

PERSONAL HEALTH BUDGETS GUIDE

Implementing effective care planning



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Personal health budgets

A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. Our vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

What are the essential parts of a personal health budget?

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

- be able to choose the health and wellbeing outcomes they want to achieve, in agreement with a healthcare professional
- know how much money they have for their health care and support
- be enabled to create their own care plan, with support if they want it
- be able to choose how their budget is held and managed, including the right to ask for a direct payment
- be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

How can a personal health budget be managed?

Personal health budgets can be managed in three ways, or a combination of them:

- notional budget: the money is held by the NHS
- third party budget: the money is paid to an organisation that holds the money on the person's behalf
- direct payment for health care: the money is paid to the person or their representative.

The NHS already has the necessary powers to offer personal health budgets, although only approved pilot sites can currently make direct payments for health care.

What are the stages of the personal health budgets process?

- Making contact and getting clear information.
- Understanding the person's health and wellbeing needs.
- Working out the amount of money available.
- Making a care plan.
- Organising care and support.
- Monitoring and review.

1 Introduction

Personal health budgets allow people to move from a world where others know best to one where their input is valued above all others, but not in isolation from others. It is a way to allow the person to be at the heart of the planning process, identifying with key health professionals the things that really matter to them and which allow them to lead a safe and fulfilling life.

- Personal health budgets peer network, 2012

This guide defines a personal health budget, its purpose, and what is distinctive about this way of working.

For healthcare professionals, it describes the preparation needed to develop a local framework that can enable best practice. It is important to put this groundwork in place, otherwise people will find it harder to create and implement their care plan.

The guide also summarises the essential topics that must be covered and recorded during care planning, and describes how these discussions may best take place.

For people who have a personal health budget, this guide explains what a care plan is and how it is different from the way the NHS has worked previously. It shows how personal health budget holders and family members can work with healthcare professionals to develop a local approach.

The function of the **local framework** for personal health budgets is to make sure both the person and the health professional know what is expected of them, so that the care plan can be created, authorised and put into action successfully. The framework informs and shapes each person's conversation with their health team and supports professionals' shared decision making.

Personal health budgets promote a shift in power and decision making to enable a changed, more effective relationship between the NHS and the people it serves. So the personal health budgets planning process is not simply a document or template – it is an active, ongoing relationship and dialogue, with changes of role for people, health professionals and commissioners.

The focus is similar to several recent NHS initiatives, including the diabetes year of care,¹ shared decision making,² and long term conditions planning.³ The aim is to improve the dialogue between people and their health professionals to combine expert clinical knowledge with a person's unique experience and capabilities – their preferences, creativity and motivation.

At the heart of a personal health budget is a **care plan** developed in partnership between health professionals and people needing treatment. In life-threatening situations, people usually want to hand over control to

skilled professionals. But there is growing recognition that the effective management of chronic disease depends more on what people do than on professionals. People play a central role in managing their own health, and personal health budgets are one important aspect of this. The Royal College of General Practitioners describes care planning as being about:

Making more effective the dialogue between the patient and the GP that is so vital to the care we provide every day, and changing the doctor–patient relationship into a doctor–patient partnership. [Care planning] will not only improve the quality of life for patients with long term conditions but will also give them more control, better health and better well-being.⁴

For people whose lives are highly dependent on healthcare, creating a plan that addresses their health needs holistically means that they can integrate health with other vital aspects of their life that affect their health – work, education, housing, family and community. A care plan that works well for important aspects of daily living will also support the effectiveness of a person's health treatment.

Personal health budgets are not only about money, and not just about enabling choice. They draw on people's skills, knowledge and natural motivation, and combine them with health professionals' clinical expertise and understanding of the existing evidence for the effectiveness of different treatments.

Learning points

A holistic approach: good care planning is about understanding the impact of a person's long-term health condition or disability on the whole of their life.

Self determination: while it is impossible to achieve a perfect life, and illness can restrict people's aspirations, personal health budgets can be used to support people in many different health circumstances to have increased control through shared responsibility.

Equality: under the Equality Act 2010, providers must make services accessible to all and meet different people's needs across all protected characteristic groups.

Capacity: in the case of people who do not have capacity to make their own decisions, there can be best interest decisions, guided by the principles of the 2005 Mental Capacity Act. This also enables people with fluctuating health conditions to plan for a time when they may not be able to discuss options or make their own decisions.

Evolution and principles of personal health budgets

Personal health budgets and shared decision making arose both within the NHS and in movements for change driven by the people it serves. Campaigners in disability rights, survivors of mental health services, expert

patients and family carers have long been calling for people's right to an independent and fulfilled life as part of their local communities, with as much control over their treatment and ongoing support as they wish to take.

The Royal College of General Practitioners describes care planning as a powerful way of creating an environment that helps clinicians to support self management:

*"When patients self care, and equally feel supported in doing so – they are more likely to have greater confidence and a sense of control, to have better mental health and less depression, and to reduce the perceived severity of their symptoms, including experienced pain."*⁴

Similarly, the Health Foundation, summarising the evidence for self management, describes:

*"A fundamental transformation of the patient–care giver relationship into a collaborative partnership."*⁵

So the combination of NHS initiatives and personal drivers for change carries the potential for significant progress.

The principles underlying personal health budgets are that they must:

- uphold NHS values, being free at the point of delivery and not dependent on ability to pay
- support safeguarding and quality
- support the tackling of inequalities and protection of equality
- be voluntary – **no-one will be forced to have a personal health budget**
- support the making of decisions as close to the person as possible
- support working in partnership.

2 Creating the local framework

The message from all the sites involved in the Department of Health's personal health budgets pilot programme⁶ is that it is critically important to get the groundwork right when offering people personal health budgets. Making these budgets work well depends on all those involved making significant changes to their thinking, feeling and behaviour. This is a process that can't be rushed and that requires a clear and mutually understood common purpose and framework.

Personal health budgets enable people to create their own effective and efficient health plan, based on a new understanding of what money is available to them both at the outset and over time.

The transparency about the money is really empowering and shifts the conversation.

- NHS Continuing Healthcare commissioner in Oxfordshire

But money alone will not achieve the main purpose. Several other critical factors must be in place to ensure equity of access to this new way of working together. These critical factors are what make up the local framework.

What would any of us want to know if we were presented with an opportunity to do something new and different from our usual experience? Thinking about this question is

the most helpful starting point in defining the deal between the NHS and a personal health budget holder, outlined in the local framework.

Personal health budgets offer a new relationship or contract: sharing power and responsibility, shifting control and decision making towards the person, and opening up to new, flexible ways to achieve health outcomes within the context of a person's whole life. It has clear and simple rules. At its best, the process of personal health budget planning is a well thought through, carefully considered and simple approach.

This guide is based on learning from pilot sites⁶ where all the people involved in personal health budgets came together to share their understanding of the local processes. People with budgets, clinicians, personal health budget brokers and health and social services commissioners discussed central questions about personal health budgets, and shared their perceptions and experiences (see page 31).

Feedback demonstrates that it is crucial to have an explicit shared understanding of the local framework before people start to discuss and create their care plan. The following are essential elements of a framework within which effective care planning can take place, which should be built by both clinicians and budget holders in partnership.

- Develop a peer network and involve everyone from the start.
- Clarify the purpose and principles.
- Be clear about all aspects of the money – when and how a budget is offered; how much money is being allocated to the person; the flexibility of spending it; and what the monitoring and review process will be.
- Develop and provide information, support and training.
- Agree a local approach to choice, safeguarding and risk enablement.
- Agree the criteria for sign off.
- Agree the process of authorisation and appeals.
- Agree how care plans will be monitored and reviewed.
- Gather and learn from feedback.
- Develop a local communication strategy and workforce development plan.

Develop a peer network and involve everyone from the start

Don't try and figure it all out alone first.

- NHS Continuing Healthcare manager

Care planning with a personal health budget is about a change in the relationship between the person and their clinician, so it's essential to involve both groups in developing new

ways of doing things. Other people also need to be involved – family carers, healthcare commissioners, health and social care managers, finance managers, administrators, and voluntary sector providers – to ensure the framework for care planning meshes with the wider systems within the NHS, the local authority and the local community.

When making cultural and professional changes in a complex system, it's important to engage people from each main part of that system, so that everyone can help develop and have ownership of the changes. This means everyone's creativity is engaged, new ideas are challenged and made more robust through discussion, and resistance to change later in the process is avoided.

Including people with direct experience of healthcare treatment as equal participants with health professionals and commissioners demonstrates that their views are valued and respected, and reflects one of the central foundations underpinning personal health budgets. Inviting social care staff to be part of developments indicates the wish for a joined-up, integrated approach – the focus is the person rather than the different service systems and organisations.

Experience in the pilot sites has shown how different people's perceptions and experiences are when everyone is brought together. If collaboration and feedback systems are not securely in place, well intentioned policies can have unintended consequences of which the NHS may be unaware.

The NHS is an institution with its own language, culture and customs, and it will take time and practice for people who are not accustomed to these entrenched mechanisms to be able to take part in discussions. Investment in developing people's skills and confidence to engage fully in the development of the local framework for care planning will yield dividends, as expressed by a manager of a pilot site:

Patient involvement in developing personal health budget systems will ebb and flow as people's conditions fluctuate, so it's ok to start with a very small group of people and build a broader group over time – and invest in that group of people.

- NHS Continuing Healthcare manager, pilot site

People from different perspectives starting to work together can be complex. Trust builds slowly and gradually. If people feel more confident, they are able to challenge each other respectfully. None of this happens without good leaders acting in a co-ordinating role to nurture and support the process of development.

In the personal health budgets pilot programme,⁶ to ensure peer input happened, the Department of Health invested in a part-time co-ordinator's role, and also funded people's travel expenses so that they could link up nationally, face to face. The DH also recognised and supported the need for people to meet initially as a separate group so that they could gain knowledge and confidence before joining the work to

develop national guidance. For local developments, some investment by commissioners will also be necessary.

Jo Fitzgerald, the leader of the personal health budgets peer network, describes how peer support can best be enabled, and why it is important:

We have clearly established that involving peers in the development of personal health budgets is crucial. Peer to peer input fosters confidence. We often talk about cultural change in the NHS and how the way people think and behave needs to adapt to realise the vision we all share for improved outcomes for people. The same needs to happen for people and families if they are going to embrace the opportunity to take more control over their health and wellbeing. They need to believe that change can happen.

The most powerful way to communicate new possibilities is for peers to talk to each other. There is an innate trust between people and families with shared experiences. A robust strategy for the dissemination of accurate and useful information is vital, along with developing a regular feedback loop. This can be done in a number of ways, but one of the most robust is to involve people at every stage of development by creating a peer network.

Too often, people with direct experience are invited to participate when important decisions have already been made. There's a tendency to believe that clear plans need to be in place and a strategy agreed before people with direct experience can be invited.

While involving everyone at the beginning may feel uncomfortable, that's exactly when it should happen.

See the Personal health budgets toolkit: 'Working together with people and families'.

Clarify the purpose and principles

Health staff must be able to explain to people what a personal health budget is, and what it is for, in a straightforward and simple way and to dispel any misunderstandings or fears. When setting up the personal health budget framework, and when implementing the care planning process, the most helpful guiding principle to underpin all decision making is to remember the purpose of the budget:

You always need someone in the group to say we need to go back to what we are trying to achieve.

- NHS Continuing Healthcare commissioner in Oxfordshire

It takes time and numerous conversations to build knowledge and consensus about the purpose and use of personal health budgets. People should be encouraged to ask questions as fresh issues arise, and supported to debate the shift in relationships and what this means to them personally and professionally. Once a group of key people locally have a shared understanding of the purpose and distinctive characteristics of a personal health budget, they can then work out, with the aid of national learning and emerging policy, what their local framework is going to be.

See the Personal health budgets toolkit: 'Introduction to personal health budgets'.

Be clear about all aspects of the money

When and how is a budget offered and managed?

People want the opportunity of a personal health budget to be available at a time that is right for them. Their confidence and readiness to consider options will vary. Offering a personal health budget shortly after a person has been through a health crisis is unlikely to be helpful. The framework needs to include how and when personal health budgets will be offered. Staff should be ready and able to work with people at the time when the person is confident enough and ready to take more control, and when they are willing and have the energy to put in the work to take more control.

A personal health budget does not have to be offered and taken up at a single point in time, or all at once. People may wish to change one small part of their care first. A personal health budget is not an all-or-nothing offer, and it is not obligatory. It is voluntary – people can be assured that they don't have to choose or change anything immediately. They may want to take time to think about what they might like to be different, or to prioritise just one part of their treatment or support. People can have a mix of NHS services and some things that they buy for themselves with their personal health budget. It is also fine to keep

everything just as it is. Many people value their NHS treatment highly and want it to continue unchanged.

People need to be able to choose to take control of a budget, and increase their take up of responsibility, at a pace that feels comfortable for them. They may choose not to manage the money directly, but use another organisation or person to hold it on their behalf, while retaining the freedom to choose how it is spent.

To ensure equity of access to this new way of achieving health outcomes, there must be a range of ways available to hold and manage the money, not solely access to a direct payment. This is because many people may not want, and some may not have capacity to use, direct payments.

How much money?

This guide starts at the point where a person has been assessed as entitled to have some ongoing health needs met by the NHS, and an indicative budget has been allocated. It does not describe how this process should happen.^{7,8}

Many challenging issues arise when considering how best to calculate appropriate budgets that can be offered instead of services. For example, the NHS is currently in the process of developing a fuller understanding of what services actually cost, because until recently many services were commissioned through large block contracts.

Understanding costs and discussing them with people can feel unfamiliar within the NHS, and people can be surprised by the cost of services they have been used to working in, or receiving treatment from. Once people have this information, there is growing evidence that they are thoughtful about how to make the money work the best for them and seek to receive good value for what is essentially public funding. Clarity from the start about what money is available allows for a realistic appraisal of options and encourages creativity and innovation.

How can the budget be spent?

People will need to know what their budget can be spent on and what is excluded.⁸

Personal health budgets cannot be used for:

- gambling
- debt repayment
- tobacco
- alcohol
- anything illegal.

Some NHS services are also excluded – people should always be able to use these services in addition to having a personal health budget. For example:

- emergency or acute services
- most primary care services such as visits to a GP.

Apart from these exclusions, personal health budgets can be used for any goods or services agreed as part of a care plan that are likely to meet the individual's agreed health and well-being outcomes.

The care planning process will have involved the person in considering what is important to them and what they are willing to commit to, along with support and information from the health professional about what might have proved useful for others and what research evidence suggests (see page 22). While some treatments are approved by the National Institute for Health and Clinical Excellence (NICE), there are currently many treatments and services provided by the NHS the efficacy of which varies person to person.

There are no treatments that are 100% reliable and 100% side effect free and there are very few clinical situations where there is just one course of action that should be followed in all cases. In circumstances where there are a number of options leading to different outcomes and the right decision depends on a patient's own particular set of needs and outcome goals, the condition is said to be preference sensitive [...] shared decision making for these conditions should be informed by the available evidence and by the patient's wishes, needs and preferences.⁹

Commissioners will need to think beyond block commissioned services and give people the opportunity to work together with the expert professional advice and knowledge of their local health team. Together, they can find creative, efficient and effective solutions, drawing also on peer knowledge and experience. PCTs should be careful not to exclude unusual requests without examining the proposal on a case-by-case basis – these may have significant benefits for people's health and wellbeing.¹⁰

There is evidence that when people are given choice and control, it leads to better health outcomes. For example, in one large randomised control trial:

The effect of giving a choice of formats for a programme of heart disease management improved physical and psychosocial functioning.¹¹

A personal health budget holder vividly describes how empowering it is to be given control:

If someone else had chosen the exact things stated in my budget, it wouldn't have had the same impact on my life; it's the fact I've thought about and chosen for myself. I've taken control and purchased back, if you like, the self worth I thought I'd lost forever.

Money monitoring and review

Irrespective of how people choose to hold and manage their budget, they will need to know the practical aspects of money management:

- what records to keep
- when and how the money will be monitored
- what happens if a mistake is made
- how much money may be set aside for emergencies or fluctuations in their condition
- how the budget will be reviewed if needs change
- what support is available if the person takes the money as a direct payment
- information about the full range of third-party options available.

The most important aspect here is the need for trust, and proportionate light-touch monitoring of the money. This needs to be integrated within a simple process for monitoring and reviewing health outcomes.

See the personal health budgets toolkit: 'How to set budgets - early learning' and 'Budget setting for NHS Continuing Healthcare'.

Develop and provide information, support and training

It is important for budget holders to be able to choose who, if anyone, they want to support them when writing their care plan. This is a critical role. Pilot sites⁶ have found that some people are happy and comfortable planning on their own, particularly when they are given clear information about what is expected of them. But when planning for the first time, many people will want to talk things through with someone else, preferably someone with whom they feel comfortable and who they believe has an understanding of their situation. This may be their healthcare professional, but some people may prefer an independent person to guide them through the process and liaise with the relevant parties. As with each aspect of personal health budgets, the best approach is enabling choice and not assuming one option will suit everyone. Not everyone – including some health professionals – will feel comfortable in this facilitating role. Staff may welcome some additional training and support in facilitation.

It is important to bear in mind that people

with long-term health conditions may feel constrained – they may find it hard to disclose what isn't working for them, feel that they ought just to be grateful, and be fearful of losing services they value. This is where peer support can play a big part. Pilot sites have made a range of support options available to people, including independent brokerage. Some are also beginning to build peer support into their care planning process. Many people are willing to offer reciprocal support to one other person. Peer support can help in fundamental ways with critical elements of the process (see page 34).

See the Personal health budgets toolkit: 'Providing information and advice' and 'Getting the message across'.

Agree a local approach to choice, safeguarding and risk enablement

Choice

While personal health budgets can offer creative choice, they may also offer far more:

Personalisation recognises that the individual has a whole life and their own real wealth – that is: someone's strengths, knowledge, resilience, community contacts, personal relationships and resources. Personalisation tries to enable services to work with the fabric of that whole life.¹²

Personal health budgets can amplify the effective use of money through combination and integration with a person's internal and external resources, for example their motivation and relationships. People need to feel it is possible for useful change to happen, and hopeful that their day-to-day life can be improved. This is necessary even when a person has a deteriorating health condition or is nearing the end of their life. Hearing about real-life examples of what others have done differently and talking with peers are two useful ways to share creative thinking and generate new possibilities.

It will also be necessary to work with local providers and specialist and mainstream community services to ensure people can access and buy what they are looking for.

Safeguarding and risk enablement

Before recent personalised care planning initiatives in the NHS,^{1,2,3} the people with most to lose if things went wrong were sometimes the very people excluded from discussions about risk. Management of risk and responsibility for safeguarding were seen as the responsibilities of professionals. When people use personal health budgets, they plan how to use their budget creatively, to tailor their care and support to improve their situation and to achieve their personal health outcomes. Part of that planning process must include weighing up benefits against any possible risks of particular aspects of their care plan.

People will want to discuss the merits of different treatment options with their clinicians. When considering a choice of care providers and third-party organisations, they may also want to seek information more widely, and to consult with other people (for example friends they trust) and perhaps with people who have similar health conditions.

Some people will use their budget to continue to purchase traditional services that they find work well for them; some will want to use it to meet their health outcomes in different ways. It will not be possible simply to rely on existing regulations and protocols to manage risk, and it could be argued that the regulations were not working well enough in the old system. NHS commissioning organisations will have to devise processes that balance protection of the person and the organisation with the person's right to self determination.

People already have the right to make choices about their care and treatment. It is neither possible nor helpful to try and eliminate all risk. 'Making shared decision making a reality'⁹ emphasises the importance of involving people in managing risk, particularly:

When it comes to clinicians trusting patients to take a course of action outside the consulting room (taking medication for example). In this case, it is tempting for clinicians to tell patients what to do in order for the clinician to feel that they are in control of the risk (in this case the risk of non-adherence). For many clinicians it is counter-intuitive to support patients to understand and manage risk for themselves, yet this is precisely the approach that supports adherence.

Part of all best practice care planning will be a discussion about possible risks that might be incurred by the proposed use of the personal health budget and how those risks can be minimised to an acceptable level. Decisions will take into account the outcomes the person is seeking and bear in mind their particular circumstances, lifestyle and beliefs.

The DH and partner organisations recently published papers to support the 'No secrets' guidance,¹³ including materials for health service managers, practitioners and NHS commissioners. This resource describes how good practice safeguarding principles can guide health services to safeguard adults. However, the NHS cannot dictate to a person what care or treatment they will receive, and risk choices are a personal issue.

Safeguarding adults is an integral part of patient care. Duties to safeguard patients are required by professional regulators and service regulators, and are supported in law.

Empowering approaches to safeguarding

Duties to empower people to make decisions and take control of their care and treatment are underpinned by the Human Rights Act 1998, the Equality Act 2010 and the Mental Capacity Act 2005.

- People have the right to make choices about their care and treatment, including making decisions about their safety, even where those decisions may seem unwise to others.
- Empowerment means enabling a person to control decisions about their care, as far as they are able.
- Any actions that do not have a person's full and informed consent must have a clear justification, be permissible in law, and be the least restrictive of the person's rights to meet the justifiable outcome.

The five principles of the Mental Capacity Act:¹⁴

- Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
- A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
- Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of people who lack capacity to make particular decisions for themselves, or who have capacity and want to make preparations for a time when they may lack it in the future. Most people who have a personal health budget are likely to have capacity to make their own decisions, and to plan ahead for a time when they may lose that capacity.

See the personal health budgets toolkit: 'Choice, risk and decision-making'.

Agree the criteria for sign off

In order for a person to be able to write their care plan and for their health team to authorise it, a straightforward summary of what it should contain must be shared with the person. Experience suggests that a care plan should achieve the following.

- Show who the person is – their strengths, skills and personal social context as well as their health needs. If the person lacks capacity to make their own decisions, the plan must show how this decision was reached and identify who will speak on their behalf.
- Describe what is working and not working from their perspective.
- Detail what is important to the person and what is important for their health.
- Identify and address any risks and how they will be mitigated to an acceptable level, including a contingency plan for

if things go wrong, and a point of contact in health services.

- State the desired health outcomes and how they will be achieved.
- Describe in broad terms how the money will be held and managed, and show how it will be used to achieve the outcomes.
- Contain an action plan that details who will do what and when.
- Include the name of the person's care co-ordinator.
- State how and when the outcomes, and the money, will be monitored and reviewed. This includes describing how people will know if the plan is going well or if things are going wrong.

Agree the process of authorisation and appeals

A best practice plan has a clear thread running through it showing how a person's health needs link to an agreed set of outcomes, and shows how the budget will be used to meet those outcomes. It details who the person is and what matters most to them, as well as what matters for their health and wellbeing. It describes how risk issues have been identified, discussed and addressed.

The plan may be signed off by the health team because they often know the person best. Ideally, sign off is delegated to a professional who is as close as possible to the person, in line with the NHS principle:

Personal health budgets must support the making of decisions as close to the person as possible. In this way, it is a decision made by health professionals who are closely involved and know the person and their unique family and community context.⁸

To support this, a risk-enablement process can be very useful, so that no single professional feels they must make all the decisions alone. These processes allow health professionals, budget holders and family members to call together a small, consistent group of people familiar with health risk enablement to consider a particular risk, should they wish to do so. The group agrees how the risk will be managed and records that learning. Over time, a log of risk-enablement strategies accumulates that can be both a helpful local resource and a source of national good practice (see page 13).

Funding panels may become unnecessary once criteria for a good plan have been made explicit, and once staff have had sufficient training and are confident and trusted to make sure the criteria for sign off have been met. Confidence is supported when staff have a back-up risk-enablement group to call on if they wish to.

Experience has shown us that panel meetings are not efficient. In some cases the cost of the attendance of the panel members is more than the budget itself. Instead we have found that devolving responsibility to the key workers and the service users themselves is a better way of delivering safe and appropriate personal health budgets.

- Project manager, Norfolk

The national peer network believes it is important for the personal health budget holder to be present when decisions are made that affect their life. If a plan cannot be signed off, then clear guidance for how it needs to be amended should be given.

Appeals

It is necessary for all parties to know what will happen if there is disagreement about signing off a plan, and to have in place a clear process of appeal.

Agree how care plans will be monitored and reviewed

In the UK, long-term conditions such as diabetes and heart disease account for around 70 percent of NHS spending. Such conditions require day-to-day management to prevent deterioration and emergency hospitalisation. This task falls far more on people and their families than on health professionals.

If there are 8,760 hours in a year, the average person with a long term condition in the UK spends no more than three or four hours a year with a health professional – that is less than 0.05% of the year.¹⁵

Monitoring and review processes must take account of the fact that many people must self monitor regularly and act to address changes in their health condition. A well written support plan will include information from the relevant health professionals about

the person's particular critical health factors and how these must be addressed. The plan will also state what actions to take when necessary to address a change in these critical factors, and who to turn to if things go beyond a specified safe limit.

The formal review of a personal health plan will be a summary reflection of the daily micro-review and monitoring by the person who holds this responsibility every day. The purpose of the review should be clear and explicit, and planned to make the best use of everyone's time. There should be no surprises, as a person can alert their health professional and call a review if there are any critical incidents or crises throughout the year. Similarly, proportionate and simple budget monitoring will have been ongoing through the year, and can be summarised for review.

Department of Health regulations for healthcare direct payments state that there must be a care co-ordinator to:

- Manage the assessment.
- Ensure an agreed care plan.
- Manage the review and monitoring process and liaise between the NHS commissioning organisation and the person receiving the direct payment.

If a person does not receive their budget as a direct payment, having a named point of contact to carry out each of these functions is equally valid and necessary.

See the personal health budgets toolkit: 'Measuring the results'.

Gather and learn from feedback

It will be helpful to use the individual review process to collect information and ongoing feedback on the use of personal health budgets. This should capture what is working, and not working, in terms of outcomes, money and the process as a whole. Aggregating the information gathered through each individual review will provide vital information for strategic planning and developing better local services.

Every decision made in a personal care planning conversation is also in effect a micro commissioning decision. Capturing this information and aggregating it can inform the macro commissioning strategy.⁹

See the personal health budgets toolkit: 'Developing the market'.

Develop a local communication strategy and workforce development plan

Once a group has worked together to create the central elements of the local framework for personal health budgets, it will need to consider carefully how best to communicate this. Information should be made available in a range of formats.

See the personal health budgets toolkit: 'Providing information and advice' and 'Getting the message across'.

3 The individual care planning process

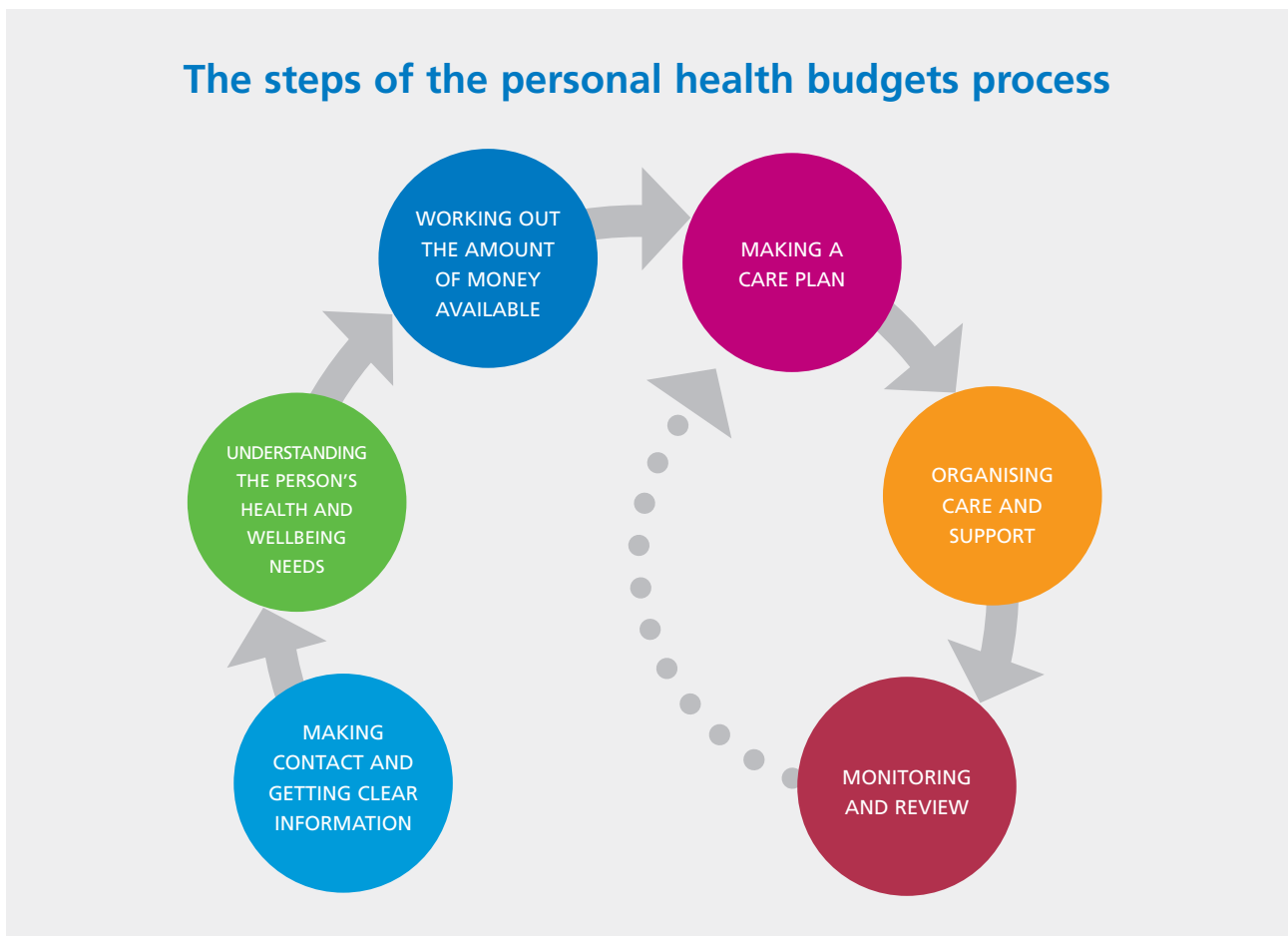
At the heart of a personal health budget is a care plan developed in partnership between a person and their health professionals.

A care plan is a record of the discussions and agreements between the person and their health team. For people using a personal health budget, it will include their health needs, the outcomes they want to achieve, how they intend to use their budget to do this, and the name of the care co-ordinator responsible for managing the care plan.

This section outlines how developing a care plan fits within the steps of the personal health budgets process shown in the diagram below.

Other publications in the personal health budgets toolkit give more information about the six steps, including steps 3 and 5:

- ‘Integrating personal budgets – early learning’
- ‘Options for managing a personal health budget’.
- ‘How to set budgets – early learning from the personal health budget pilot’ and ‘Budget setting for NHS Continuing Healthcare’



Making contact and getting clear information

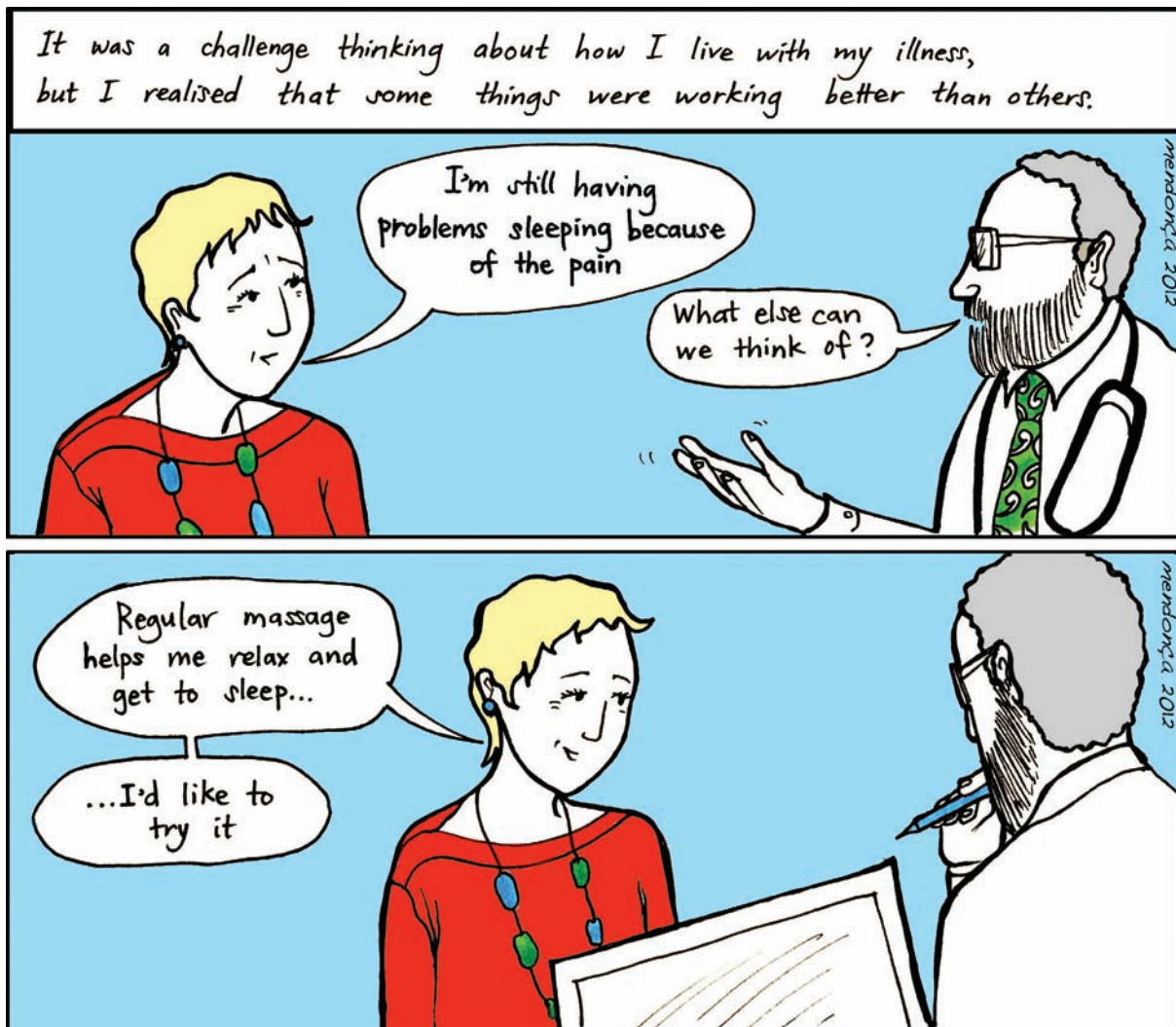


Before starting to plan, people will need clear, accessible information about what a personal health budget is, its purpose and how it will work for them (how much money is in their personal health budget; the choice of ways to hold the money; the choice and range of support for planning; what could be possible). Capacity issues will also need to be addressed in the initial stages of the process.

This is a lot of information for people to take in, and this first stage needs to be

given sufficient time. Staff should explore people's understanding and allow space for questions and clarification. Sending a leaflet or directing people to a website is unlikely to be sufficient, although this may be a helpful part of a broader approach. Linking people with others who have a personal health budget already in place can be particularly helpful, both in person and via virtual links and forums (eg www.peoplehub.org.uk).

Understanding the person's health and wellbeing needs



What is working and not working?

The opening conversation should seek to build a trusting relationship and allow people space in which to consider what is working and not working in their life, related to their health. People may need to explore this with peers, to begin to move from a passive acceptance of everything remaining the way it is, to a realisation that things could change. For example, if a parent carer has never been able to go out for the day with their child because the shift of agency staff

ends every day at 2 pm, they may not appreciate that by using a personal health budget to organise the shift times differently, they could enable their child to have the same opportunities as other children and to live a more flexible life.

For people with long-term health conditions, their health needs tend to be woven into every aspect of their life. This part of the planning process gradually starts to build a picture not only of health needs, but of who the person is and how they want to shape their life by

making the decisions about their health and wellbeing that matter most to them.

Previously, the vital question of how a person would like to live their life was never asked. There was little planning around the person and often the debate would be around generic symptom management, and too often on the professional assumption that any other way would be too costly, too risky or too onerous.

- Personal health budgets peer network member, 2012

The point at which a health professional's views are incorporated into the planning process is very important. The health professional's view is not put in at the very beginning, or at the very end. There needs to be space first for exploratory discussion, active listening and respectful questioning and reflection, in order to find out the most important things that are working and not working from the person's perspective.



What is important to me and for my health?

It is vital to consider together what is important to the person in terms of:

- What matters most to them, and
- What matters for their health.

The person in question is the only one who can know what matters to them, and they will also (unless newly diagnosed) have a good idea of what is important for their health. The professional can then add their expertise. In thinking together about what is important to, and for, a person, health professionals can helpfully contribute their expert knowledge about the specific “important for” information. For example, the person may be aware that they need to keep their blood sugar or oxygen saturation at a certain level, and the professional can give specific advice about how to monitor and maintain the correct level for their particular illness, age and context. Health professionals play a vital part in helping people explore difficult issues around loss and adjustment to a different life after accidents or strokes, or following a life-limiting diagnosis.

So it is at this point where the health professional can most usefully begin to

input their knowledge, ideas and expertise.

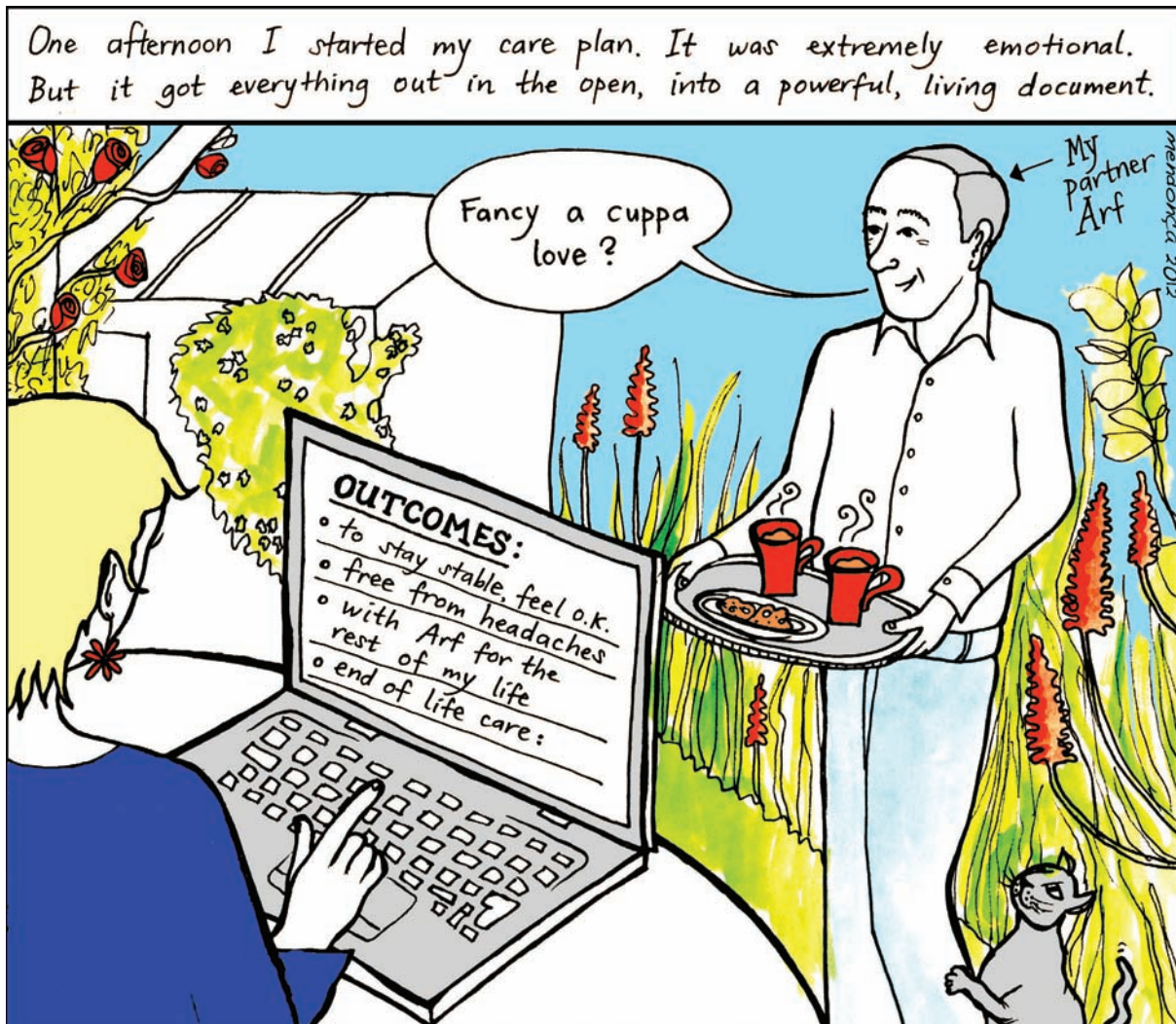
One thing that some of our patients have told us was really helpful was to advise them to have the questions in the toolkit (personal health budgets information eg What is important to you and for you?, What is working well, what isn't working well?) out on the side so that they could jot things down as they discussed them with family, friends and different health professionals. This preparation helped them to write the plan but also to think of ideas for meeting outcomes that maybe they wouldn't have thought about on their own.

- Project manager, Northamptonshire

The best planning process will lead to a plan that integrates what matters most to someone with what matters most for their health. This joining together of best clinical practice with a person's own motivations and creativity leads to plans that are:

- Acted on and not ignored.
- A live, participatory process, not a prescription.
- Making best use of both professional and individual knowledge and ideas.

Making a care plan



Priorities and outcomes

All the priorities and outcomes that flow from the above must be the person's own outcomes. It is important not to add on "professionals' health outcomes" at the end, in the same way as they should not be imposed at the beginning.

Individual goals need to feel important to the patient – action planning may feel uncomfortable to the clinician where the

patient is not willing to agree to something which the clinician sees as important. Engaging with the process is essential to find out what the patient is prepared to do.

Patients and clinicians have similar aims to improve long term outcomes by increasing length of life and reducing morbidity – also in short term improving quality of life; but they often prioritise differently, with clinicians emphasising the former and people with long term conditions the latter.

Accepting a person's quality of life and their knowledge, skills and confidence to manage their own health and healthcare are important outcomes in their own right, poses newer and harder challenges.⁴

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

When developing outcomes, care needs to be taken against thinking of services and therapies too soon. Outcomes are not services, treatments or therapy. Outcomes are changes in, or sustaining of, physical behaviours or mental states or emotions. The care plan needs to describe clearly what is being aimed for, and in specific terms what will be working better, be maintained or be avoided. This can include what is hoped for even in a deteriorating health condition, or at the end of life.

The health outcomes need to come from the person. The health professional's role is to help support the identification of the person's own outcomes and to contribute to making them as specific and individually relevant as

possible. The actions that follow are then fully and clearly linked to the specific outcomes.

Risk enablement

At this point any risks should be identified and addressed. When planning with a personal health budget, risk and responsibility are openly discussed and can be shared. If a person wishes to have more power and control, there is an expectation that they will begin to share more responsibility for managing their health condition.

Everyone has different views on how much risk and responsibility they may want to take at different times, and there should never be any compulsion to do things differently. Personal health budgets can be used for all, some or none of a person's treatment, depending on what that person wants and feels capable of taking on. If a person is feeling vulnerable, scared and unwell, they may prefer a health professional to determine what is in their best interest.

But over time, when they may feel more confident, or if they feel that something vital to them is at risk of being lost or never achieved, they may want to take more control and responsibility, and they may view risk differently. A more open, trusting and respectful dialogue can lead to better quality decision making and better outcomes, as the person commits to carrying out the personal plan they have written.

There are also workforce development and cultural issues to be addressed:

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

Whilst evidence is emerging, there is still a long way to go before we understand the education support necessary to optimise clinicians' attitudes, skills and behaviours towards self management. This also calls for a fundamental shift of power dynamics and the way both patients and professionals view their roles.⁵

Finding personalised ways of managing risk

When developing the care planning process, it is helpful for both people with budgets and clinicians, commissioners and service providers to work together on how this part of the care plan will be discussed, agreed and recorded. It can be helpful to have a separate sheet in the care plan that is used to address the issues of risk, where the person and anyone supporting them can record what might go wrong with the plan and how they plan to minimise the likelihood of this happening.

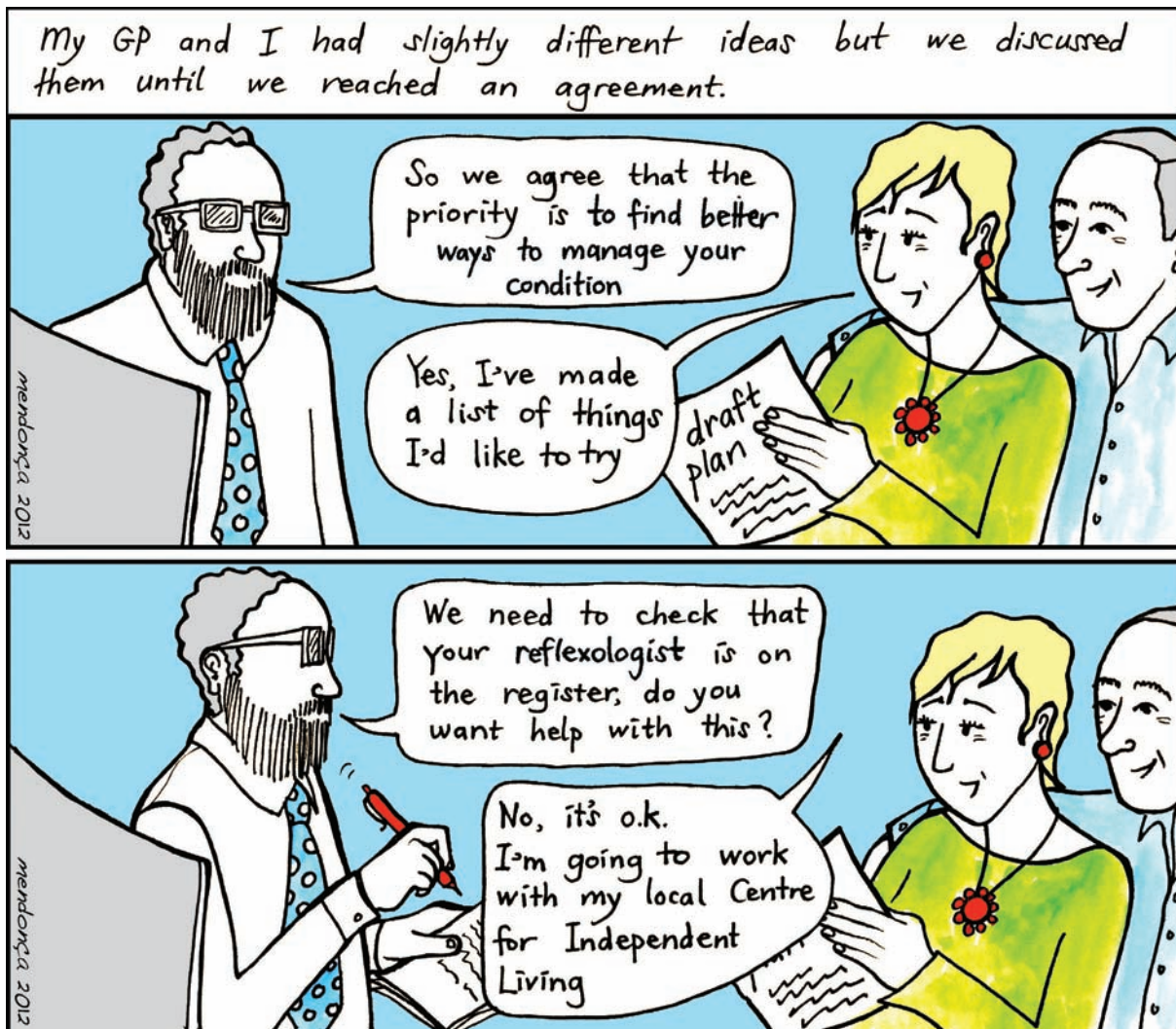
On this sheet, it can be helpful to have a simple checklist of prompts such as:

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

The King's Fund publication 'Making shared decision making a reality' argues that there should be a formal process for documenting the:

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

While all of the above is usually formalised in the process of consenting to a medical or surgical intervention, healthcare providers should ensure that they have documentation systems and processes in place when there has been a shared decision about any course of action, such as adhering to a medication regime or undertaking a lifestyle or behaviour change. As well as providing a useful record for patients and other professionals they may encounter during their care, this practice could provide protection from legal challenge if clinicians can demonstrate that patients were offered choices and provided with reliable information about the options.⁹



Action planning

The action planning section of the care plan must specify clearly who will do what and when. It should show who is taking responsibility for each task and how they will do it. For example:

Clinician will input particular therapies at frequency agreed, person will purchase equipment and has access to the information of where to get this, and commissioner will check if preferred agency is appropriately registered.

If someone is planning to employ their own personal assistants to undertake specific health tasks, the plan will state how relevant training will be provided and the process for competency to be signed off.

The ideas about actions to take in order to achieve outcomes will draw together the person's own solutions, which they are committed and motivated to do, with the health professional's expertise about what might have proved useful for others and what research evidence suggests.

The actions in the plan should be specific and linked to the outcomes. There must also be clear identification of likely risks and ways to address them (see page 13).

Professionals need to trust people's own solutions. This is at the heart of the shift in the relationship – people exploring what matters to them and finding their own ways to participate actively in achieving their outcomes.

Effective action planning will produce a set of specific tasks, which form the person's explicit plan for meeting their health outcomes. These should be integrated with the other important parts of their day-to-day living. Personal ownership and control, together with the recognition of health as interwoven into a person's whole life, makes the plan effective.



Sign off

Since the process of developing a care plan is an ongoing dialogue between a person and their health team, the plan can often be signed off by the same people who have been part of its development. After family and friends, the health team are often the people who know the family best.

For sign-off processes to be simple and sustainable, criteria for a good plan need to have been made explicit, and staff need to

have sufficient training and feel confident and trusted to ensure the criteria for sign off have been met. Plans may be written in many different styles, but they must include the main criteria agreed in the local framework (see page 15).

Personal health budgets must support the making of decisions as close to the person as possible. In this way, it is a decision made by health professionals who are closely involved and know the person and their unique family and community context.⁸

Monitoring and review



Alongside training and good working knowledge of the criteria, risk-enablement processes can be helpful (see page 13).

The frequency of reviews should be sensitive to each person's unique situation and health condition.

People with personal health budgets will need to be fully aware that they do not have to wait for a scheduled review if their circumstances or health condition have significantly changed, but can call for a review as necessary (see page 16).



4 Conclusion

Personal health budgets can be transformative, efficient and effective. Their quality and effectiveness can be evaluated locally, in an ongoing way, by putting in place simple feedback mechanisms to assess their impact from the perspective of budget holders, health professionals, provider organisations and commissioners.

It is helpful to see a personal health budget as one useful tool or mechanism, which on its own is not sufficient to achieve useful change. The budget is, however, an important lever to support the changing relationship between people and professionals and to enable effective planning and innovation.

The local framework contains the elements essential to care planning for personal health budgets. And the care planning process itself is at the heart of the shift in power, to ensure that people with long-term health conditions and disabilities have the chance to shape their lives by making the decisions about their health and wellbeing that matter most to them.

The personal health budgets planning process encourages blue-sky creative thinking, and is not constrained by existing services. It seeks to find the right way forward for each person. If carried out successfully, and supported at an early stage with an indicative budget, this can be a therapeutic and enlightening process.

We all know that planning alone can be an isolating and frustrating process, but when done collaboratively, exciting solutions can emerge that make a real difference to people's lives.

Having a personal health budget allows people to have a real say in how their future should look. It allows them to work with people they trust to deliver their support when they need it and how they need it. It allows personal assistants to develop skills that are directly relevant to the person's needs. It allows for flexibility and is adaptable to changing situations. It allows people to move from a world where others know best to one where their input is valued above all others but not in isolation from others.

- Personal health budgets peer network member

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Appendix 1

Developing the local approach – questions to consider

Pilot sites found it helpful to have considered a range of questions before offering personal health budgets to people.

“Knowing the deal” includes some pivotal issues, and it is critical to have at least workable tentative answers before offering people personal health budgets, even if they can’t all be fully resolved before starting the process.

Pilot sites⁶ were asked to convene a meeting with roughly equal representation from people interested in, or using, personal health budgets, clinicians, commissioners and finance staff. For each of the five sets of questions below, they considered their local answers to these three questions:

- Is there a shared and commonly agreed answer? or
- Do people have a variety of views? or
- Have we not yet developed an answer for some of these questions?

What is this all about?

- How do I find out about personal health budgets?
- Where did this idea come from?
- Is it about saving the government money?
- Is it about privatising the NHS?
- What is a personal health budget – is there a definition?
- What are they for?
- What is the purpose of them?
- Is it about just more choice, or is it about changing the relationship between people and the NHS?
- When is a personal health budget offered to me?
- Is it only offered once, and can I change my mind?
- Do I have to have one?
- Can I keep things how they are?

What are the rules around the money?

- What can the money be spent on?
- What can it not be spent on?
- How is the amount of money I can have control of worked out, and for how long is this put in place?
- When do you tell me how much money is available to plan with?
- Can I have help with holding and managing the money?
- Can everyone have the money given directly to them, and if not, how else can I still have control of the decisions while someone else holds the money on my behalf?
- What do you expect of me in terms of keeping records?
- What can I expect of you in terms of flexibility in using the money, and keeping the processes simple and trusting me to use the money well?
- Is it paid monthly or yearly?
- Can I save some for contingencies or emergencies, or do I have to pay back anything underspent each month?
- What happens if I spent too much, or too little?
- What happens if I make a mistake?
- What if my needs change – is there an opportunity to have more money if I become more unwell, or does it stay the same for the year?

- Do I have to cash in every part of my health-funded care, or can I choose to control just the things that matter most to me?
- Can I have a mix of NHS services and some things that I buy for myself?

What about how to create my plan?

- What are the local criteria for agreeing any care plan – and can I see these so I can write my own plan?
- Who explains what a care plan is for and what needs to be included in it?
- Do I need separate plans for social care and health money?
- Is there a booklet or guide I can read to tell me about what I have to do?
- Can I talk with someone else who's done this before?
- Are there any examples of what others have done?
- Who can help me with this plan?
- Does it have to fit into a predesigned form?
- What is an outcome?
- How do I keep myself safe?
- If I want to employ staff, what help can I have with that?
- How will we agree the skills and competencies needed for any staff and what training they should have?

- Who will support my staff, agree rotas, and manage payroll, sick pay and holiday cover?
- Can I have help to find the things and the kind of people I want?
- How much control will I have?

How is the care plan agreed?

- Who authorises or agrees the plan, where are the decisions made, and if it has not been agreed, do they have to tell me why?
- How long do I have to wait to know if my plan has been agreed?
- Can I keep my own copy?
- How can I let you know my wishes if I can't express myself easily?
- What if I'm not able to make decisions for myself – who will speak for me?
- Where does the buck stop – whose responsibility is all of this – mine, yours or ours?
- Is it now always about me knowing best, or is this a shared agreement between expert professionals and myself?
- If we can't agree, who makes the final decision?

How is the care plan reviewed?

- How will we know if it's working well?
- What happens if what I planned doesn't work out, and who can I call if I'm worried?
- Is it OK to try some things and fail?
- How often will reviews happen, and who can request one?
- Whose perspectives are considered? (mine, health professionals', family carers', social care professionals', commissioners', finance staff's?)
- Will we focus on whether the outcomes have been achieved, or on what has been bought?
- Will there be a separate process for reviewing the money, or will we have one process to consider both money and outcomes together?
- Are local people involved in developing the local care planning process alongside health professionals and commissioners from health and social care?

Appendix 2

How peer support can help

Experience shows that peer support can help in the following ways.

- Help people begin to feel hopeful and begin to see that some things could change for the better, even in the most challenging situations.
- Encourage people to say what's not working well, and so consider priorities for change.
- Let people hear ideas about possible alternative ways of achieving health outcomes. For example, how can a person choose red or green if the only colour they have ever seen is blue? How can they know there are other ways to meet people, learn and have fun outside a segregated day care centre?
- Allow people to learn from others' direct experience.
- Enable people to plan at a pace that feels comfortable to them.
- Support people to decide how they want to have the money held and managed after they have thought about everything they want the plan to achieve. People shouldn't be rushed into choosing a direct payment, or any other option, until they've understood what it means.
- If a person chooses a third party to hold the money, peer support can help them to consider what to beware of and to look for in a third-party organisation, so they can retain the amount of control that they want.

Appendix 3

Risk enablement example

Merseyside mental health personal health budgets pilot, Recovery Enablement Panel: draft terms of reference

It is anticipated that the large majority, if not all, cases involving personal health budgets will be agreed and implemented at the multidisciplinary assessment and care planning stages of the care programme approach and that referral to the Recovery Enablement Panel will be exceptional.

Introduction

Members of the Merseyside Mental Health Pilot (NHS Sefton, NHS Knowsley, Liverpool PCT and Mersey Care NHS Trust) recognise that risk can be a consequence of people taking decisions about their lives. These terms of reference describe the arrangements that the Merseyside personal health budget pilot has put in place to manage what are deemed to be high-risk or complex situations and to support people on the road to recovery.

To make good choices, we all need to understand the consequences of the decisions we make and to take proportionate responsibility for them. The Merseyside personal health budget pilot aims to promote a culture of choice that entails responsible, reasonable, supported and shared decision making.

Reasonable risk means striking a balance between empowering people to make choices while still supporting them to take informed everyday risks. The Recovery Enablement Panel will share decision making in situations considered to be of higher risk, with the aim of mitigating the risk in an effective, transparent and safe way, based on the information available. The Recovery Enablement Panel will provide a forum to consider identified risks and mitigating actions in the small minority of cases where these cannot be satisfactorily resolved during the normal processes of multidisciplinary assessment, support care planning or review as supported by the care programme approach. Risks can be physical or emotional, by or to the service user or others, linked to the capacity or capability of people or organisations, reputational and/or linked to service cost or type.

Purpose

The purpose of the Recovery Enablement Panel is as follows.

- To guide, advise and support staff, service users and their carers to ensure that risks with potentially high repercussions are managed and minimised to protect staff, service users and the organisations involved. The Panel has been designed to be a safe and supportive environment for both the person and staff.
- To ensure a consistent and enabling approach to managing risk decision making, where the risk to independence is balanced with the risk of not supporting choice.
- To seek positive solutions and outcomes for people and resolve issues relating to the sharing of risk between people, third parties and the NHS organisations.
- To ensure that no person is left to make a difficult decision without support and that NHS organisations involved in the pilot can demonstrate they have fulfilled their duty of care in the support of service users and staff.
- To provide a forum where staff at different levels in the organisations and service users can share risk decision making where there is raised concern over levels of risk.
- To take the final decisions on issues involving risk or complex issues which member of staff, service users or others refer to the Panel.
- To promote a consistent approach to managing complex risk decision making.

Scope of Responsibility

It is anticipated that the large majority, if not all, cases involving personal health budgets will be agreed and implemented at the multidisciplinary assessment and care planning stages of the care programme approach, and that referral to the Recovery Enablement Panel will be exceptional.

The Panel will act as decision maker for cases referred. It will explore, with the clinicians involved in the case, how the risk may be mitigated and managed to promote recovery and advise the clinicians accordingly.

Decisions to proceed with support packages, based on the guidance of the Panel, can be sanctioned only by unanimous agreement of the Panel.

It is the responsibility of the care team and management to implement the decisions of the Panel.

The Recovery Enablement Panel will liaise with the personal health budget steering group and the relevant NHS organisation regarding any issues arising from the management of complex risk cases.

The Recovery Enablement Panel will not consider complaints arising from the refusal of Primary Care Trusts or Mersey Care to fund cases found not to meet the relevant eligibility criteria for funding or service provision.

Each NHS organisation has separate procedures for dealing with such complaints. The Recovery Enablement Panel will not replace or substitute existing processes and procedures

such as safeguarding and complaints where it is more appropriate to use these.

Referrals to the Recovery Enablement Panel

Referrals to the Recovery Enablement Panel should be made to the steering group representative of the relevant Primary Care Trust (Panel Convenor) a minimum of seven working days before a decision is required.

Referrals may be made, in writing, by the service user, carer, clinician, Primary Care Trust Panel Manager, broker, peer support worker, project manager and members of the steering and project groups. The Recovery Enablement Panel will consider referrals on the grounds of risk directly related to the use of a personal health budget:

- Physical or emotional risk.
- Anticipated risk to or by others.
- Political or reputational risk to the NHS organisations or partners.
- Financial or budgetary risk that cannot be addressed through existing NHS processes.
- Legal or regulatory issues.

The Recovery Enablement Panel may refer to other organisational processes or seek advice where this is considered appropriate.

Suitability criteria

The Recovery Enablement Panel will determine a service's suitability by ensuring that the proposed intervention fulfils the following criteria.

- The proposed service will help work towards specific longer-term outcomes identified in the service user's care plan and specifically the service user's agreed outcomes.
- The proposed service represents a reasonable balance between risk and empowerment.
- The service user is realistically likely to engage with the service.
- The proposed service is legal.
- The proposed service is directly or indirectly related to the service user's core condition.
- The proposed service has been chosen following consultation with family and/or carers where appropriate.
- The proposed service will not pose a major risk to the PCT or Trust (eg adverse publicity, legal action).

Membership

The Recovery Enablement Panel will comprise a minimum five from the following:

- Team manager (chairperson).
- Care co-ordinator (from a different team).
- Primary Care Trust representative.
- Mersey Care representative.
- Project manager.
- Clinician responsible for the support package.
- One or two independent service users (one could be a supporter of the other).
- The service user (or representative).
- Finance representative of the relevant Primary Care Trust.

The Panel may invite relevant others (Primary Care Trust Panel Manager, communications lead, broker) to join the Panel as appropriate.

Where a Panel member cannot attend, they may nominate an appropriate deputy or submit written comments.

A quorum will be five members. This must include the team manager, the clinician responsible for the support package, and the PCT and/or Mersey Care representative as appropriate.

Frequency and format of meetings

Each Panel will have a designated chairperson to ensure accountability, continuity and commitment. The chairperson will normally be the team manager of the accountable team.

Panels will meet as appropriate to the needs of the personal health budgets pilot. There is no set frequency for meetings; they will be convened as the need arises.

All paperwork should be with the Panel convenor at least seven days before a decision is required.

Panel meetings should be well documented and decisions accurately recorded to clarify outcomes and allow actions to be demonstrated.

The Panel may set review dates to satisfy itself of the continuing efficacy of the agreed care plan.

Gateway Ref No. 17753

Personal health budgets team

Websites: www.personalhealthbudgets.dh.gov.uk/toolkit
www.nhs.uk/personalhealthbudgets

Email: personalhealthbudgets@dh.gsi.gov.uk

Department of Health customer service centre: 020 7210 4850