Llywodraeth Cymru
Welsh Government

Guidance on Direct Payments for Continuing NHS Healthcare: Understanding the Regulations

Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

1. Aim of this guidance

1. This guidance has been developed to support understanding and implementation of the National Health Service (Direct Payments) (Wales) Regulations 2026, made in accordance with the new powers inserted into Part 1 of the National Health Service (Wales) Act 2006 ("the 2006 Act") by the Health and Social Care (Wales) Act 2025. The Welsh Ministers have exercised these powers to make the Regulations and have determined that direct payments may be considered in the first phase of implementation in the case of persons eligible to receive Continuing NHS Healthcare ("CHC"). This guidance will be of interest to:

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

2. Any inconsistency between this guidance and the legislation is to be interpreted in favour of the legislation. It is the responsibility of each Local Health Board ("LHB") to ensure it acts within the scope of relevant legislation and complies with its statutory duties. In the event that an LHB is unsure of the position, it should seek its own legal advice.

2. Introduction

3. This guidance is not intended to be a comprehensive 'how to' guide covering everything someone needs to know about direct payments – it is intended to explain the regulatory requirements. This will be maintained as a live document and reviewed regularly during the first three years of implementation.

4. LHBs will need to develop and maintain their own local policies to suit their own local circumstances, guidelines and procedures. Those policies must be in line with the relevant legislation and this guidance, however, and must promote the ability of the direct payments recipient to exercise voice and control over their care.

5. Equality and diversity are key priorities across NHS Wales standards and frameworks *such as the Values and Standards of Behaviour Framework; Health and Care Quality Standards for Wales; and Governance Framework* which highlight the importance of:

- Ensuring fairness, dignity, respect, and autonomy for all individuals

- Promoting equality of opportunity and eliminating discrimination across all protected characteristics (under the Equality Act 2010)
- Embedding equality and diversity in service delivery, employment practices, and policy development
- Aligning with UK legislation and international treaties, including the UN Convention on the Rights of Disabled People (UNCRDP)[1]

6. The UNCRDP reinforces these principles by setting out obligations for public bodies to:

- Recognise and uphold the rights of disabled people to live independently and be included in the community (Article 19)
- Ensure equal access to health services without discrimination (Article 25)
- Respect autonomy, dignity, and freedom of choice in all aspects of care and support
- Promote participation and consultation with disabled people in decisions affecting their lives (Article 4(3))

2.1 Direct Payments for CHC explained

7. Direct payments are a mechanism through which eligible individuals can receive funds to arrange and manage their own care and support, rather than receiving traditionally commissioned care services. They are an important mechanism by which people can exercise choice, voice and control to decide how to meet their needs for care and support and achieve their personal outcomes.

8. Direct payments may be made to an eligible individual who is entitled to CHC. CHC is a complete package of ongoing care and support arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need. Direct payments are therefore a mechanism through which eligible individuals who are entitled to receive CHC can receive funds to arrange and manage their own care and support, rather than receiving services directly commissioned by the NHS. This approach is intended to promote greater choice, flexibility, and control for people in how the assessed health and wellbeing needs required to meet their primary health need are met in their home.

9. The introduction of direct payments for healthcare in Wales builds on the principles of person-centred care and co-production and aligns with the broader policy ambitions set out in 'A Healthier Wales' and the Social Services and Well-

[1] Within this guidance the convention is referred to as the 'Convention on the Rights of Disabled People' or UNCRDP rather than the given name 'Convention on the Rights of People with Disabilities'; to align with the Social Model of Disability.

being (Wales) Act 2014. It reflects the Welsh Government's commitment to enabling people to have a stronger voice in decisions about their care, and to support more integrated and responsive services.

10. This guidance supports the implementation of direct payments for CHC in Wales. It clarifies the legal duties and policy expectations that LHBs must follow, in line with the Regulations. While it complements the regulatory framework for CHC, it is not intended to serve as a comprehensive operational manual. It should be read alongside the Continuing NHS Healthcare National Framework for Implementation in Wales ("Welsh CHC Framework") and is intended to apply to those adults, over the age of 18, who are eligible for CHC across Wales. The Welsh CHC Framework sets out the overarching principles and processes for eligibility, assessment, and provision of CHC.

11. A direct payment for CHC is a monetary payment made by an LHB to an individual, or to a representative or nominee on their behalf, to enable them to arrange and manage their own care and support in their own home.[2] The payments are not income, but funding specifically intended to meet assessed, eligible needs identified in a person's care plan. The direct payment, based on an agreed care plan, is intended to offer greater choice, flexibility and control over how assessed health and wellbeing needs are met.

12. The care planning process is to be used to identify the services and/or support the direct payment must be used for. This needs to consider the individual's strengths and preferences.

13. Direct payments are flexible and may be used to:

- Meet ongoing care and support needs under CHC
- Support a one-off direct payment to help a person to achieve specific goals or outcomes[3]
- Support continuity of care where people move from social care direct payments to CHC, recognising that care arrangements may need to expand to meet increased health needs

  or

- Pooled to support several people to come together to achieve a common health and wellbeing goal

[2] Supported-living arrangements fall within the category of "own home" for the purposes of this guidance, as opposed to a care home where the individuals cannot treat the setting as their "own home".
[3] A "one-off direct payment" means a payment for a single item or service, or a single payment made for no more than 5 items or services where that payment is the only payment a patient would receive from the LHB in terms of a direct payment in any financial year. See regulations 14 and 15.

2.2 Direct payments

14. Unless otherwise stated when direct payments are referred to in this guidance, this means **direct payments for CHC**.

15. Direct payments have been a well-established feature of social care in Wales for many years, enabling individuals to receive funds directly to arrange and manage their own care in ways that best support their personal outcomes. This longstanding approach has created a valuable foundation of practical learning across local authorities, commissioners, and providers about how to promote voice, choice and control in care arrangements. Such experience built up over time, including understanding what enables people to manage payments confidently, how to ensure good governance, and where flexibility can remove barriers, offers valuable insight to inform the implementation of direct payments in CHC.

2.3 Integrated working: health and social care

16. 'A Healthier Wales: Our Plan for Health and Social Care' (2018) sets out a long-term vision for integrated, person-centred care in Wales, driven and overseen by Regional Partnership Boards, with a focus on prevention, seamless services, and collaboration across health and social care.

17. The Social Services and Well-being (Wales) Act 2014 provides the legislative framework for collaboration and partnership working across health and social care in Wales. This supports integrated service delivery for individuals and families, including through Regional Partnership Boards and joint commissioning arrangements.

18.LHBs may enter into arrangements with other bodies, including local authorities or voluntary organisations, to provide assistance in connection with the delivery of direct payments for CHC as a result of new powers inserted into Part 1 of the 2006 Act by the Health and Social Care (Wales) Act 2025 (see section 10D).

19. The Welsh CHC Framework provides a consistent, person-centred approach to determining eligibility for NHS-funded care and support for persons who have a primary health need. The Welsh Government's approach is also underpinned by its commitment to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which promotes the rights of disabled people to live independently and participate fully in all aspects of life. The implementation of direct payments for CHC reflects these principles by enabling greater choice and control over how care and support are delivered.

3. Scope of direct payments in CHC

3.1 Who can receive a direct payment?

20. A direct payment can be made to, or in respect of, eligible persons who are entitled to receive CHC. This provision should be read in conjunction with the Welsh

CHC Framework, which sets out the principles and processes for determining eligibility and delivering CHC and with the provision made in the Regulations[4]. Direct payments can be made to, or in relation to:

- a person who has the capacity to consent to receiving a direct payment and consents to receive one
- a person who does not have the capacity to consent but has a representative who consents to the making of a direct payment who consents to act as a 'suitable person' and to receive the direct payments on their behalf

And where:

- a direct payment is appropriate for that person, having regard to their circumstances, the nature of their health condition or conditions, and the impact of that condition on their life
- a direct payment represents value for money and, where applicable, any additional cost is outweighed by the benefits to the person
- a direct payment would promote the person's voice, choice and control
- a direct payment would support continuity and familiarity in care arrangement
- the person is not subject to certain criminal justice orders for alcohol or drug misuse. However, such a person's care may be able to be offered in other ways as appropriate

21. Persons eligible for CHC who have capacity, and representatives of people who lack capacity, can request that the direct payment is received and managed by a 'nominee' (see section 4.8 and regulation 8 – nominated persons).

22. Decisions about providing direct payments should be based around need rather than being based around a particular medical condition or severity of condition or clinical pathway. Evidence from the Health and Care Research Wales Evidence Centre (2025) indicates that direct payments can lead to improved health and well-being, particularly for people with complex needs, when personalised care is supported by trusted relationships and sustained over time.

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

- The person's wishes and feelings in relation to their care and support and receiving direct payments

[4]See regulations 3 and 5.

- The person's capacity to consent to the making of a direct payment and where appropriate the provision of support in the form of a nominee or representative
- The benefits to the person of having a CHC direct payment in both the short and longer term
- Whether the benefits of receiving a direct payment represent value for money and, where applicable, outweigh any direct additional financial costs
- What support is needed for the person (or their representative or nominee) to be able to plan and manage direct payments

This list is not intended to be exhaustive.

3.2 Services that direct payments cannot be used for

24. A CHC direct payment may not be appropriate for all aspects of NHS care that a person may require within the context of a CHC package. A hybrid approach may be appropriate in some cases but, as for all direct payment decisions, consideration of this approach should be undertaken in conjunction with the individual receiving the care and should form part of the care plan where it is considered appropriate. A hybrid approach is one where most elements of the care plan are delivered via direct payments and some defined elements are delivered via traditional directly commissioned NHS services.

25. A direct payment cannot be used to purchase primary medical services provided by GPs as part of their primary medical services contractual terms and conditions nor is a direct payment suitable for the following public health services (see also regulation 11):

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

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

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

28. While LHBs should not include services which require unplanned emergency access they may consider it appropriate to develop advance and future care plans, contingency, or crisis plans with people and include these in their care plans. This

will help to ensure their wishes are taken into account when a crisis happens or that they have increased support or services available to prevent the need for emergency care or hospital admission.

29. A direct payment cannot be used for planned surgical procedures.

30. A direct payment cannot be used to pay for any NHS charges, such as dental, optical charges or those for drugs, medicines, appliances or pharmaceutical services (where levied).

31. A direct payment cannot be used:

- to purchase alcohol or tobacco
- for gambling
- to repay a debt
- to purchase anything illegal or unlawful

3.3 What can a direct payment be spent on

32. In principle, other than the exclusions listed in section 3.2, a direct payment can be spent on a broad range of things that will enable the person to meet their health and wellbeing needs, as set out in the care plan (see section 5).

33. For brevity, the term ‘services’ is used throughout this document, although it refers to anything that can be bought, and which will meet someone’s health needs. This may include health and personal care, as well as other services which arise from the person’s primary health need. The care plan must be agreed by both the LHB and the person receiving care, or their representative.

34. Before signing off the care plan, the LHB in consultation with the direct payment recipient or their representative, must be reasonably satisfied that the services identified in the care plan can meet the needs identified in the care plan by means of the direct payment.

35. People need the right information to make informed decisions about their care. The person, with support from professionals, carers and others, should make the choices about how their needs are met. This would include any evidence available about the effectiveness of potential services. It may also be helpful to involve independent brokerage services, peer support and advocates in these discussions.

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

37. LHBs should be careful not to exclude different requests without examining each proposal on a case-by-case basis as there may be significant benefits for people’s

health and wellbeing. Direct payments work best where people have real flexibility over how they are used.

38. In some cases, it may be sensible for an LHB to agree a service which has been funded by social care or another funding stream if that service is likely to meet a person's agreed health and wellbeing outcomes. LHBs should not refuse to the inclusion of such a service within the care plan because it has been traditionally commissioned elsewhere. In the case of the Welsh CHC Framework the NHS is responsible for funding all the care and support a person eligible for CHC is assessed as needing where those needs arise from the person's primary health need and they are specified in the agreed care plan.

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

3.4 Deciding not to offer a direct payment

40. An LHB may decide not to provide someone with direct payments if, for example, it considers:

- that it is inappropriate for that person given their condition or the impact on that person of their particular condition
- that the benefit to that person of having a CHC direct payment does not represent value for money
- that providing services in this way will not provide the same or improved outcomes
- that the person (or their nominee, or representative) even with appropriate support would not be able to manage them
- where there is clear evidence that the direct payment will not be used in accordance with the agreed care plan

This is not intended to be an exhaustive list.

41. If an LHB decides not to give someone a direct payment it must inform the person, and any nominee or representative, in writing within 4 weeks of the decision being made and give its reasons. This should be in an appropriate and accessible format.

42. The person, their nominee or representative may request that the LHB reconsiders its decision not to agree a direct payment in relation to the person's entitlement to CHC. They may also provide additional evidence or relevant information to inform that decision. The LHB must reconsider its decision in the light of any new evidence and then notify and explain the outcome of its deliberation in

writing. LHBs only need to reconsider the decision not to give a direct payment once unless a new assessment is required due to changing needs.

43. To ensure equal access to a direct payment it will be useful for LHBs to monitor local activity to identify any population groups where uptake seems to be low. This will identify where local processes and decision making may need to be reviewed. This supports compliance with the Public Sector Equality Duty and aligns with the UN Convention on the Rights of Disabled People and the social model of disability.

3.5 Information governance

44. It is essential to understand the information sharing aspects of delivering direct payments to ensure that the privacy and confidentiality of the person is considered at all times. LHBs should carefully assess what personal data needs to be shared and with whom, keeping in mind that this should be minimised wherever possible to meet the relevant purpose. LHBs should ensure all actions undertaken in the delivery of direct payments are in line with the Data Protection Act 2018 and UK General Data Protection Regulation.

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

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

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

4.1 Consent

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

- a person who has the capacity to consent to the making of direct payments to them
- the representative of a person who lacks the relevant capacity to consent (see sections 4.10 to 4.12)

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

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

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

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

52. When providing direct payments, LHBs must be satisfied that the person receiving the direct payment understands what is involved and has given informed consent. Where necessary, obtaining this consent might be a process involving a number of discussions, rather than a single event, and should be part of the wider care planning process. This is an area where people may need additional support, which can be provided by the LHB directly, or by another organisation working in partnership with the LHB. This support might include information about how direct payments work, what to expect when receiving direct payments, and how to access advocacy services.

53. These discussions should also explain how personal information, such as contact or bank details, may be shared with organisations involved in managing direct payments. See section 3.5 for further information.

54. When offering direct payments, LHBs should make it clear that receiving direct payments is optional. There should be no presumption towards the use or not of direct payments, they should be an option which is available to give increased choice and control. They should not be obligatory and conversely there should not be a blanket veto on offering them to certain groups except for those exclusions specified in the Schedule within the Regulations.

4.2 Capacity to consent

55. LHBs must assume that a person has the capacity to make decisions about the making of direct payments to them unless the person is assessed to lack capacity under the Mental Capacity Act 2005.

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

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

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

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

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

4.3 Fluctuating capacity

60. Where a person who has consented to the making of direct payments to them subsequently loses their capacity to consent, the LHB may, where it is satisfied that the loss of capacity is temporary, allow a representative to be appointed to receive direct payments on their behalf, or an existing nominee to continue to receive them, until they regain capacity. In these circumstances, the role will be similar to that of a representative for someone who has been assessed to lack capacity on an ongoing basis.

61. Where someone's capacity to consent to the making of direct payments fluctuates (in that it impairs their capacity to make decisions at certain times but not others) it is important that there should be continuity of care, and any disruption should be as minimal as possible. It may be helpful to work with people with fluctuating conditions to draw up advance care plans under the Mental Capacity Act or include advance decisions within their care plans for the times they lack capacity.

62. Contingency plans within care plans can also help to ensure that people's care in a crisis better meets their wishes, including the identification of a nominee or representative who may take control of the direct payment at such times.

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

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

- if the person and their representative or nominee consents, the LHB may continue to make direct payments to the representative or nominee of the person in accordance with the care plan; or
- if the person does not consent to the continued making of direct payments to the representative or nominee, the LHB must stop making the direct payments; and

- the LHB must, as soon as is reasonably possible, review the making of the direct payments (see Section 8 for monitoring and review)

4.4 Ability and support to manage direct payments

65. Wherever possible, LHBs should offer appropriate support to help people access and manage direct payments. When deciding whether or not someone has the ability to manage direct payments, LHBs should especially consider:

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

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

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

- the person's understanding of direct payments, including the actions and responsibilities required on their part
- whether the person understands the implications of receiving or not receiving direct payments
- what kind of support the person might need to manage a direct payment
- what help is available to the person, including via the use of a managed account. A managed account is one held by an organisation or third party appointed by the direct payment recipient, their representative or nominee, to hold the direct payment on their behalf and apply the payment in accordance with their instructions. Such managed account arrangements must be approved by the LHB, which must also be able to have oversight of the use of the account for audit and monitoring purposes
- what arrangements the LHB or the person could make to obtain the necessary support

68. When considering whether someone is capable of managing direct payments, the LHB should take into account the support available to that person and should

consider whether providing additional support would enable them to receive direct payments (see section 4.7).

69. A judgement by an LHB that someone is unable to manage direct payments should only be made as a last resort after exhausting all support options available. Decisions should be on an individual basis, taking into account the views of the person, and the help available to them. Assumptions should not be made due to the existence of a particular condition, or that whole groups of people will or will not be capable of managing direct payments.

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

71. If the LHB concludes that someone would not, even with assistance, be able to manage direct payments the organisation should inform them in writing of their decision, giving their reasons and as set out in section 3.4, the person, their representative or a nominee can ask for a review of this decision.

72. The LHB should also consider other means of supporting the person to personalise their care and support. People should not be disadvantaged by not being able to manage direct payments themselves.

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

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

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

- the person receiving care
- anyone identified by the person involved as someone to be consulted for these purposes
- the individual primarily involved in the person's care
- anyone else who provides care for the person
- an independent mental capacity advocate or an independent mental health advocate appointed for the person

- any health professional or other professional who provides healthcare to the person
- the person's social care team
- if the person has one, a deputy appointed by the Court of Protection in relation to matters in respect of which direct payments may be made
- a lasting power of attorney with the power to make the relevant decisions (see section 9 of the Mental Capacity Act (2005))
- a person vested with an enduring power of attorney with the power to make the relevant decisions (see schedule 4 of the Mental Capacity Act (2005))
- where relevant, anyone named by the person for whom direct payments may be made, when they had mental capacity, as a person to be consulted for this purpose
- anyone who the LHB considers is able to provide relevant information about the person. LHBs should be aware that carers will have particular insights and should be seen as partners in care wherever possible[5]

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

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

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

- their overall health
- the details of the condition(s) in respect of which the person receiving care may be eligible to receive direct payments
- any bank, building society, post office or other account into which direct payments would be paid

77. The LHB should ensure that only the necessary information needed to make this judgement is requested and that as far as possible, the privacy and confidentiality of the person for whom a direct payment is contemplated is protected[6].

4.7 Information, advice or other support

78. Having the right information and support is key to successful outcomes with direct payments. LHBs must make arrangements to provide the person to whom

[5] Regulation 9 applies here
[6] See regulation 10

direct payments may be made (including representatives or nominees) with information, advice or other support. This can be provided either directly or by another organisation working in partnership with the LHB.

79. The LHB must ensure that the person receives adequate information and support at every stage of the process, including during the discussion about whether to receive direct payments, as the regulations require that information is provided in advance of the decision to make a direct payment so that the patient (or their representative) is able to give properly informed consent to the receipt of direct payments.

80. Information and support must also be available during care planning discussions and to assist in managing and accounting for a direct payment. Information and support for people, representatives or nominees using a CHC direct payment to employ staff is included in section 7.

81. It is important to ensure that whatever support arrangements are made available, they are adequate to meet the full range of requirements that people receiving direct payments may have. The Regulations do not specify either the type of support or the information that LHBs must provide, as there are a large number of possible options available and individual needs for support will vary. Examples given in the Regulations to assist LHBs to meet this obligation are:

- specifying the amount of the direct payment and how it is calculated
- being clear about how a person, representative or nominee can request a review of the person's direct payment and care plan
- outlining when a person may no longer be eligible for direct payments
- clarifying what direct payments can and cannot be used for
- describing the process for drawing up and agreeing the care plan
- ensuring access to advocacy services, where a third-party assists a person, representative or nominee in understanding the care plan, or managing contracts related to the services funded by direct payments
- putting in place arrangements to help with commissioning services, so the person, representative or nominee can be supported in sourcing and securing services using their direct payment
- providing access to employment related support such as payroll, training, sickness cover or other employment related services to assist a person, representative or nominee where an employee provides services through direct payments

- providing information on integration on occasions where a health body and a local authority are working jointly or in co-operation in meeting a person's needs

This is not intended to be an exhaustive list.[7]

82. LHBs should ensure that the information, advice or other support they provide or commission (hereafter collectively referred to as "support") is comprehensive, relevant, up-to-date, and accessible. This may include using different forms of media, and different formats or languages, depending on the groups the support is aimed at. LHBs should ensure they adhere to the Accessible Communication and Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with an impairment, sensory loss or who are disabled.

83. While support may be provided directly by the LHB, it may also be appropriate for people to purchase their own support, for example purchasing a payroll service to help when employing personal assistants. This should be discussed within the care planning process, and the care plan should specify any requirement for information, advice or other support. This can then be funded as part of the care plan, within which it must be costed and agreed in the same way as for any other service to be purchased by the person.

4.8 Nominees for people with capacity

84. If a person receiving care has capacity but does not wish (for whatever reason) to receive the direct payments themselves, they may nominate someone else to receive them on their behalf. A representative (for a person who does not have capacity) may also choose to nominate someone (a nominee) to hold and manage the direct payment on their behalf (see section 4.10 and regulation 8).

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

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

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

[7] See also regulation 12

- using the direct payment in line with the agreed care plan; and

- complying with any other requirement that would normally be undertaken by the person receiving care as set out in this guidance (e.g. in relation to review, providing financial information etc)

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

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

89. If a proposed nominee in respect of a person aged 18 or over is barred the LHB must not give their consent to that person acting as a nominee. This is because the Safeguarding Vulnerable Groups Act 2006 prohibits a barred person from engaging in the activities of managing cash or paying the bills of a person who seeks a direct payment. Such activities fall into "the provision of assistance in relation to general household matters to an adult who is in need of it by reason of age, illness or disability", which is a regulated activity relating to vulnerable adults within the meaning of Part 2 of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006.

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

- consult with relevant people (see section 4.5)

- require information from the person for whom the direct payments may be made on their state of health or any health condition they have which is included in the services for which direct payments are being considered

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

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

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

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

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

94. A managed account is where a third-party, which can be a named person (e.g. a solicitor or accountant) or an organisation (e.g. a direct payment support service), holds the money in a dedicated account for the person but does not take any responsibility for the ways in which it is spent or enter into any contractual arrangements on behalf of the person.

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

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

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

4.10 Representatives

98. If a person does not have capacity and so may not receive direct payments personally, the LHB should establish whether someone could act as that person's representative. In some cases, someone may already be acting as a representative in another capacity. In others it may be appropriate for the LHB to appoint someone to act as a representative. This should occur if the person receiving care would benefit from direct payments, and there is no-one else who is able to act as a representative (i.e. no-one falling into categories a-to-f in the definition of "representative" in regulation 2(1) of the Regulations).

99. A representative is someone who agrees to act on behalf of someone who is otherwise eligible to receive direct payments but cannot do so because they do not

have the capacity to consent to receiving one, or because they are a child. Representatives are responsible for consenting to a direct payment and fulfilling all the responsibilities of someone receiving direct payments. This is similar to the appointment of an 'suitable person' in the context of a social care direct payment.

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

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

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

103. An appointed representative could be anyone deemed suitable by the LHB. However, it will be important for LHBs to take into account previously expressed wishes of the person on whose behalf the representative is being appointed, and as far as possible their current wishes and feelings.

104. Where possible, LHBs should consider appointing someone with a close relationship to the person, for example a close family member or a friend. As far as is reasonably practicable, the LHB should also take into account the views of the people within the list set out in paragraph 74 before appointing someone as a representative.

105. A representative can be:

- a deputy appointed by the Court of Protection (under section 16(2)(b) of the Mental Capacity Act (2005)) to make decisions relevant to healthcare and direct payments ("the relevant decisions")
- a donee of a lasting power of attorney with the power to make the relevant decisions (see section 9 of the Mental Capacity Act (2005))
- a person vested with an enduring power of attorney with the power to make the relevant decisions (See schedule 4 of the Mental Capacity Act (2005))
- someone appointed by the LHB to receive and manage direct payments on behalf of a person who lacks capacity

106. When considering whether a representative is suitable, the LHB should be aware of the terms under which someone has been appointed under a Lasting Power of Attorney made by the person or by the Court of Protection as the person's attorney or deputy may only make decisions about the person's healthcare and securing services on the person's behalf to meet their care needs if they have been

appointed to deal with these matters. A Lasting Power of Attorney can cover matters relating to the person's personal welfare as well as property and financial affairs but can be subject to a range of exclusions and restrictions.

107. If an attorney or deputy lacks suitable powers, the LHB should consider whether, if they were to manage the direct payment, this would undermine the decision made by the person when they had capacity to give identified individuals the authority over specific aspects of their life only. In such circumstances, the LHB may, in line with the Regulations, appoint another person as a representative.

4.11 The role of the representative

108. A representative is responsible for managing direct payments on behalf of the person receiving care. They, or their nominee, must:

- act on behalf of the person, e.g. to help develop care plans and to hold the direct payment[8]
- act in the best interests of the person when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer
- use the direct payment in line with the agreed care plan
- comply with any other requirement that would normally be undertaken by the person as set out in this guidance (e.g. in relation to a review, providing information, etc)

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

4.12 Deciding whether to make direct payments to a representative

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

- whether the person receiving care had, when they had capacity, expressed a wish to receive direct payments, or have someone receive them on their behalf

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

- whether the person's beliefs or values would have influenced them to have consented or not consented to receiving a direct payment
- any other factors that the person would be likely to take into account if deciding whether to consent or not to receiving direct payments
- as far as possible, the person's past and current wishes and feelings

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

112. The LHB must satisfy itself of the person's suitability for the role of representative, including, where appropriate, requiring the representative to apply for an enhanced DBS check, with a check of the barred list.

5. Care planning and CHC direct payments

5.1 Care planning

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

114. This process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. (See regulation 11). It addresses the things that are not working in the person's life and identifies outcomes and actions to resolve these.

115. The care plan is at the heart of a direct payment. Drawing up a care plan should involve discussions between the person receiving the care, their nominee or representative, their care co-ordinator (see section 5.6), the appropriate health and social care professionals and any others the person would like involved in their care.

116. Wherever possible, LHBs should work with local authorities and other healthcare providers to ensure that the person has a seamless transition from social care to CHC.

117. The care plan is the basis of an agreement between the LHB and the person receiving direct payments and includes responsibilities on both sides. It is therefore vital that people are supported throughout the care planning process. This will help ensure that they are able to make informed decisions, in their best interests, and that they do not find the process overly burdensome or overwhelming.

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

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

120. Having set out the health needs, the care plan should also set out the outcomes that are intended to be achieved. These may relate to both health and wellbeing outcomes. The decision-making process is intended to be comprehensive, considering all aspects of an individual's needs, not only those that are strictly medical or nursing in nature. CHC can encompass a broad range of services to meet the holistic needs of a person with a primary health need. A good care plan should address people's needs holistically. It can in some circumstances include outcomes that may be met in ways that do not involve the use of the direct payment but are complementary to those aspects funded.

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

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

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

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

- the health needs of the person and desired health and wellbeing outcomes to be achieved through purchase of services in the care plan (the term 'services' is used throughout this document to refer to anything that can be bought and which will meet a person's needs for care and support arising from a primary health need)
- what the direct payment will be used to purchase (see section 3.3)
- the amount of the direct payment, and how often it will be paid (see section 6.1)
- the name of the care co-ordinator responsible for managing the care plan (see section 5.6)

- who will be responsible for monitoring the health condition of the person receiving care
- the anticipated date of the first review, and how it will be carried out (see section 8)
- Agreed ways to manage any escalation in health needs, or changes in a person's health condition not initially covered in the care plan
- A section on any significant potential risks and how to manage those; where necessary, an agreed procedure for discussing and managing any further risks which may arise (see section 5.5)
- the plan should consider safeguarding and promoting liberty, especially where people lack capacity or are more vulnerable
- the period of notice required if the LHB decides to reduce the amount of the direct payment

5.3 Agreeing the care plan

124. When agreeing the care plan, the LHB must be satisfied that:

- the health needs of the person can be met through the purchase of services in the care plan (see section 3.3 for more information on what direct payments can be spent on)
- the amount of money in the care plan will be sufficient to cover the full cost of each of the specific services in the plan
- the care plan will be reviewed as required (see section 8)
- any significant potential risks have been discussed with the person, their representative or nominee and appropriate procedures to eliminate, reduce or manage these risks have been included in the care plan (see section 5.5)
- where people lack capacity or are more vulnerable, procedures such as safeguarding and promoting liberty have been included appropriately in the care plan

125. The person or their representative must also agree that:

- the person's care needs will be met by the services agreed in the care plan
- the amount of direct payment is sufficient to cover the full cost of the care plan
- the care plan will be reviewed (see section 8) and their needs may be re-assessed as part of that review

126. No service should be included in the care plan if the LHB considers that the benefits are outweighed by the possible damage to health.

127. Where the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG) has concluded that a treatment is not cost effective, LHBs should apply their existing exceptions process before agreeing to such a service. However, when NICE has not ruled on the cost effectiveness or otherwise of a specific treatment, LHBs should not use this as a barrier to people purchasing the service if it could meet the person's health and wellbeing needs.

128. People need the right information and support to enable them to make an informed decision about how to use their direct payments. Where relevant, people should be given the opportunity to review the underpinning evidence and the conclusions drawn up by NICE. NICE provide a lay version of their guidance that can help people make decisions about this type of healthcare.

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

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

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

132. The LHB must reconsider its decision in the light of the new evidence and then notify and explain the outcome of its deliberation in writing. The LHB can only be required to reconsider its decision once. If the dispute persists, the LHB should refer the person to the complaints procedure. This should include making people aware of Llais' free, independent complaints advocacy service; additionally if someone has a complaint and wishes to escalate it to the Ombudsman, they should be informed of how to do so. (see section 8.2).

5.4 Reviewing and revising the care plan

133. The care plan should be open to review and revision as necessary and should be reviewed at clinically appropriate intervals. It must be initially reviewed within the first three months, and then at least annually (see section 8 and regulation 18 for more information on monitoring and review).

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

5.5 Managing risk

135. During the care planning process, the LHB should have a detailed discussion with the person, representative or nominee about potential risks, including those arising in relation to the making of direct payments, and how to manage them. This

should be part of an ongoing dialogue between the person and the LHB on how to effectively manage risk.

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

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

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

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

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

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

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

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

5.6 Named care co-ordinator

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

- liaising between the LHB and the person receiving the direct payment
- managing the assessment of the health needs of the person as part of the care plan
- ensuring that the person, or representative and the LHB have agreed the provision of services specified in the care plan will meet the needs of the person
- ensuring the agreement of the person, or representative that the amount of the direct payment is sufficient to cover the full cost of the services specified in the care plan
- ensuring that the person, or the representative acknowledges that the person's requirements will be subject to review
- undertaking or arranging for the monitoring and review of the direct payment, the care plan and the health of the person

144. The care co-ordinator should be someone who has regular contact with both the person receiving care, and their representative or nominee if they have one. They do not need to have 'care co-ordinator' in their job title – the important thing is that they fulfil the responsibilities above and that the direct payment recipient is aware of who they are, their role and the duties they are required to carry out. Strong ongoing liaison should be maintained with the care co-ordinator role described in the Welsh CHC Framework who is responsible for co-ordinating the whole process of assessment for longer-term care. Both roles may (but need not) be undertaken by the same person.

145. It is the responsibility of LHBs to decide who is best placed in their organisations to take up the role of care co-ordinator. LHBs may also find it helpful to build on the experience of local authorities.

6. Managing the money

6.1 Setting the amount of a direct payment

146. LHBs must set direct payments at a level sufficient to cover the full cost of each of the services agreed in the care plan. NHS services, including direct payments, are free at the point of delivery.

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

148. It is not anticipated that it will be usual practice to include equipment in a direct payment, and certainly not if it is available via another route within the NHS, e.g. Community Equipment services. If the direct payment includes agreement to purchase equipment, then any insurance or maintenance costs should be included in the budget.

149. LHBs must ensure direct payments cover the full cost of the care agreed in the care plan. Direct payments complement existing Welsh Government policy around additional private care. In no circumstances should the budget be set at a level where someone is expected to pay for care privately, for example via the payment of top-ups, to meet their agreed health needs.

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

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

152. LHBs are advised to include a contingency fund in the direct payment, either for the person or as part of a collective risk pool, to ensure that the budget is available to fully fund the care plan. This can be used to cover unforeseen circumstances and emergencies.

6.2 Receiving a direct payment

153. NHS services are free at the point of delivery. LHBs must pay direct payments in advance. Under no circumstances should people have to pay for services

themselves and be reimbursed, even if receipts are available, for services agreed in the care plan.

154. With the exception of one-off direct payments (see paragraph 157 below), LHBs must pay direct payments into a separate bank account used specifically for this purpose and held by the person receiving them (or held by a managed account provider). That person may be the person receiving care, or a nominee or representative. The bank account should only be accessible to people agreed to by the LHB, which should normally be limited to the person purchasing services, be they the recipient of the direct payments, their nominee or representative.

155. When receiving direct payments, the person holding the account should keep a record of both the money going in and where it is spent, for example, through keeping bank statements and receipts. Where there is a managed account service, such record keeping should be part of the management service provided.

156. As far as possible, LHBs should endeavour to ensure that monitoring is not onerous. These processes and conditions should be included in the LHB's own local direct payments policies as well as the person's own direct payment agreement.

157. Where someone is receiving a one-off direct payment, it can be paid into the person's ordinary bank account (or that of a nominee or representative). A one-off payment is defined as a payment made for a single item or service; or as a single payment for no more than five items or services where that payment is the only payment a person will receive from the LHB within a single financial year. People will need to provide evidence that the direct payment was used as agreed in the care plan. However, for one-off direct payments, this could be done by producing receipts of services purchased, rather than by providing copies of bank statements.

6.3 Stopping or reducing a direct payment

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

159. Before making a decision to stop or reduce a direct payment, the LHB must consult with the person receiving it and give reasonable warning of the intention to make changes, to enable any misunderstandings or inadvertent errors to be addressed and enable any alternative arrangements to be made.

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

161. Direct payments may be reduced:

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

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

163. Full consideration should be given to how the direct payment may be used in hospital to meet the person's support needs or to ensure employment arrangements are maintained. For example, the person may prefer the personal assistant to visit hospital to help with personal care matters. This should not interfere with the medical duties of hospital personnel but be tailored to work alongside health provision. Alternatively, the personal assistant could be encouraged to update their training or take annual leave during this time.

164. Suspending or even terminating the payment could result in the person having to cease the employment of a trusted personal assistant, causing significant distress and a lack of continuity of care when discharged from hospital. Stopping payments without sufficient notice could also lead to breach of a personal assistant's employment contract, possibly leading to unfair dismissal claims and would be likely to cause financial hardship to the employee.

165. Advance planning will be required if a hospital stay is a possible or likely occurrence. The care plan will need to set out clear lines of communication and to give consideration of provision about such eventualities in any contractual arrangements relating to the provision of care and support.

166. If a direct payment is suspended or terminated, all rights and liabilities related to the care agreed in a person's care plan pass back to the LHB and any period of notice required for staff and other contracts and costs incurred due to the stopping of the direct payment must be met by the LHB. (See regulation 21 – Stopping direct payments)

167. Where direct payments have been reduced or stopped, the person receiving care, a representative or nominee may request the LHB to reconsider the decision and may provide evidence or relevant information to be considered as part of that deliberation. Where this happens, the LHB must inform the person receiving care

and any representative or nominee in writing of its decision after reconsideration and state the reasons for the decision. The LHB is not required to undertake more than one reconsideration of any such decision. If the person is still unhappy with the decision to reduce or stop the direct payment, they should be referred to the local NHS complaints procedure.

168. An LHB must stop paying direct payments if:

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

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

- the person no longer needs care
- as part of monitoring and review (see section 8) direct payments are deemed to no longer be a suitable way of providing the person with care, for example because of changes to their health conditions
- the LHB has reason to believe that a representative or nominee is no longer suitable to receive direct payments, and no other person has been appointed
- a nominee withdraws their consent, and the person receiving care or their representative does not wish to receive the direct payment themselves
- the person has withdrawn their consent to the nominee receiving direct payments on their behalf
- the direct payment has been used for purposes other than the services agreed in the care plan
- fraud, theft or an abuse in connection with the direct payment has taken place
- the person has died

170. If, for whatever reason, the person receiving care and anyone involved in managing their direct payment are no longer able or willing to manage the direct payment, the LHB is responsible for fulfilling the contractual rights and liabilities of the person, nominee or representative.

171. In some cases, it may be necessary to stop the direct payment immediately, for example if fraud or theft has occurred. In these cases, ‘reasonable notice’ may include immediate termination of the direct payment. In these circumstances, the LHB should endeavour to protect public money as far as possible, whilst being

mindful that they are still under a duty to provide healthcare if the person requires it. No person should ever be denied the care they need.

172. Where possible, LHBs should also endeavour to continue to provide a service and maintain a continuity of care. For example, an independent user trust[9] could be established to manage the budget or the LHB could directly commission the services agreed in the care plan.

173. However, LHBs should be mindful that genuine errors can occur and also that circumstances beyond people's control can result in, for example, surplus or unspent funds. In such situations LHBs should work with budget holders to understand the situation and explore alternative options for using the direct payment to meet the person's health and wellbeing needs.

6.4 Repayment of a direct payment

174. In some circumstances, the LHB may ask for all, or part of, the direct payment to be repaid. The decision to seek repayment, and the amount of money to be reclaimed, is at the discretion of the LHB with consideration to the requirement to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the exercise of its functions in accordance with the Standing Financial Instructions issued by the Welsh Ministers.

175. However, any decision should involve the recipient of the direct payments being made aware of the reasons and rationale for the repayment.

176. The LHB may reclaim direct payments if:

- they have been used to purchase a service that was not agreed in the care plan
- theft, fraud or other offences have occurred
- the person receiving care has died, leaving part of the direct payment unspent
- the care plan has changed substantially resulting in surplus funds
- the person's circumstances have changed substantially, such as admission to hospital resulting in the person not using the direct payment to purchase their care (but see paragraph 162 - 165 relating to hospital stays)
- a significant proportion of the direct payment has not been used to purchase the services specified in the care plan resulting in money being accumulated

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

[9] See Continuing NHS Health Care paragraph 5.53

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

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

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

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

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

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

184. LHBs should be aware of their responsibilities under the Data Protection Act 2018 and General Data Protection Regulation 2016 when contacting individuals or organisations in relation to the reclaiming of funds.

185. If the LHB has decided to seek repayment, it must give the relevant person reasonable notice in writing, stating:

- the reasons for its decision
- the amount to be repaid
- the time in which the money must be repaid
- the name of the person responsible for making the repayment
- If the account is a managed account, the monies can be taken directly out of the managed account, again with adequate notice given to the recipient of the direct payment

186. On receipt of notice from the LHB regarding an intention to reclaim direct payment monies, the person, representative or nominee may request the LHB to

reconsider its decision. They may also provide additional evidence or relevant information to inform that decision. The LHB must reconsider its decision in light of any new evidence and then notify and explain the outcome of their deliberation in writing. The LHB can only be required to reconsider its decision once. If the person is still unhappy with the decision, they should be referred to the local NHS complaints procedure. See also section 8.2 Complaints below.

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

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

7.1 Using a direct payment to buy services from a provider

188. When using a direct payment to buy services as agreed in the care plan, the person receiving the direct payment is responsible for contracting directly with the provider or employing people directly and so normal NHS procurement processes do not apply. See guidance on the Health Services (Provider Selection Regime) (Wales) Regulations 2025 for more details.

189. Direct payment recipients may wish to pay a third-party organisation to employ a personal assistant on their behalf. The third-party organisation should allow the person to have as much choice and control in the recruitment and management of the personal assistant as appropriate. However, in such cases the ultimate accountability for meeting employer responsibilities remains with the third-party organisation.

7.2 Using a direct payment to employ staff

190. Direct payments can be used to employ staff / personal assistants to provide care and support outlined within the care plan. LHBs should provide appropriate support for this whenever possible.

191. For some people who receive direct payments, it may be their first experience of being an employer, and it will be vital that there is good information, advice and support available to them. Supporting good employment practice and promoting positive working relationships between personal assistant / employee and employer can help ensure a sustainable and successful package of care. It can contribute to the retention of staff and prevent a breakdown of care arrangements which could impact adversely on the person’s health or in some instances lead to hospital admission.

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

advice or other employment related information and services. To comply with this, LHBs could work with their local authorities who may have arrangements in place, often through voluntary, third-party or user-led organisations to provide support and advice to direct payment holders and their personal assistants, and to people interested in receiving direct payments.

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

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

195. Where it becomes clear that payments, or returns detailing employee information deductions, have not been made, or that the person is failing to meet their obligations as an employer generally, the direct payment arrangement should be reviewed. Consideration should be given to whether alternative arrangements be made that result in the direct payment recipient no longer directly handling those tasks or making those returns, such as via use of a managed account system or the services of a third-party organisation.

196.Not doing so may result in the person building up arrears of tax and National Insurance due to HMRC, which may then lead to enforcement action to recover any debt. This situation should be avoided by effective, proportionate monitoring, and by providing clear, accessible upfront information about the responsibilities of becoming an employer.

197.LHBs could work with local authority partners who may have commissioned voluntary and community or other third-party organisations to provide support to direct payment holders on these matters.

198. People who would otherwise be willing and able to manage a direct payment but are concerned about becoming an employer should be informed of the local support available in relation to being an employer and the different options in relation to taking on staff. This could include the use of agencies or third-party organisations such as those offering payroll services, which will take responsibility for administering wages, tax, pensions and National Insurance on their behalf. Costs for such services should be factored in when setting the budget.

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

7.3 Paying staff living in the same household

200. A direct payment can only be used to pay a family member or friend living in the same household to deliver care agreed in the care plan if the LHB is satisfied that this is necessary to meet the person receiving care's need for that service. LHBs will need to make these judgements on a case-by-case basis.

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

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

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

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

- the spouse or civil partner of the person receiving care
- someone who lives with the person as if their spouse or civil partner
- their parent or parent-in-law
- their son or daughter
- son-in-law or daughter-in-law
- stepson or stepdaughter
- brother or sister
- aunt or uncle
- grandparent
- the spouse or civil partner of their parent or parent-in-law, or someone who lives with them as if their spouse or civil partner

7.4 Safeguarding and employment

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

205. LHBs should ensure that there is readily available advice in relation to the provision of DBS checks in respect of people whom direct payment recipients may wish to employ to undertake regulated activity within the meaning of the Safeguarding Vulnerable Groups Act 2006.

206. It is likely that most personal assistants' work would be classified as regulated activity under the Safeguarding Vulnerable Groups Act 2006 and this is what makes them eligible for enhanced DBS checks and a check of the Adults' or Children's Barred List. A collection of documents that can be used to decide whether a role is eligible for a basic, standard or enhanced DBS check is also available.

207. A person or their nominee or representative in their role as a would-be employer of an individual as a personal assistant for example, may now require a potential employee to apply for an enhanced DBS certificate with barred list check.

208. The person who will be the employer, or their nominee or representative, would be responsible for making the "suitability" decision in such circumstances.[10]

209. This would include when employing or contracting with people providing care to the person, such as:

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

210. A local authority or NHS organisation can still, if they wish, apply for DBS checks themselves or decide to commission the processing of DBS checks through an umbrella body. This could be, as part of their safeguarding duty, for persons such as nominees. The umbrella body will be responsible for processing a DBS application; however, unless the umbrella body employs someone to make the "suitability" decision in regard to DBS checks the responsibility for the suitability decision would remain with the organisation requesting a check.

[10] Since 21 January 2026 amendments made to article 3(1) of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 enables persons who are self-employed and those employed by personal employers to apply for an enhanced criminal record certificate or an enhanced with barred list criminal record certificate, if the role or activity being undertaken is eligible for these kinds of check.

211. Based on the results of the DBS check, the person making the suitability decision must make the decision in relation to the particular role under consideration. The person who assesses suitability should be checking against relevant local safeguarding and recruitment of ex-offenders policies to reach a decision on suitability. The decision should be an objective one based on facts.

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

213. The individual employer cannot be involved in making the suitability decision in relation to the DBS check if it has been requested by the LHB or local authority, although in such cases the final decision regarding suitability can and must be shared with them. If the person is deemed suitable in relation to the DBS check, then the individual employer can make a further decision about their employment in relation to other aspects of their suitability.

214. The person on whom the DBS check was conducted may choose to show their DBS check to the person intending to employ them if they so wish. Data protection rules as outlined in the Data Protection Act 2018 must be adhered to when they do so.

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

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

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

7.5 Insurance, indemnity and accountability

218. Direct payments do not release the NHS from their duty of care to people within their care. Where people employ their own staff, through the use of a direct payment, LHBs are responsible for ensuring that everything necessary to deliver safe care is included in the care package and that any significant risks have been discussed with the person or their representative and appropriate procedures to manage these risks

have been included. Direct payments increase the level of choice and control people have but they do not change the statutory duty of care that the NHS has to all individuals.

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

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

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

222. Personal assistants employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover unless they are a member of a regulated health profession, even if carrying out activities which might otherwise be performed by health professionals.

223. If a personal assistant causes an injury to the person they are supporting, however, this may result in a clinical negligence claim against the personal assistant by or on behalf of the person they are supporting. It is therefore advisable for them to have clinical indemnity insurance when employed to carry out tasks of a clinical nature.

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

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

226. LHBs should include appropriate funding within the direct payment so that the direct payment recipient and personal assistants are provided with a level of

protection that reflects the risk associated with the care package. They should ensure there is enough money in the direct payment year on year to cover the annual cost of agreed insurance.

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

1. Employers' liability – This is a legal requirement under the Employers' Liability (Compulsory Insurance) Act 1969. Employers are responsible for the health and safety of their employees while they are at work. Employers' liability insurance provides a level of insurance cover for an employer in the event that an employee is injured at work or becomes ill as a result of their work and seeks redress or compensation from a responsible employer. Employers' liability insurance enables the employer to meet the cost of a compensation claim arising out of, or in the course of, the employment. Anyone who employs personal assistants through a direct payment must take out Employers' liability insurance and there are a number of companies that offer such insurance.

2. Public liability – Provides cover if a third-party (i.e. not an employee) suffers injury or damage to their person or property for which the individual employer is held legally responsible. If a personal assistant causes injury or damage to a third-party arising out of their employment with the individual employer, it is likely that the individual employer would be found vicariously liable for their actions. The employer therefore needs insurance cover against such liability. Public liability insurance covers claims made by members of the public or businesses, but not for claims by employees.

3. Clinical indemnity – Some insurers will insure personal assistants to carry out a designated range of complex healthcare tasks, provided they have proof of appropriate training. If a personal assistant causes an injury to the person they are supporting, this may result in a clinical negligence claim against the personal assistant by or on behalf of the person they are supporting.

4. Insurance for personal assistants – There are also specific policies designed to protect personal assistants from claims against them, for example where the personal assistant accidentally harms the employer (e.g. spilling a cup of hot tea on the employer).

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

227. Where people buy services from professionals who are required to be registered with the Health and Care Professions Council (HCPC), it will be important

that they check their registration status. This will also act as assurance that professional indemnity cover is in place since this is a condition of registration.

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

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

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

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

7.6 Registration and regulated activities

232. If someone wishes to buy a service which is a regulated activity as listed under Section 2 of the Regulation and Inspection of Social Care (Wales) Act 2016, they will need to inquire as to whether their preferred provider is registered with Care Inspectorate Wales (CIW). A direct payment cannot be used to purchase a regulated activity from a non-registered service provider.

233. Regulated services in Wales are set out under the Regulation and Inspection of Social Care (Wales) Act 2016 and must be registered with Care Inspectorate Wales. It should be noted that the definition of regulated activity in relation to the Regulation and Inspection of Social Care (Wales) Act 2016 is different from the definition of regulated activity in the Safeguarding Vulnerable Groups Act 2006.

234. Personal assistants who are directly employed by an individual or related third-party, and self-employed personal assistants with an agreement to work directly for a person to meet that person's own personal care requirements do not need to be registered with Social Care Wales (SCW). This is only the case where the personal assistant is directly employed without the involvement of an employment agency or employment business and working wholly under the direction and control of that individual or related third-party.

235. Additionally persons who provide domiciliary support services to four or fewer people are an exception to the definition of "domiciliary support service" within the Regulated Services (Service Providers and Responsible Individuals) (Wales)

Regulations 2017 so such persons can lawfully provide domiciliary support without being registered with CIW and SCW.[11]

236. A related third-party means:

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

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

c) A trust established for the purpose of providing services to meet the health or social care needs of a named person

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

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

239. A recipient of a direct payment should satisfy themselves before they commission a service if the person is providing a service that requires them to be registered as a member of a body that is regulated by a body mentioned in section 25(3) of the NHS Reform and Health Care Professions Act 2002.

240. In some circumstances, the provider may also need to be a registered member of a professional body affiliated with the Professional Standards Authority for Health and Social Care. If the care plan specifies that a task or tasks require a registered professional to undertake it, only a professional who is thus registered may be employed to perform that task or tasks.

241. In the first instance it will be the responsibility of the person buying the service to check whether the provider they are purchasing from is appropriately registered. They can request the LHB to investigate this, and if they ask, the LHB must do so.

[11] Social Care Wales (SCW) is the body that is responsible for the regulation and training requirements for specified categories of social care workers. There is no requirement for a personal assistant to be registered with SCW. PAs are employed directly by the person receiving a direct payment, not by a service provider (within the meaning of the Regulation and Inspection of Social Care (Wales) Act 2016 (RISCA)). By contrast, domiciliary care workers must register with SCW because they are employed by a regulated provider who provides a domiciliary support service.
Since the care recipient is not a service provider under RISCA, their employees (PAs) are not required to be registered.

As with indemnity cover, the LHB must also review this as part of their assessment as to whether the direct payment is being effectively managed.

242. While some service providers, for example counsellors and complementary therapists, are not statutorily required to be registered, there are professional associations with voluntary registers that practitioners can choose to join. The Professional Standards Authority assesses organisations such as these who register practitioners and are not regulated by law.[12]

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

8. Monitoring and review

8.1 Monitoring and reviewing direct payments

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

245. Reviews should be done with, and not to, the person in receipt of direct payments. Reviews that focus on outcomes rather than processes can be the most effective way of identifying what works well and what does not work well for the person. Depending on what is agreed at the review, changes can be made to the resources, support or controls described in the care plan.

246. Reviews are a crucial part of direct payments and of safeguarding and need to be carried out effectively. The aim of the review is to support the person and their care team to work together towards achieving the outcomes that matter most to the person.

247. Reviews should be proportionate to the person's circumstances and should place as few burdens on people receiving care, representatives and nominees as possible. Some people will need more frequent monitoring and detailed review than others, for example, people who lack mental capacity, those who are particularly isolated or have a degenerative or fluctuating condition or where other particular risks are identified during care planning.

[12] To note however, the Public Health (Wales) Act 2017 introduced a mandatory licensing scheme for certain defined "special procedures" such as acupuncture and electrolysis.

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

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

- whether the care plan adequately addresses the needs of the person arising from their primary health need, and whether the agreed health and wellbeing outcomes are being met. This includes considering whether their health needs have changed, and if so whether the care plan is still appropriate
- any change in the person's and/or representative/nominee's circumstances
- whether the direct payment has been used effectively and/or as agreed in the care plan
- whether the direct payment is sufficient to cover the full cost of each of the services
- whether the person, or their representative or nominee, has used the direct payment appropriately and fulfilled their obligations, including where relevant their obligations as an employer to pay employment tax and National Insurance
- whether the risks have changed, and whether the risk management is still effective
- if it is the first review, or if a service has been changed, reassesses indemnity and registration if applicable
- any safeguarding issues particularly if the person lacks capacity or is vulnerable
- LHBs should also consider whether the person's voice and control are being promoted by the care plan

250. When carrying out a review, the LHB may:

- re-assess the health needs of the person
- consult anyone mentioned in section 4.5
- review receipts, bank statements and other information relating to the use of direct payments or consider any managed account information stored via a portal
- consider evidence around whether direct payments have been effectively managed, including if the person or their representative/nominee is able to carry out their employer role effectively, and any evidence as to whether PAs

or service providers have or had appropriate indemnity and registration if applicable

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

252. During the care planning discussion, there should be discussion about what the review will look at, and the information that will need to be provided by the person, the representative or the nominee. This information must be:

- legible
- accompanied with authorisation for the LHB to make copies or take extracts
- if requested by the LHB, accompanied with an explanation of the information provided
- if requested, accompanied with a statement informing the LHB where information is held which the person has been unable to provide

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

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

255. The person, their representative or nominee may request that the LHB undertakes a review at any time. If this happens, the LHB must decide whether or not to undertake this review, taking into account local practices and the circumstances relating to the person. The LHB must provide reasons for its decision and do so in a permanent and accessible format.

256. Following a review, the LHB may:

- amend the care plan
- decide to pay the direct payment to the person receiving care, rather than to the representative or nominee
- decide to pay the direct payment to a representative or nominee rather than to the person
- increase, maintain or reduce the size of the direct payment
- require that a direct payment not be used to purchase a service from a particular individual, provider or organisation
- require that the person, representative or nominee provide additional information

- take any other action the LHB considers appropriate including declining further payments or making a referral to any relevant agencies if any risks are identified. Action should be proportionate, person-centred and should normally be to ensure the safe and effective running of the direct payment or care plan, or to protect public money

257. The LHB must ensure that the person receiving the direct payment is given reasonable notice, and an explanation, regarding any changes arising as a result of monitoring or review. This must be done in writing, and it should be accessible and understandable to the person involved.

8.2 Complaints

258. In addition to informing a person of their right to request that an LHB reconsiders a decision it has made in relation to a direct payment, as part of the discussion around the care plan, there should be a discussion around how people can make complaints if something goes wrong. This should include making people aware that Llais offers a free, independent complaints advocacy service to support individuals who wish to raise concerns about the health or social care services they have received.

259. The NHS complaints procedure under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 will continue to apply to any decision made by the LHB. LHBs should ensure that people are aware of the process for accessing that procedure.

260. For complaints relating to providers, people will need to use the provider's complaints procedure. A complaints process is a requirement for services registered with CIW, and people should contact the provider to explore how to use that process. LHBs should consider how best to support people who wish to make a complaint about their provider and may wish to work with both parties to resolve disputes.

261. In some circumstances, small providers will not have a complaints procedure (this should not necessarily be a barrier for people to purchase services from them, though the implications should be discussed as part of the discussion around risk). In these circumstances people should follow the process agreed in their care plan or contract of employment.

262. Where employment disputes arise that are not covered by the NHS complaints procedure or provider complaints processes, they may be subject to employment law and advisory services such as ACAS.

263. The Public Service Ombudsman for Wales can also investigate complaints about any service purchased by a direct payment that is referred to them. The LHB should ensure that if someone has a complaint and wishes to escalate it to the Ombudsman, they should be informed of how to do so. Generally, other mechanisms to resolve complaints should be explored and exhausted before appealing to the

Ombudsman. The Ombudsman will be concerned to ensure that the actions of LHBs and providers are reasonable, and LHBs should ensure that proper records of all decisions are kept, including explanations for those decisions.

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