult regains relevant mental capacity. An authorised person has a duty to notify the ICB that the adult has regained relevant capacity. Where capacity is likely to have been regained permanently or in the longer term, care practitioners will work with the adult to decide whether the management of the direct payment should be transferred to the adult (with their consent) or to any suitable person nominated by them. Where regaining capacity is likely to be temporary, care practitioners can continue to make direct payments to the authorised person if during the period that the adult has capacity to request a direct payment and is capable of managing the direct payment, the authorised person allows the adult to manage the payments for him or herself.

Where the adult’s representative is unable to continue managing the direct payment, it may still be appropriate for the adult’s needs to be met via a direct payment. Where the care practitioner considers it appropriate, alternative arrangements may be made for another suitable person to receive the direct payment on the adult’s behalf. Any such alternative arrangements will be dependent on the suitable person entering into a written agreement with the ICB (itself or acting via Focus) and complying with the terms and conditions under which direct payments are provided.

A direct payment will not be ended arbitrarily or unreasonably. Wherever possible, a direct payment will only be ended following a review of the available options, and on reasonable notice. What is reasonable notice will depend on the circumstances including (for example) the reasons why the direct payment is being ended, the way in which the direct payment is being utilised and whether there are any resulting implications to be taken into account, such as employment obligations. Twenty-eight days’ notice will be provided wherever possible. Ending a direct payment without notice is likely to be exceptional; however, there may be serious cases, such as where the representative is not using the direct payments in the adult’s best interests, where it may not be possible to give any notice.

Wherever possible, when considering ending a direct payment, reviews will include:

* the adult
* the adult’s carer (where applicable)
* the adult’s representative (where applicable)
* any person involved in administering or managing the direct payment
* anyone else the adult wishes to involve
* where the adult lacks relevant mental capacity, those that the MCA requires to be included in decision making.

Where the adult has eligible needs which must continue to be met, a review of the adult’s care and support plan will be required to explore and agree alternative ways to meet those needs.

### 4.6.3.1 Practicalities on ending a direct payment

When a direct payment ends, it must be determined that no outstanding liabilities remain. Where contracts of employment require terminating, the employer (usually the adult/ their representative) is responsible for terminating it in a timely manner to avoid unnecessary costs.

When the direct payment ends, an exit audit will be undertaken; all information and paperwork relating to the direct payment account must be made available to the Focus finance team. Once all outstanding expenses have been determined and paid, any money remaining in the direct payment account must be returned to the ICB. The ICB will seek the return of remaining monies in all circumstances, including on the death of the adult.

Where misuse or misappropriation may amount to theft or fraud, the matter will be reported to the police for investigation.

### 4.7 Disputes

Care practitioners must take all reasonable steps to agree with adults how to meet their needs (taking ‘all reasonable steps’ does not equate to a duty to reach agreement at any cost; Davey, paragraph 158). Where the adult lacks relevant mental capacity, reasonable steps should be taken to reach agreement with the person authorised under the MCA to make decisions about the adult’s needs for care and support or if there is no such person, any person who appears to care practitioners to be interested in the adult’s welfare (which will include those authorised to receive direct payments).

Efforts to reach agreement should be carefully documented. The care practitioner’s role is to ensure that the way in which they adult’s eligible needs will be met is appropriate, and represents the best value for money and maximisation of outcomes for the adult. Care practitioners discharge this role in conjunction with finance practitioners.

In the event that agreement cannot be reached with the adult, or their representative, the care practitioner should state the reasons for this and the steps which must be taken to ensure that the care and support plan – including provision of the direct payment - is signed-off. This may require going back to earlier elements of the planning process. Adults must not be left without support while a dispute is resolved.

If a dispute still remains, and the care practitioner feels that all reasonable steps have been taken to address the situation, they should direct the adult to the local complaints procedure. It is not appropriate to suspend service provision during the making of a complaint.

## 5 Training

This policy will be drawn to the attention of all relevant individuals as part of the implementation process (see 7 below).

## 6 Impact analysis

### 6.1 Equality

This policy has been created with due regard for the ICB’s public sector equality duty under the Equality Act 2010, s149. All staff connected with the implementation of this policy, in the exercise of their public functions, must also have due regard to the matters within s149(1).

An Equality Impact Assessment (EIA) has been conducted with regard to this policy.

### 6.2 Bribery Act 2010

The Bribery Act 2010 is relevant to this policy. Under that Act it is a criminal offence:

* To bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so; and
* To be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so
* To bribe a foreign public official - A person will be guilty of this offence if they promise, offer or give a financial or other advantage to a foreign public official, either directly or through a third party, where such an advantage is not legitimately due
* For commercial organisations to fail to embed preventative bribery measures.  This applies to all commercial organisations which have business in the UK. Unlike corporate manslaughter this does not only apply to the organisation itself; individuals and employees may also be guilty.

These offences can be committed directly or by and through a third person.

Anyone with concerns or reasonably held suspicions about potentially fraudulent activity or practice should refer to the Local Anti-Fraud and Corruption Policy and contact the Local Counter Fraud Specialist.

## 7 Implementation

This policy will be disseminated via key individuals within the Council, the ICB, Navigo and Focus with the expectation that each will cascade the information within it amongst their relevant teams. Providers will be expected to ensure that it is available electronically to their staff. The policy will be further communicated through team briefings, and training sessions, led by each provider’s key individuals.

Each organisation delivering direct payment functions will create operational procedures to support their staff in delivering on this policy.

Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under the ICB’s disciplinary procedure, or that of the organisation which employs the staff member in breach.

This policy is publicly available at: <https://www.northeastlincolnshireccg.nhs.uk/publications-1/>. More information on the local approach to direct payments is available at: <https://livewell.nelincs.gov.uk/direct-payments>

## 8 Policy monitoring and review

This policy will be reviewed in 3 years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in law/ guidance, as instructed by the senior manager responsible for this policy.

## 9 References and links to other documents

External documents:

* 1. European Convention on Human Rights
  2. UN Convention on the Rights of Persons with Disabilities
  3. The NHS Constitution
  4. The Care Act 2014, Statutory Guidance and supporting Regulations
  5. The Children and Families Act 2014
  6. The Health and Social Care Act 2012
  7. The Equality Act 2010
  8. The Bribery Act 2010
  9. National Health Service Act 2006
  10. The Mental Capacity Act 2005 and Codes of Practice
  11. The Human Rights Act 1998
  12. The Mental Health Act 1983 and Code of Practice
  13. The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care and Decision Support Tool (both published March 2018, revised July 2023)
  14. Guidance on Direct Payments for Healthcare: Understanding the Regulations, December 2022 [NHS England » Guidance on direct payments for healthcare: Understanding the regulations](https://www.england.nhs.uk/long-read/guidance-on-direct-payments-for-healthcare-understanding-the-regulations/)
  15. NHS (Direct Payment) Regulations 2013
  16. Who Pays? Determining Responsibility for Payments to Providers (NHS England 2013) – amended 2024 ([NHS England » Who Pays?](https://www.england.nhs.uk/who-pays/))
  17. NHS Commissioning Board and Clinical Commissioning Groups’ (Responsibilities and Standing Rules) Regulations 2012 (amended by the 2013 and 2016 ‘Standing Rules’)
  18. Personal Health Budget’s Guide: Integrating Personal Budgets, Myths and Misconceptions (Department of Health, 2012)
  19. National Audit Office Successful Commissioning Guide (guidance on securing value for money in public spending) (<https://www.nao.org.uk/successful-commissioning/general-principles/value-for-money/assessing-value-for-money/>)

Internal Documents:

* 1. Direct Payments Policy; this can be found at <https://www.northeastlincolnshireccg.nhs.uk/publications/>
  2. Mental Capacity Act 2005 and Deprivation of Liberty Policy; this can be found at <https://www.northeastlincolnshireccg.nhs.uk/publications/>
  3. S117 Memorandum of Understanding can be found at: [ ].