NHS
Dorset
Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

Governance for Personal Health Budgets



Supporting people in Dorset to lead healthier lives

PREFACE

This policy sets out the governance process for ensuring that patients commissioning their own services with a personal health budget are supported

DOCUMENT HISTORY

Document Status: Current	
Policy Number	ID 8
Date of Policy	January 2014 V2.5
Next Review Date	January 2016
Sponsor	Director of Quality
Approved by / on	Directors Meeting 31 March 2014

Version	**Date**	**Comments**	**By Whom**
V1	7/2/2014	Draft Policy	Patient Safety and Risk Manager
V2.1	10/02/2014	Comments	Deputy Director of Quality
V2.2	10/02/2014	Comments	Deputy Director of Review, Design and Delivery
V2.3	11/02/2014	Comments	Personal Health Budget Manager
V2.4	11/02/2014	Comments	Deputy Head of Continuing Health Care
V2.5	27/02/2014	Comments and changes	Deputy Head of Continuing Health Care, Patient Safety and Risk Manager

Evidence Base References	Date
Human Rights Act	1998
The Equality Act	2010
The Local Government and Public Involvement Act (duty to involve for the NHS)	2007/2008
Health and safety at Work Act	1974
Mental Capacity Act	2005
Guidance on direct payments for community care, service for carers and children's services	2009
Safeguarding Adults: The role of health service practitioners	2011
National Framework for NHS Continuing Health Care and NHS Funded Nursing Care	2012 Revised
The NHS Direct Payment Regulations	2013

Target Audience	All staff within NHS Dorset Clinical Commissioning Group	
Distribution		
Intranet	Trust Website	Communications Bulletin
√	√	√

GOVERNANCE FOR PERSONAL HEALTH BUDGETS

CONTENTS

APPENDICES

GOVERNANCE FOR PERSONAL HEALTH BUDGETS

1. INTRODUCTION

1.1 Personal Health Budgets (PHBs) were piloted nationally between 2009 - 2012 and Dorset PCT was one of these pilots.

1.2 The evaluation demonstrated better outcomes for people and proved cost effective for people with high health service use. PHBs also reduced use of other health services.

1.3 The Government confirmed a commitment so that people eligible for NHS Continuing Healthcare (CHC) will have a "right to ask" for a PHB from April 2014.This changes to a "right to have" from 1 September 2014.

2. DEFINITION

2.1 A PHB is defined in the Continuing Healthcare National Framework as helping people to get the services they need to achieve their health outcomes by letting them take as much control over how money is spent on their care and support as is appropriate for them. This can be through a direct payment.

3. PROCESS

3.1 Applications made for a PHB result in a visit being undertaken by either the PHB case co-ordinator, the Continuing Healthcare Co-ordinator Adult and/or Children, Community Learning Disability Nurse, Community Psychiatric Nurse or any other lead health professional or a combination of the above to assess the patient's requirements and needs and to produce an individualised care plan in agreement with the patient and/or their representative if they lack capacity.

3.2 A risk assessment is also completed at the same time, identifying all risks pertaining to the patient and what the mitigation actions are to reduce the risk to an acceptable level.

3.3 These assessments are reviewed to agree a PHB indicative budget.

3.4 A number of items will be considered during the risk assessment. These are as follows:

- whether there are any sanctions in place for any of the care providers such as non-compliance with CQC standards;
- whether there are blocks or cautions in place for agencies or care homes;
- confirming a Disclosure and Barring Services check has been completed where relevant and whether that has highlighted any issues;

- where a patient lacks capacity, what safeguards are in place to protect them?

3.5 The process for the above can be found in Appendix 1.

4 RISK AND SCRUTINY PROCESS FOR NON CHC FUNDED PHBS

4.1 A meeting is held once every calendar month or as required if there are insufficient cases for a monthly meeting to review PHB case summary reports for patients that are non CHC funded and make a recommendation regarding the agreement to grant a PHB.

4.2 Membership of this meeting consists of the following:

- Deputy Director of Review, Design and Delivery (East);
- Project Manager for PHB;
- Case-Co-ordinator for PHB;
- Patient Safety and Risk Manager.

4.5 The above will consider a number of items. These are as follows:

- whether there are any sanctions in place for any of the care providers such as non-compliance with CQC standards;
- whether there are blocks or cautions in place for agencies or care homes;
- confirming a Disclosure and Barring Services check has been completed where relevant and whether that has highlighted any issues;
- where a patient lacks capacity, what safeguards are in place to protect them;
- whether all risks have been identified and actions put in place to mitigate to an acceptable level;
- whether the level of funding agreed for the PHB will meet all requirements for the patient.

5 OUTCOME

5.1 Once agreement is reached for CHC funded and non CHC funded patients, there is a process in place to gain consent from the patient or their representative to set up payments either as a direct payment to a bank account or through a holding account that will make the payments to the relevant provider or person on behalf of the patient or their representative. Detail can be found in the Operational Policy for Personal Health Budgets.

6 MONITORING AND ASSURANCE

6.1 Where a patient has been granted a PHB through a holding account, there are robust processes in place that scrutinise statements of income and expenditure to ensure there are no unusual payments and that the expenditure is not over or under the budget set. Any unusual occurrences are investigated immediately and action taken where necessary.

6.2 Patients who have direct payments to their own account are reviewed as a minimum after three months and again at the end of the financial year to ensure the funding is not over or under budget.

6.3 As people receiving PHB are generally only people who are CHC eligible, the financial reporting for PHB is contained in the CHC finance report to the Dorset Clinical Commissioning Group Governing Body on a bi-monthly basis.

6.4 The Directors meeting also receive a monthly financial report for PHBs.

6.5 A report will be provided to the Quality Group on a quarterly basis which will report up to the Audit and Quality Group which is a sub-committee of the CCG Governing Body. This will ensure that assurance for quality governance and that the processes in place for PHB management are robust in order to minimise risk.

7 REVIEW

7.1 This policy will be reviewed on a bi- annual basis unless there are changes in legislation which impacts on processes in place.

NHS
Dorset
Clinical Commissioning Group

PERSONAL HEALTH BUDGET PROCESS MAP FOR CHC CARE COORDINATORS

1

Application Process for Continuing Healthcare Funded Patients

CHC Care Co-ordinator

To make an application for a Personal Health Budget will require:-

- Decision Support Tool with supporting evidence;
- Care and Support Plan (PHB1) or CHC Care Plan;
- identifies elements of package that are to remain a commissioned service and the elements to be transferred to the PHB budget and advises CHC Commissioning Manager;
- PHB Risk Assessment Form (PHB2);
- evidence that the individual has the capacity to manage a PHB or, if the individual does not have capacity, evidence of an EPOA or LPOA that their representative has the authority to manage the PHB on their behalf;
- update Caretrack database.

2

Set Indicative Budget

Commissioning Manager

- completes Indicative Budget Sign-off Form (PHB3). Indicative budget is the PHB budget subject to line manager approval.

3

Budget Exceeds Indicative Budget

CHC Care Co-ordinator

- completes Approval of PHB Above Indicative Budget (PHB4).

PHB Approval

CHC Care Co-ordinator completes and presents to line manager:-

- PHB Risk Assessment (PHB2);
- Care and Support Plan (PHB1) or CHC Care Plan;
- Indicative Budget Sign-off Form (PHB3) and PHB Above Indicative Budget (PHB4);
- sign off for the weekly cost of the PHB is the same as the CHC delegated authority limits (NHS Dorset CCG CHC Procurement Procedure). If required use the CHC High Cost Approval Form.

Referral to Independent Support Agency

CHC Care Co-ordinator

- sends PHB Referral (PHB5) to Support Agency (and if required PHB5a PROdisability Holding Account Referral Form);
- sends Care and Support Plan (PHB1) and Indicative Budget Sign-off Form (PHB3) to support agency;
- update Caretrack database.

Inform Individual of Budget

CHC Care Co-ordinator

- sends letter to individual to inform start date of budget (PHB6) including choice of independent support agency and any conditions;
- request confirmation slip (PHB7) is completed and returned;
- ensure bank account details form (PHB8) witnessed and countersigned by CHC Care Co-ordinator **or** completion of holding account contract;
- update Caretrack database.

7

Inform Local Authority

CHC Care Co-ordinator

- inform LA if individual has been in receipt of direct payment and inform LA of start date of PHB.

8

PHB Contract

Commissioning Manager

- PHB Contract (PHB9) is issued;
- set up account information on SBS;
- set up care package on Caretrack;
- when PHB Contract returned, update Caretrack database and scan to individual's Caretrack file.

9

Review

CHC Care Co-ordinator

- the PHB review will be held at the same time as the CHC review;
- a review will also be held when the individual's needs decrease or increase;
- completes PHB Review form (PHB10) to record how outcomes in the Care and Support Plan are being achieved;
- if care package changed email Commissioning Manager;
- sign off for the weekly cost of the PHB is the same as the CHC delegated authority limits (NHS Dorset CCG CHC Procurement Procedure).

Commissioning Manager

- completes a new Indicative Budget Sign Off Form PHB3 if there is a decrease or increase in the budget;
- issues PHB Contract (PHB9);
- update care package in Caretrack.

10

Monitoring of Budget

CHC Care Co-ordinator

- monitors accounts as part of the review process to ensure that funds are being managed appropriately;
- for individuals using an Enham holding account, quarterly returns from the holding account will be sent to the CHC Care Co-ordinator for monitoring;
- for individuals using a Prodisability holding account, quarterly returns from the holding account will be sent to the Commissioning Manager who will forward to the Care Co-ordinator;
- for individuals using their own bank account quarterly bank statements will be sent to the CHC Care Co-ordinator.

11

Ceasing Payments

CHC Care Co-ordinator

- sends letter to the individual or representative giving the reason for ceasing payments and giving notice period (PHB11) the standard notice period is 28 days but can vary according to individual circumstances;
- cease package on Caretrack.

12

Reclaiming Personal Health Budget Money

CHC Care Co-ordinator

- identifies unused funds in the individual's account and either reduces the care package in Caretrack to adjust payments or identifies money to reclaim.

CHC Finance and Information Manager

- arranges a negative onetime cost to reclaim the money. This will then automatically be coded to the correct budget.

PHB TEMPLATE LIST		VERSION
PHB1	CARE AND SUPPORT PLAN	1
PHB2	RISK ASSESSMENT FORM	1
PHB3	INDICATIVE BUDGET SIGN OFF FORM	1
PHB4	APPROVAL OF PHB ABOVE INDICATIVE BUDGET	1
PHB5	REFERRAL FORM	1
PHB5a	PRODISABILITY HOLDING ACCOUNT REFERRAL FORM	1
PHB6	LTR ADVISING BUDGET.DORCHESTER	1
PHB6	LTR ADVISING BUDGET.POOLE	1
PHB7	AGREED BUDGET CONFIRMATION SLIP.DORCHESTER	1
PHB7	AGREED BUDGET CONFIRMATION SLIP.POOLE	1
PHB8	BANK ACCOUNT DETAILS FORM.DORCHESTER	1
PHB8	BANK ACCOUNT DETAILS FORM.POOLE	1
PHB9	CONTRACT	1
PHB10	PHB REVIEW FORM	1
PHB11	LTR CEASE PAYMENTS.DORCHESTER	1
PHB11	LTR CEASE PAYMENTS.POOLE	1
	YOUR WORKBOOK	1

PHB1

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

EXAMPLE	e.g. elimination: urine I require assistance to access the toilet (or commode) each time.	I will require support by a carer to access the toilet 5 times per day and once overnight.	6 X 5 mins = 30 mins X 7 days =	I will have been able to maintain my continence.
1.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**

PHB1

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

2.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**
3.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**

PHB1

NHS
Dorset
Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

4.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**
5.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**

PHB1

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

6.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**
7.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**

PHB1

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

8.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**
9.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**

PHB1

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

10.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**
11.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**

PHB1

NHS
Dorset
Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

12.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**
13.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**

PHB1

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

14.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**
15.	**IDENTIFIED HEALTH/CARE NEED**	**NEEDS TO BE MET BY THE FOLLOWING ACTIONS**	**RESOURCE NEEDS/WEEK**	**OUTCOME INDICATORS**

PHB1

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET – CARE AND SUPPORT PLAN

NAME:		**ADDRESS:**	
DATE OF BIRTH:			
DATE OF PLAN:			
COMMENCEMENT DATE:		**REVIEW DATE:**	

16.	IDENTIFIED HEALTH/CARE NEED	NEEDS TO BE MET BY THE FOLLOWING ACTIONS	RESOURCE NEEDS/WEEK	OUTCOME INDICATORS

CARE AND SUPPORT PLAN COMPLETED BY:-

NAME	POSITION/QUALIFICATION OR PATIENT/REPRESENTATIVE	SIGNATURE	DATE	CONTACT TEL NO.

NHS
Dorset
Clinical Commissioning Group

PERSONAL HEALTH BUDGET RISK ASSESSMENT PHB2							
NAME:		**NHS NO:**		**DATE OF BIRTH:**			
IDENTIFIED RISK		**MITIGATION AGAINST RISK**		**ACCEPTABLE RISK**			
Clinical:							
1			Yes		No		
2			Yes		No		
3			Yes		No		
Financial:							
4			Yes		No		
5			Yes		No		
6			Yes		No		
Reputational:							
7			Yes		No		
8			Yes		No		
9			Yes		No		
Other:							
10	Adult/Child Protection		Yes		No		
11	Mental Capacity		Yes		No		
12			Yes		No		
Providers to be used:							
13			Yes		No		
14			Yes		No		
15	Personal Assistants:	Ensure that DBS checks are taken up.	Yes		No		
		Ensure public liability insurance is in place.	Yes		No		
		Ensure training arrangements are in place.	Yes		No		
		Referral to support services (if required).	Yes		No		

NHS
Dorset
Clinical Commissioning Group

PERSONAL HEALTH BUDGET RISK ASSESSMENT PHB2						
NAME:		**NHS NO:**		**DATE OF BIRTH:**		

Contingency procedure:	Yes		No	
If yes please give details:				

Additional steps to be taken:	Yes		No	
If yes please give details:				

Signature:		**Print Name:**	
Designation:		**Date:**	

PHB 3 **DORSET CLINICAL COMMISSIONING GROUP**

INDICATIVE BUDGET SIGN OFF FORM

Patient for PHB			
Type of care required	**No of hours per day**	**No of days per week**	**Total hours per week**
		7	0
		7	0
		7	0
		7	0
			0
		Per Week	**Per Year**
Basic Package of care costs		**£0.00**	**£0.00**
Mileage	**No of visits per day**	**No of days per week**	**Total per week**
		7	0
			0
			0
		per week	**per year**
		£0.00	**£0.00**
Extras			
			£0.00
			£0.00
			£0.00
			£0.00
		per week	**per year**
		0.00	**0.00**
Total Annual Cost			**£0.00**

Respite Package			
Type of care required	**total hours per week**	**Cost Per Week**	**cost for 52 weeks**
Respite Package		£0.00	£0.00
Mileage for respite x 20			£0.00
		Total per annum	**£0.00**
		Total per weekly for total package	**£0.00**

Authorised Signature:	
Print Name:	
Job Tile:	
Date:	

NHS
Dorset
Clinical Commissioning Group

PHB4

APPROVAL OF PHB ABOVE INDICATIVE BUDGET

PROPOSER:	
NAME OF INDIVIDUAL:	
LEAD MANAGER:	
DATE:	

SPECIFIC CARE ISSUES

COMMISSIONING INPUT

CARE HOME OR DOMICILIARY PROVIDER

NHS
Dorset
Clinical Commissioning Group

PHB4

PRICE AND FINANCIAL IMPACT

JUSTIFICATION FOR REQUEST

APPROVAL

*APPROVED/REJECTED	
PRINT NAME:	
SIGNATURE:	
DATE:	
COMMENTS:	
FURTHER ACTION:	

PHB5

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET REFERRAL FORM

Please complete the form (all parts in sections one, two and three) and send it to the chosen provider by email or fax. The contact details are shown at the end of the form.

Once the referral form has been received, a support worker will be allocated within 5 working days.

1.	DETAILS OF PERSON INTERESTED IN OR ALREADY USING A PERSONAL HEALTH BUDGET

NAME:	
PHB REF:	**DATE OF BIRTH:** DD/MM/YYYY
ADDRESS:	**CONTACT TELEPHONE NUMBER/S:**
	EMAIL:

PRIMARY CONTACT IF DIFFERENT FROM ABOVE	
PRIMARY CONTACT ADDRESS IF DIFFERENT FROM ABOVE:	**PRIMARY CONTACT TELEPHONE NUMBER/S IF DIFFERENT FROM ABOVE:**
	PRIMARY CONTACT EMAIL ADDRESS *IF DIFFERENT FROM ABOVE:*
START DATE OF RECEIVING PERSONAL HEALTH BUDGET: DD/MM/YYYY	**NOT APPLICABLE** ☐
DATE FINANCIAL ASSESSMENT COMPLETED: DD/MM/YYYY	**NOT APPLICABLE** ☐

PHB5

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET REFERRAL FORM

2.	REFERRAL DETAILS	
NAME OF PERSON MAKING REFERRAL:		
ADDRESS:		**CONTACT TELEPHONE NUMBER/S:**
		EMAIL:
RELATIONSHIP WITH PERSON NAMED IN SECTION 1:		

REFERRAL INFORMATION		
IS THIS REFERRAL NEW OR A RE-REFERRAL	NEW ☐	RE-REFERRAL ☐
DOES THE PERSON HAVE A COMPLETED CARE AND SUPPORT PLAN	YES ☐	NO ☐
IS THE PERSON CURRENTLY RECEIVING DIRECT PAYMENTS	YES ☐	NO ☐
DOES THE PERSON HAVE AN AGREED CARE PACKAGE	YES ☐	NO ☐

REASON FOR REFERRAL		
THE PERSON WOULD LIKE TO KNOW MORE ABOUT HOW THEY COULD USE A PERSONAL HEALTH BUDGET	YES ☐	NO ☐
THE PERSON IS CONSIDERING EMPLOYING A PERSONAL ASSISTANT AND WOULD LIKE TO FIND OUT WHAT THIS WOULD INVOLVE.	YES ☐	NO ☐
THE PERSON WOULD LIKE TO KNOW MORE ABOUT PAYROLL SUPPORT	YES ☐	NO ☐

THE PERSON HAS INDICATED THEY WILL USE AN AGENCY OR A BUSINESS OPERATED BY SELF EMPLOYED PERSON.	YES ☐	NO ☐
THE PERSON HAS LIMITED CAPACITY TO AGREE TO OR MANAGE A PERSONAL HEALTH BUDGET AND REQUIRES SUPPORT TO SEE IF THERE IS A WAY THEY CAN RECEIVE A PERSONAL HEALTH BUDGET I.E. VIA A SUITABLE PERSON, INDEPENDENT LIVING TRUST, SUPPORT PLANNING.	YES ☐	NO ☐
A SUITABLE PERSON HAS BEEN IDENTIFIED	YES ☐	NO ☐
THE PERSON HAS AN INDEPENDENT LIVING TRUST	YES ☐	NO ☐
THE PERSON HAS / REQUIRES A HOLDING ACCOUNT	YES ☐	NO ☐
THE PERSON APPEARS TO BE FINDING IT DIFFICULT TO ORGANISE SERVICES OF AN ADEQUATE STANDARD TO MEET THEIR ELIGIBLE ASSESSED CARE NEEDS.	YES ☐	NO ☐
OTHER?	YES ☐	NO ☐
	IF YES, PLEASE DESCRIBE	

SAFETY

ARE THERE ANY SAFEGUARDING ISSUES THE PROVIDER SHOULD BE AWARE OF?	YES ☐
	NO ☐
	IF YES, PLEASE DESCRIBE

IF THIS IS NOT ANSWERED A REFERRAL WILL NOT BE ACCEPTED

PHB5

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET REFERRAL FORM

THE DP SUPPORT WORKER MAY NEED TO VISIT THE PERSON AT THEIR HOME. PLEASE PROVIDE DETAILS OF ANY ANIMALS, PEOPLE OR ENVIRONMENTAL ISSUES THAT MAY POSE A RISK TO THE HEALTH OR SAFETY OF THE PROVIDER'S STAFF.
IF THIS IS NOT ANSWERED A REFERRAL WILL NOT BE ACCEPTED

COMMUNICATION

HOW WOULD THE PERSON LIKE TO BE COMMUNICATED WITH?	FACE TO FACE	☐	TELEPHONE	☐
	EMAIL	☐	OTHER	☐
	DO NOT WISH TO DISCLOSE	☐	*PLEASE DESCRIBE*	

PLEASE ENSURE THAT THE PERSON'S CONTACT DETAILS ARE COMPLETED

3. ASSESSMENT DETAILS

PLEASE PROVIDE BRIEF DETAILS OF SUPPORT REQUIRED AND DURATION E.G. PERSONAL CARE EACH WEEK.	PLEASE SEE ATTACHED CARE PLAN
PLEASE PROVIDE DETAILS OF WEEKLY BUDGET ALLOCATION.	
PRINT NAME OF REFERRER	TITLE
DATE OF FORM'S COMPLETION	DD / MM / YYYY

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET REFERRAL FORM

4.	EQUAL OPPORTUNITIES (This information may be used by the provider and Dorset Clinical Commissioning Group for monitoring purposes only)

GENDER AND SEXUAL ORIENTATION MONITORING				
GENDER	MALE	☐	TRANSGENDER	☐
	FEMALE	☐	DO NOT WISH TO DISCLOSE	☐

DISABILITY MONITORING				
DOES THE PERSON HAVE A DISABILITY, IMPAIRMENT, OR LONG-TERM HEALTH CONDITION?			YES	☐
			NO	☐
			DO NOT WISH TO DISCLOSE	☐
IF YES, WHAT IS THE NATURE OF THE DISABILITY, IMPAIRMENT OR LONG-TERM HEALTH CONDITION?	PHYSICAL/MOBILITY	☐	SPEECH	☐
	LEARNING	☐	HIDDEN	☐
	MENTAL	☐	DISEASE/SYNDROME	☐
	VISUAL	☐	OTHER	☐
	HEARING	☐	PLEASE DESCRIBE	
	DO NOT WISH TO DISCLOSE	☐		

PLEASE GIVE DETAILS OF PEOPLE OR EQUIPMENT THAT HELP THE PERSON TO COMMUNICATE (IF APPLICABLE)

PHB5

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET REFERRAL FORM

ETHNICITY MONITORING				
NATIONALITY(IES)				
ETHNICITY	WHITE – BRITISH	☐	PAKISTANI	☐
	WHITE – IRISH	☐	BANGLADESHI	☐
	ANY OTHER WHITE BACKGROUND	☐	ANY OTHER ASIAN BACKGROUND	☐
	MIXED – WHITE / BLACK CARIBBEAN	☐	CARIBBEAN	☐
	MIXED – WHITE / BLACK AFRICAN	☐	AFRICAN	☐
	MIXED – WHITE / ASIAN	☐	ANY OTHER BLACK BACKGROUND	☐
	ANY OTHER MIXED BACKGROUND	☐	CHINESE	☐
	INDIAN	☐	OTHER *PLEASE DESCRIBE*	☐
	DO NOT WISH TO DISCLOSE	☐		

RELIGIOUS BELIEF MONITORING				
WHAT IS THE PERSON'S RELIGIOUS BELIEF?	AGNOSTIC	☐	JEWISH	☐
	ATHEIST	☐	MUSLIM	☐
	BUDDHIST	☐	SIKH	☐
	CHRISTIAN	☐	JAINIST	☐
	HINDU	☐	OTHER *PLEASE DESCRIBE*	☐
	DO NOT WISH TO DISCLOSE	☐		

PHB5

NHS Dorset Clinical Commissioning Group

PERSONAL HEALTH BUDGET REFERRAL FORM

5.	PERSONAL HEALTH BUDGET SUPPORT SERVICE CONTACT DETAILS
Organisation: **Enham**	
Contact number(s): **0845 5040726 / 0845 8735507 (tel)** **0845 5040 725 (fax)**	Email: **directpayments.dorset@enham.org.uk**
Organisation: **PRO Disability**	
Contact number(s): **01202723301**	Email: **info@prodisability.org.uk**
Organisation: **Dorset Advocacy**	
Contact number(s): **0300 343 7000** **01305 266853 (fax)**	Email: **enquiries@dorsetadvocacy.co.uk**
Organisation: **Penderels Trust**	
Contact number(s): **0845 6000 289/01202 862570** **01202 862571 (fax)**	Email: **dorset@penderelstrust.org.uk**
Organisation: **Agincare UK Ltd**	
Contact number(s): **01305 769418** **01305 778868 (fax)**	Email: **julia.harrison@agincare.com**

Equality Impact Assessment Form

What are the intended outcomes of this work? *Include outline of objectives and function aims* For all staff to be aware of process of governance in place for the management of Personal Health Budgets
Who will be affected? *e.g. staff, patients, service users etc.* Patients and their representatives

Evidence
What evidence have you considered?
Disability *Consider and detail (including the source of any evidence) on attitudinal, psychological and social barriers.* **This may be relevant and mental capacity will be assessed if required**
Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).* **Not relevant**
Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.* **There is an element of choice within this process. Individual needs are taken in to account when the care plan is agreed**
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.* **Consent and safeguarding are all part of the risk and assessment process**
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.* **Consent and choice are part of the assessment process**
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.* **There is an element of choice within this process. Individual needs are taken in to account when the care plan is agreed**
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.* **There is an element of choice within this process. Individual needs are taken in to account when the care plan is agreed**
Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*

There is an element of choice within this process. Individual needs are taken in to account when the care plan is agreed
Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.* **There is an element of choice within this process. Individual needs are taken in to account when the care plan is agreed**
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.* **There is an element of choice within this process. Individual needs are taken in to account when the care plan is agreed**

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

Not applicable

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.*

None

Name of person who carried out this assessment: **Mel Fish**
Date assessment completed: 07/02/2014
Name of responsible Director: Director of Service Delivery
Date assessment was signed: 07/02/2014