NHS
Southend
Clinical Commissioning Group

NHS Funded Care Team Joint Operational Policy

SCCG QP10

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Responsible Officer	Head of NHS Funded Care
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Equality Impact Assessment	This document has been assessed for equality impact on the protected groups, as set out in the Equality Act 2010. This Policy is applicable to the Board, every member of staff within the CCG irrespective of their age, disability, sex, gender reassignment, pregnancy, maternity, race (which includes colour, nationality and ethnic or national origins), sexual orientation, religion or belief, marriage or civil partnership, and those who work on behalf of the CCG

Contents

1 Introduction

This operational policy sets out the key standards, principles and processes for NHS Continuing Healthcare and NHS funded care e.g. neuro rehab/D2A in Castle Point & Rochford CCG (CP&R) and Southend CCG. It is built on the cornerstones of partnership and collaboration with the public and our health and social care partners across the region. As a policy, it provides clear guidance and outlines the Clinical Commissioning Group (CCG) and the Local Authority's (LA) statutory responsibilities for delivering NHS Funded Care; including NHS Continuing Healthcare and NHS Funded Nursing Care (FNC). The policy sets out the roles, eligibility and responsibilities for health and social care staff in the delivery of the National Framework for NHS Continuing Healthcare & NHS funded-nursing care (2018)

This policy describes the processes that will be followed in CP&R & Southend CCG's and should be read in conjunction with other supporting documents, including:

- The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (DoH, 2018, revised)
- NHS Continuing HealthCare Practice Guidance
- Who pays? Establishing the Responsible Commissioner (DoH 2013)
- The National Health Service Commissioning CCG and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013
- National Framework for Children and young People's Continuing Care (DoH 2016)
- Essex-wide policies; including Disputes policy, Children & Young People's Continuing Care policy, Without Prejudice etc.

This Policy will also give assurances to the CCG Quality and Finance Committee, Governing Body and NHS England on how the National Framework for NHS Continuing Healthcare is being implemented locally.

2 Purpose and scope

This policy sets out the roles, eligibility and responsibilities for health and social care staff for the delivery of the National Framework for NHS Continuing HealthCare & NHS funded-nursing care within the South-East Essex.

It provides the process for determining eligibility for CHC funding and the procedures to be followed. The policy also sets out the responsibilities of CCG in those situations where eligibility for NHS CHC has not been agreed, and for the management of situations that may arise as a result of NHS CHC eligibility decisions.

The policy describes the way in which will commission care in a manner that supports patient choice and preferences, whilst balancing the requirement to provide best value for money commissioning.

This policy applies to all NHS Funded care applications for adults 18 years or older who are registered with a General Practice in South-East Essex or who are resident within the area covered by CP&R and Southend CCG's and are **not** registered with a General practitioner elsewhere. This includes all care groups including:

- Physically Disabled
- Older People
- Learning Disabilities
- Young people in transition
- People with an organic mental health condition
- Functional Mental Health
- Acquired Brain Injury

These procedures do not apply to:

Children (below age 18)

3 Definitions

Continuing care	Care provided outside of a hospital to patients with long-term health or social care needs; may include joint health and social care funding.
NHS Continuing HealthCare (CHC)	A package of Health and Social Care provided and solely funded by the NHS
NHS Funded Care	Care funded by the NHS to meet Rehabilitation or Convalescence or Discharge needs in advance of a formal NHS CHC assessment.
Care packages	Suite of intervention services (nursing, therapies, home care etc.) that are designed to match the assessed needs of a client/patient.
Care plan	Plan drawn up by a clinician/Carer to meet the needs of a patient/client, centered on the DST outcomes, which establishes the Primary health needs, NHS Funded Care Team to monitor quality of care.
Health Needs Assessment HNA	An assessment undertaken by a registered Nurse, that identifies individual patient needs, including issues, frequency and stability. The output of a HNA can be used to inform Care Planning.
CHC Checklist	A standardised National Tool used to identify whether someone's needs warrant consideration against the eligibility criteria, or not. A positive Checklist outcome does not indicate CHC eligibility, but that the person has some level of need, which warrants a formal assessment against the eligibility criteria.
Decision Support Tool (DST)	A standardised National tool used by clinicians to collate the needs of a patient. The outcome of the Decision Support Tool is used to consider the eligibility of a client/patient to a NHS funded package.
CHC Panel	A Panel of Health & Social Practitioners, coordinated by the CCG, that review the MDT recommendations of eligibility for CHC funding, based on the Decision Support Tool and the overall assessed level of need. The panel may invite a family representative to join the panel in an advisory capacity. This panel will be arranged when required; it is anticipated that most issues should be resolved prior to this level of escalation.
Case manager/ Nurse Assessor	An NHS employed registered nurse to coordinate drawing-up a care plan; monitoring the needs of the clients/patients receiving a care package and assessing the suitability of the package.

4 Principles

4.1

Continuing Care means care provided over an extended period of time to a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness.
NHS Continuing HealthCare means a package of continuing care arranged and funded solely by the NHS. (National Framework for NHS Continuing HealthCare & funded- nursing care. 2012, DoH) (now the revised 2018 version)

4.2

An individual who needs "continuing care" may require services from NHS bodies and/or from Local Authorities. Clinical Commissioning Groups have responsibility to ensure that the assessment of eligibility for NHS CHC is completed within 28 days from the receipt of the CHC Checklist and in a consistent fashion.

4.3

Both CCG's and the Local Authorities are committed to working in partnership to review and monitor

these timeframes, together with local provider services.

4.4 The principles underlying this policy are that the residents of South East Essex have fair and equitable access to NHS funded care including NHS Continuing Healthcare. These principles are:-

- The CCG is required to ensure that wherever it appears that a person has care needs which are greater than would be reasonably met by a Local Authority, it should consider NHS funded care; this could be delivered via a bespoke commissioned service; such a s rehabilitation, or convalescence, and in all cases, where it might appear that someone might be required to contribute towards the cost of their care, the NHS is required to demonstrate it has first considered and excluded NHS funded Continuing Healthcare.

- The individual's informed consent will be obtained before starting the process to determine eligibility for NHS Continuing Healthcare.

- If the individual lacks the mental capacity either to refuse or consent, a 'best interests' decision should be taken and recorded in line with the Mental Capacity Act 2005 as to whether to proceed with assessment for eligibility for NHS Continuing Healthcare. A third party cannot give or refuse consent for an assessment of eligibility for NHS CHC on behalf of a person who lacks capacity, unless they have valid and applicable Lasting Power of Attorney for Welfare or have been appointed as a Deputy by the Court of Protection for Welfare only. Both CCG's will act in the best interest of the individual and convene best interest meeting if there is a dispute and no one has power of attorney.

- The NHS Funded Care Team will work in partnership with individual patients, their families and social care professionals, throughout the process.

- All individual patients and their representatives will be provided with information to allow them to participate in the process, as much as is practicable. However, where there is a clinical need, the need for review/assessment will take precedence over representative availability.

- Both CCG's will support the use of advocacy for individuals through the process of application for NHS Continuing Healthcare, as in other services where advocacy is required.

- The process and mechanism for making decisions about eligibility for NHS CHC will be clearly set out for individual patients and their representative and for partner agencies.

- Once an individual has been referred for a full assessment for NHS Continuing Healthcare, following the completion of a Checklist, all assessments will be undertaken ensuring, as much as possible, a comprehensive multi-disciplinary assessment of an individual's health and social care needs.

- Assessments and decision making about eligibility for NHS CHC will be undertaken within 28 days of the completion of the CHC Checklist to ensure that individuals receive the care they require in the appropriate environment and without unreasonable delays.

- Both CCG's are working towards individuals being discharge under the Discharge –to-Assess (D2A) pathway. This is ongoing and we acknowledge that for patient that fall under the Southend Local Authority, Checklists are being completed prior to discharge. The next stage of the process (the 'Decision Support Tool'), full assessments in all but exceptional circumstances will take place outside of the acute trust. This will maximise the independence and well-being of the individual before going through the full assessment process.

- The D2A model once fully implemented will support the assessments being processed in the community. This will then reduce/stop the Decision Support Tool being completed in the hospital.

5 Procedures

5.1 Eligibility for NHS Continuing HealthCare (CHC)

The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (revised, 2018) provides a consistent approach to establishing eligibility for NHS Continuing Healthcare. This is achieved through the use of the revised National Tools and Guidance developed to assist in making decisions about eligibility for continuing healthcare.

As a result of the Coughlan Judgment (1999) and the Grogan Judgment (2006), under the National Health Service Act 2006, the Secretary of State has developed the concept of a "primary health need" to assist in deciding which treatment and other health services it is appropriate for the NHS to provide under NHS Continuing Healthcare.

Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality. Where a person is identified as having a "primary health need", they are considered to be eligible for NHS Continuing Healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs from the assessment process. Where an individual has a primary health need, the NHS is responsible for providing all of the care to meet that need, including accommodation, if that is part of that need.

Consideration of primary health need includes consideration of the characteristics of need and their impact on the care required to manage the needs. In particular to determine whether the quantity or quality of care is more than the limits of responsibility of Local Authorities (as in the Coughlan Judgment).Consideration is given to the following areas:-

- **Nature and type of need:** the particular characteristics of an individual's needs and the overall effect of those needs on the individual, including the type of interventions required to manage them
- **Intensity of need:** both extent (quantity) and severity (degree) of the needs, including the need for sustained care (continuity)
- **Complexity of need:** how the needs present and interact to increase the skill required to monitor and manage the care. This may arise with a single condition or the interaction between numbers of conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs
- **Unpredictability of need:** the degree to which needs fluctuate, creating difficulty/challenges in managing the need. It also relates to the level of risk to the person's health if adequate and timely interventions/care are not provided

To minimise variation in interpretation of the principles and to inform consistent decision making, the NHS CHC Decision Support Tool has been developed for use by practitioners to obtain a full picture of needs and to indicate the level of need that could constitute a primary health need. The Decision Support Tool combined with the practitioners own experiences and professional judgment should enable them to apply the primary health needs test in practice in a way which is consistent with the limits on what can be legally provided by a Local Authority.

Eligibility for NHS CHC is based on an individual's assessed health and social care needs. The Decision Support Tool provides the basis for decisions on eligibility for NHS funded continuing healthcare. The Decision Support Tool must be completed by the multi-disciplinary team, which as a minimum should include a health professional and a social care practitioner, or two healthcare practitioners from different specialties. Wherever possible, Social care staff should be involved in the completion of the Decision Support Tool. Specialist staff and mental health staff should also be involved, dependent on the individual's needs.

The multi-disciplinary team will make recommendations on eligibility of the individual patients/clients. The CCG will consider the MDT recommendation and can make the following decisions with regard to

recommendations about eligibility for NHS Continuing Healthcare:-

5.2 Application for eligibility process

The first step in the process for the majority of people will be the screening process using the NHS CHC Checklist. The purpose of the Checklist is to encourage proportionate assessments so that resources are directed towards those people who have a higher level of need and therefore may be eligible for NHS Continuing Healthcare.

Before applying the Checklist, it is necessary to ensure that the individual and their representative, where appropriate, understand the Checklist cannot identify that the individual will be eligible for NHS Continuing Healthcare, only that they are entitled to consideration for eligibility. At this stage, the threshold is set deliberately low to ensure that all those who require a full consideration of their needs get the opportunity.

A nurse, doctor or other qualified healthcare professional or social care practitioner can apply the Checklist to refer individuals for a full consideration of eligibility from within the community or hospital setting. Whoever applies the Checklist will have to be familiar with, and have regard to, the National Framework for NHS Continuing HealthCare revised 2018 & NHS funded- care (DoH 2012) and the Decision Support Tool.

All appropriately completed NHS CHC Checklist with a consent or MCA and best interest assessment, should be sent to the NHS Funded Care Team at:

Castle Point & Rochford NHS Funded Care Team, Castle Point & Rochford CCG, 12 Castle Road, Rayleigh SS6 7QF
Secure email: cprccg.chc@nhs.net

Southend NHS Funded Care Team, Civic Centre Southend-On-Sea

Secure email: SCCG.southendCHC@nhs.net

The NHS Funded Care Team currently operates Monday to Friday only; 09.00-17.00.

Receipt of the completed Checklist and consent is the start of the 28 day target for eligibility decisions and will ensure that monitoring of timelines and activity takes place.

In a hospital setting, the Framework indicates that rather than completing a Checklist a decision is made to provide interim NHS-funded services to support the individual after discharge. It is preferable for eligibility for NHS Continuing Healthcare to be considered after discharge from hospital.

Local protocols are in place to set out a clear pathway in relation to discharge from hospital. Following the discharge we ensure that there is an appropriate system in place to undertake a screening for NHS Continuing Healthcare using the Checklist.

If an individual's needs reduce in a short time frame between a positive Checklist and a full assessment of eligibility taking place, it is legitimate to undertake a second Checklist, rather than necessarily proceeding to full assessment of eligibility for NHS Continuing Healthcare. The individual should be kept fully informed of the changed position.

If completion of the screening Checklist indicates that the individual patient is entitled to a full assessment to determine their eligibility for NHS funded continuing healthcare, a health needs assessment and care plan should be undertaken to inform the completion of the Decision Support Tool.

The completed Decision Support Tool provides practitioners with a framework to bring together and record the various needs in the 'domains' specified within the tool. The multi-disciplinary team use the Decision

Support Tool to apply the primary health needs test, ensuring that the full range of factors which have a bearing on the individual's eligibility are taken into account in making their recommendation.

5.3 Fast Track Applications

The Fast Track application is there to ensure that individuals who have a "**rapidly deteriorating condition,** which may be entering a terminal phase" get the care they require as quickly as possible. No other test is required.

The National Framework for NHS Continuing HealthCare revised 2018 provides the Fast Track Tool for use in these circumstances. The Fast Track Tool needs to be completed by an 'appropriate clinician' described in the National Framework as:

"Someone responsible for an individual's diagnosis, treatment or care, as a registered medical practitioner, or registered nurse". These can include senior clinicians employed in the voluntary and independent sectors that have a specialist role in end of life needs and are appropriately trained to complete the fast track tool and that they are organisations services commissioned by the NHS".

The completed Fast Track Tool should clearly state the patient's **diagnosis, prognosis and current condition**, as this will enable approval to take place immediately upon receipt of the document.

Others involved in supporting those with end of life needs, including those in the voluntary and independent sector organisations may identify the fact that the individual has needs for which use of the Fast Track Tool would be appropriate. They should contact the appropriate clinician.

Both CCG's support the direct involvement of hospital staff in this process to ensure the timely discharge for these patients, supporting end of life care decisions and providing clear accountability for decision making.

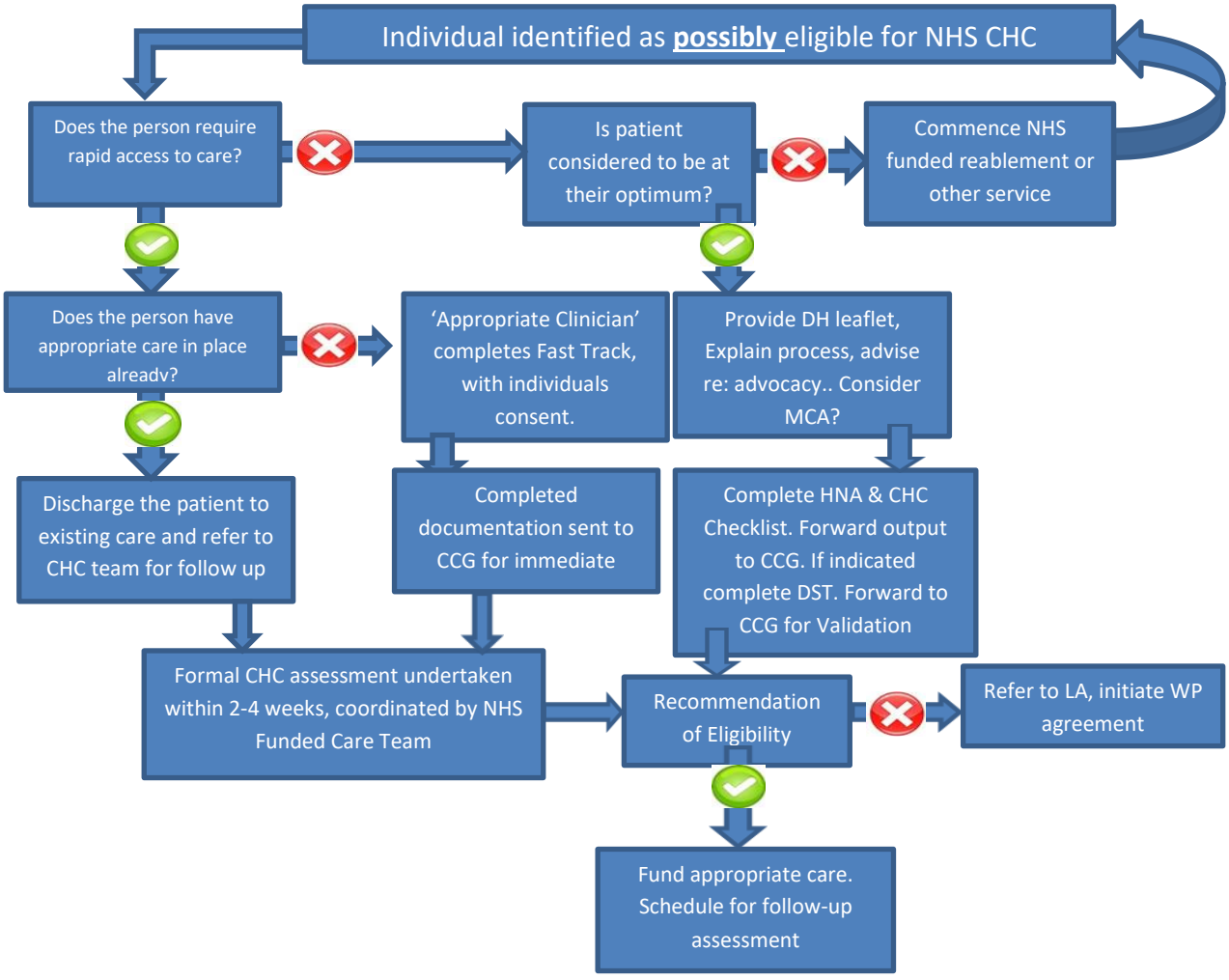
Once this has happened, it will be important to review an individual's care needs and the effectiveness of the care arrangements. In doing this, there may be certain situations where the needs indicate that it is appropriate to review eligibility for NHS Continuing Healthcare. CCGs should make any decisions about reviewing eligibility in Fast Track cases with sensitivity.
A CHC Case Manager/Nurse Assessor should consider a follow-up review to ensure that the provided care is meeting the identified needs. Where the nature of provided care does not appear to indicate a primary health need, a formal CHC assessment will be considered.

The procedure for Fast Track applications covering Monday to Friday is set out in (Appendix 3) and ensures that same day decisions about eligibility for NHS funded CHC can be made to support the preferred priorities of the individual for their end of life care, where possible. For patients discharged from hospital over the weekend under the Fast Track guidance the NHS Funded Care Team will require the fully completed Fast Track Tool on the next working day.

Do we need to put something in here about the delegated Hospital discharge?

Use of Fast Track applications will be closely monitored and action taken where improper use of the process is felt to have occurred.

5.4 **REFERRAL AND PROCESS FLOWCHART**



6 Management of Appeals

6.1
The decisions of CCG's are communicated to the individual patients, or their representative, in writing and to lead health and social care professionals making the application. The decision is communicated in writing within 48 hours of the validation. The patient, or their representative, and the lead health and social care professionals making the application can be informed verbally of the decision, if they have not been present and pending receipt of the formal correspondence.

6.2
Where an application has been recommended to be not eligible, individual patients can appeal the decision in writing within 6 months of the notification of eligibility decision. A request for an appeal can only be made once the recommendation has been validated by CCG. The decision will remain unchanged until such time as it is overturned.

When an appeal is received this is acknowledged (see appendix 7) and the evidence is reviewed by a Senior Lead Nurse and if the appeal cannot be resolved at this stage an offer of an informal resolution meeting with the individual patient or their representative is made to go through the process of decision and rationale for the decision.

Appeals in the first instance should be sent to:-

NHS Castle Point & Rochford CCG
NHS Funded Care Team
Pearl House
12 Castle Road
Rayleigh
Essex SS6 7QF

Email: cprccg.chc@nhs.net

NHS Southend CCG
NHS Funded Care Team,
Civic Centre, 6th Floor
Victoria Ave
Southend-On-Sea
SS2 6ER

Secure email: SCCG.southendCHC@nhs.net

If, as a result of the Local Resolution process the decision is overturned, NHS funding will normally be back dated to the date of the DST recommendation.

- Any refund will be in line with the Refunds Guidance incorporated in The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care, 2012.
- A copy of this procedure will be sent to all those who wish to challenge a decision regarding eligibility.

6.3
If following informal resolution the patient or their representative remains unhappy with the CCG's decision, a hearing will be arranged of the Local Review Panel. The members of the Review Panel will not have been involved with the initial decision makers that reviewed the eligibility application.

6.4
The individual patient, or their representative, will be invited to submit evidence as to why they disagree with the CCG's decision and to specify those areas of disagreement. Families and individuals are encouraged to attend Local Review Panel meetings to participate in the discussions.

6.5
Where an individual remains dis-satisfied by the Panel outcome they can request an Independent Review by writing to the NHS Commissioning CCG at:

NHS England Midlands and East
Victoria House Capital
Park Fulbourn
Cambridge CB21 5XB

Tel: 0113 825 5320

The Independent Review (IR)'s key tasks are, at the request of the CCG, to conduct a review of the following:

a) The procedure followed by a CCG in reaching a decision as to that person's eligibility for NHS Continuing Healthcare; or
b) The application of the primary health needs decision by a CCG.

They are also required to make a recommendation to the CCG in the light of its findings on the above

matters. It is particularly important that, before an IR is convened, all appropriate steps have been taken by the relevant CCG to resolve the case informally, in discussion with the CCG where necessary. The CCG should have a named contact, which is the first port of call for queries from partner organisations for the relevant locality.

No individual should be left without appropriate support while they await the outcome of the review. The eligibility decision that has been made is effective while the independent review is awaited.

6.6
The CCG will continue to fund the package of care pending the outcome of the Local Review Panel, or sooner, if the complainant is unable to agree to attend the panel within a reasonable time frame. If the CCG decision is upheld and the patient is deemed no longer eligible for NHS CHC funding, the CCG will cease funding care within a 28 days' notice period from the date of the decision letter.

6.7
The Local Authorities and their employees are not able to appeal against a decision made by NHS Funded Care Team on behalf of a client. Appeals may only be made by individual applicants themselves or their representative. If the LA's disagrees with the CCG outcome, they should use the jointly agreed **Continuing Healthcare Disputes Agreement**.

7 Complaints

If an individual patient or their representative is dissatisfied with the manner in which the overall process has been conducted rather than specifically the outcome regarding eligibility for NHS Continuing Healthcare, they may make a complaint to the CCG through the NHS Complaints Procedure.

Complaints should be sent to:-

CCG Complaints Manager NHS
Castle Point & Rochford CCG
Pearl House
12 Castle Road
Rayleigh
Essex SS6 7QF

Email: cprccg.complaints@nhs.net

8 Disputes:

8.1
If a dispute arises between NHS Funded Care Team and a Local Authority this should not delay the provision of the care package. The funding of the care package should rest with the current funding agency until the dispute is resolved.

8.2
The disputed case will be reviewed by CCG and the Local Authority will be informed of the outcome.

8.3
Should the Local Authority not agree with the decision made by CCG then the case will be escalated and reviewed by two line managers (usually senior social workers/senior clinicians) from the CCG and the Local Authority. A decision regarding eligibility will be agreed at this stage but in *exceptional* circumstances, the Director for Adult Social Care can escalate to the Chief Nurse and the use of the Continuing Healthcare

Disputes Agreement Policy can be evoked for Disputes with Essex County Council. Southend Borough Council have their own Disputes policy in the event of a dispute with them.

8.4
If an appeal is received at the same time from the individual or family member, then the appeals process will take precedence as there is further recourse by the individual/family for Independent Review/Ombudsman.

8.5
Agree to adopt a **"without prejudice"** approach to such situations whereby the final outcome of the dispute will be backdated to the time of the date of disputed Decision Support Tool. **(Annex F: Guidance on responsibilities when a decision on NHS CHC eligibility is awaited or is disputed, National Framework 2018)**. This means if LA has continued to fund an arrangement that was subsequently decided to be NHS Continuing Healthcare, The CCG funding should be backdated to the date of the DST recommendation and the individual should also be reimbursed any charges that they have paid during the interim period.

8.6
Similarly, where the CCG has continued to fund an arrangement that subsequently is decided to have been a Local Authority responsibility, The Council will reimburse the CCG to the date of CHC recommendation.

9 Previously un-assessed periods of care – PUPoC.

9.1
The CCG can only consider requests for retrospective reviews where it is satisfied that one or more of the following grounds for the review exist:

- The CCG, or local NHS or Local Authority providers failed to carry out an assessment of the claimant's eligibility for NHS CHC funding when requested to do so.
- Family request for a retrospective review for periods of un-assessed care.
- Requests for the period 1/04/2004 - 31/03/12 are no longer accessible, following the NHS England 'Closedown'.
- If alive, the patient can make a request via a questionnaire or their representative who holds LPA (registered with the Court of Protection). If patient deceased the CCG will need evidence they are executor or named within the deceased person's will.

9.2
If an individual, or the person representing them, feels that they could have met the eligibility criteria for NHS Continuing Healthcare whilst they paid for care, then in those cases, it would be normal for an application for a retrospective review of health needs to be made.

9.3
On receipt of a retrospective review request the CCG will establish if they are the 'Responsible Commissioner' for the individuals care and if confirmed the CCG will review the request for a retrospective review.

9.4
If it is agreed that the retrospective review will be undertaken the CCG will implement the process for assessing eligibility retrospectively.

9.5
The CCG will initially ascertain if the individual requesting the retrospective review has the authority to do so and can provide financial information to confirm that the individual or their representative have contributed towards their care.

9.6
The CCG will gather and scrutinise all available evidence, which will include all the patient's health and social

care records for the appropriate timeframes of the case, together with any evidence submitted by the individual or their representative.

9.7
Where relevant documentation is for some reason not available, a record must be made of all attempts to obtain that documentation.

9.8
The CCG will compile a robust and accurate Needs Portrayal for each timeframe of the case. When complete the individual or their representative will be involved as far as possible in building the Needs Portrayal.

9.9
Following agreement of the Needs Portrayal the completed document will be reviewed by the MDT and a recommendation made to the CCG regarding the eligibility of the individual for all, part or none of the review period.

9.10
A decision letter and copy of the Decision Support Tool will set out the rationale for agreeing/ refusing the claim, explaining in appropriate detail why individual under review did or did not meet the eligibility for NHS Continuing Healthcare.

9.11
If the individual or their representative disagrees with the outcome of eligibility they will be informed how to appeal and this will follow the appeal process for current assessments.

9.12
If the individual is eligible for all or part of the review period, the CCG will reimburse the patient or their estate for any monetary loss they incurred as a consequence of having to pay for the individuals care.

9.13
NHS Continuing Healthcare Refreshed Redress Guidance – See appendices 8

10 Commissioning of Care Packages

10.1
It is the responsibility of both CCG's to:

- Plan strategically
  - Monitor trends with provision and to plan in order to ensure sufficient appropriate resources continue to be available
- Specify outcomes
  - Placement contracts will have key performance indicators, based on patient centered approach which maximises their potential.
- Procure services
  - Commissioned services will adhere to procurement guidelines and reflect strategic planning requirements.
- Manage demand
  - Monitor volume and nature of requests, to ensure that there are sufficient in-house resources to manage demand
  - Develop a training programme to support other Health or Social Care Practitioners to help to support a standardised approach to CHC assessment and processes.
- Manage provider performance for all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare

- Arrange for periodic reviews of provider activity, outcomes and achievements
- Undertake periodic patient focused audit, to gauge the quality of provided services
- Liaise with Adult Social Care (ASC) contract management colleagues

- Manage provider performance for the healthcare component of joint packages of care.
  - Arrange for periodic reviews of provider activity, outcomes and achievements

10.2
The services commissioned will include on-going case management, by a designated named CHC Case Manager/Nurse Assessor, for all those entitled to NHS Continuing Healthcare, as well as for the NHS elements of joint packages of care, including the assessment and review of individual patient needs.

10.3
The CCG's take a strategic as well as an individual approach to fulfilling their NHS CHC commissioning responsibilities within the context of quality, innovation, prevention and productivity agenda. (QIPP)

10.4
Care packages will be commissioned from care homes, domiciliary care providers and from nursing agencies, where a NHS contract is in place for CHC provision. When a care package is commissioned by the CCG, where there is no agreement in place, a spot contract purchasing arrangement will be agreed in order to ensure that there are quality standards in place to meet the requirements of the provision of NHS services.

10.5
Care will not be commissioned from those care providers where there are concerns raised about the quality of the care provided or where they are known not to meet the Care Quality Commission minimum standards for care homes. The CCG will work in partnership with Local Authorities as required, to ensure the quality of care in care homes meets the required standards.

10.6
Where concerns about standards are raised, the owners of the care home provision will be informed that commissioning arrangements for NHS funded CHC will be suspended until improvements have been made to achieve the Care Quality Commission minimum standards of care and the quality standards within the CHC spot purchasing contract. Where care is already commissioned for patients in a care setting, a risk assessment currently called 'care review' will be undertaken in partnership with the individual patient and their family to ensure appropriate controls are in place to assure the individual's safety and the quality of care provided.

11 Amenity Charges & 'Top Ups'

11.1
NHS Continuing Healthcare funding is fully funded by the NHS and therefore 'top-ups' are not possible, unlike with social care placements and care packages.

11.2
A top up can only be paid when a person is in receipt of NHS CHC as long as it is not for care. The only way that the NHS CHC package can be topped up privately is if you pay for additional private services on top of the services you get from the NHS. These private services should be provided by different staff and preferably in a different setting *e.g.* larger rooms with a sea view.

11.3
This could be called an amenity charge but in either case, the service provided must be different from the core services funded by the NHS and must be separately and privately purchased.

12 De-commissioning of care packages

12.1
Neither the NHS nor a LA should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the

proposed change of arrangement. It is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding, in order to ensure continuity of care. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If agreement between the LA and NHS cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding and care management responsibilities should remain in place until the dispute has been resolved.

The CHC service will notify the Local Authority that the patient is no longer eligible for NHS funding and may require a community care assessment. When it is agreed following assessment and recommendation by the MDT that a patient is no longer eligible for NHS CHC, NHS funding will cease from the date the DST for which the MDT recommended "no longer eligible". Without prejudice joint agreement will apply.

Any funding paid by the CCG for care while the Local Authority is setting up a care package, will be reclaimed by the CCG from the appropriate Local Authority to the date of the no longer eligible decision.

12.2
If the individual declines a community care assessment or following a community care assessment is not eligible for local authority funding e.g. because they are responsible for funding their own care, the CCG will continue to fund care costs pending a new care package being put in place by the individual/carer who will then be charged for the care costs paid by the CCG from the date of the no longer eligible decision. The CCG will fund for a maximum of 4 weeks.

13 Jointly Funded Packages of Care

13.1
The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2018, DoH) states that if a person does not qualify for NHS CHC fully funded care, the NHS may still have a responsibility to effectively contribute to that person's health needs. This is known as a 'joint package of care'. The most common way in which this is provided is by means of the Funded Nursing Care (FNC – Previously the Registered Nurse Contribution of Care – RNCC), in a nursing home setting. Practitioners should draw on their knowledge and skills regarding the assessed needs and their organisation's powers to meet them and work together to agree respective responsibilities for care provision in a joint package.

13.2
Joint packages of care may also be provided through the provision of NHS commissioned services such as Community nursing, Community Psychiatric Nurses or Community Physiotherapy, for example. A joint package of care with the Local Authority will only involve joint funding where there is a particular identified health need requiring an identified care package to be commissioned. In these circumstances the CCG will fund the care costs for the identified health element of the package. Joint packages of care can be provided in any setting as appropriate to the assessed needs of the individual.

13.3
Care should be taken to ensure that it is clearly recorded what aspect of care the NHS is funding and why, to enable any follow-up assessment is able to determine whether the joint funded aspect continues to be appropriate or requires increasing or decreasing, based upon presentation.

14 Personal Health Budgets

14.1
The CCG is required to be able to offer personal health budgets to people in receipt of NHS CHC funding, in order to give patients better flexibility, choice and control over their care. A personal health budget helps people to get the services they need to achieve their agreed health and wellbeing outcomes (agreed between the patient and clinician). Financially, personal health budgets can be managed in a number of ways, including:

• A notional budget held by the CCG commissioner

• A budget managed on the individual's behalf by a third party, and
• A cash payment directly to the individual (a 'healthcare direct payment').

14.2
Since October 2014, people in receipt of NHS CHC funding have had the right to request a personal health budget if they so choose.

14.3
People newly in receipt of NHS CHC funding for home care packages will be introduced to the concept of personal health budgets, preferably at the initial point of assessment, but certainly before or during their first CHC Review undertaken within 12 weeks. If they would like to investigate this option, based on the outcome of the individual's DST, an indicative budget will be produced and shared with the patient during an introductory meeting to explain the personal health budget process. The CHC Case Manager/Nurse Assessor supported by the CCG Business Manager will then liaise with the patient to fully consider this option.

14.4
The CHC Case Manager/Nurse Assessor, or other commissioned organisation, will work with the individual and/or their carer or representative(s) to agree health and wellbeing outcomes. They will then also work with the individual to think creatively about how they could best make use of their available budget to meet their health and wellbeing outcomes.

14.5
The CHC Case Manager/Nurse Assessor or other commissioned organisation will then create a final budget and care plan which will be reviewed by the CCG. Going forward, the approval will be carried out by a Lead Nurse, unless there is anything in the care plan which suggests an unacceptable risk to the patient, an unacceptable financial risk, or where the final budget is greatly above or below the indicative budget. In this case, the care plan will be reviewed by the CCG. The patient and their representatives will be invited to take part in the meeting. Once a care plan has been agreed the nurse coordinator (or other commissioned organisation) will work to put the care plan in place. Support services will be provided to help people with direct payments, and support and advice will be provided for those wishing to employ personal assistants directly.

14.6
The CCG will encourage this approach when an individual who was previously in receipt of a Local Authority direct payment begins to receive NHS CHC to avoid unnecessary changes of provider or of the care package.

14.7
Since April 2016, People who are not assessed as eligible for NHS funded CHC also have the right to be considered for a Personal Health Budget. Where patients are known the CHC team with joint funded packages of care, but where CHC eligibility has not been identified, these people may now be considered for a personal Health budget; based upon their existing allocated budget as a personal health budget.

15 Choice

15.1
The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2018, DoH) states:-

"Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health and associated social care needs."

15.2

The CCG will commission the provision of NHS funded CHC in a manner which reflects the choice and preferences of individuals as far as is reasonably possible, ensuring patient safety, quality of care and making best use of resources. Cost has to be balanced against other factors in each case, such as a patient's desire to live at home. Funding decisions should be made in line with the CCG's Equity & Choice Policy. See appendix 6

16 Transition from Children's Services to Adult Continuing HealthCare Services

16.1

The National Framework for NHS Continuing HealthCare & funded-nursing care (2018, DoH) and the supporting guidance and Tools only applies to people aged 18 years or over. It is important that both the Adult and the Children's Frameworks consider transition.

- Participate in and engage where appropriate, in timely discussions with relevant Adult and Children's Services managers/commissioners regarding all proposed placements / support packages funded by Children's Services that may require Adult Services funding post 18 (for example residential school placements) prior to any formal agreements being made from 14 years of age.
- Liaise where appropriate, with relevant children and Adult Services to assist them to ensure that all necessary planning and financial negotiations are completed in good time, enabling the transition from Child to Adult Services to be as seamless as possible for all concerned.
- Liaise with Adult and Children's Services where appropriate, to assist with the prevention of any legally binding financial commitments or contractual agreements being made by Children's Services that will impact on Adult Services budgets when the person reaches eighteen without prior formal agreement from the relevant manager(s) within Adult Services eligibility criteria Consider eligibility for NHS CHC and inform Children's Services of need to initiate application process where necessary. Share information and participate in joint planning meetings such as MAP

17 Training

17.1

The NHS Funded Care Team will work towards developing training opportunities to hospital staff, community staff and adult social care staff involved in the implementation and application of the National Framework of NHS Continuing HealthCare & funded-nursing care. Training will focus the use of the National Tools, the identification of a 'primary health need', the concept of 'nursing services being considered to be ancillary and incidental to the provision of care', 'Greater than a Local Authority can be reasonably expected to provide' and the application/referral process and the timescales for completion of assessments.

17.2

All professional will need to have completed the NHSE e-learning online training before attending the training days. This knowledge and understanding needs to be undertaken before completing Checklists and being part of MDT's. See link below:

https://www.england.nhs.uk/healthcare/nhs-ch/

18 Governance

18.1

Implementation and delivery of the requirements of the National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2018 (October), DoH) will be monitored through performance reports to NHS CP&R and Southend CCG.

19. Reference

1. National Framework for NHS Continuing HealthCare & NHS funded-nursing care (October 2018) revised:

   https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf

2. The National Health Service Commissioning CCG and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

   http://www.legislation.gov.uk/uksi/2012/2996/contents/made

3. Who Pays? Determining responsibility for payments to providers (2013):
   www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

4. Documents and tools applied

   NHS Checklist
   NHS Decision Support Tool
   NHS Fast Track Tool
   Equity & Choice Policy
   Disputes Policy

Appendices Below

Appendix 1

Referral Procedure for Continuing HealthCare Assessment
NHS Continuing HealthCare Checklist

The process for referral for CHC assessment is identified within the National Framework for NHS CHC and NHS-funded Nursing care, November 2018 (revised). The use of the Fast Track Pathway Tool for NHS CHC and the NHS CHC Checklist will be the only acceptable routes into the CHC service within NHS CP&R and Southend CCG. The assessment may proceed straight to a DST if there is evidence that the individual would checklist above the threshold, however should notify the NHS Funded Care Team that they are doing so as soon as possible.

The Checklist is to help practitioners identify people who need a full CHC assessment, although referral for a CHC assessment does not in itself indicate eligibility for continuing healthcare.

The Checklist is based on the NHS CHC Decision Support Tool, which is used for full CHC assessment, and the National Framework for NHS Continuing HealthCare & NHS Funded Nursing Care guidance.

NHS CHC Checklist:

1. Any health or social care professional with training can use the Checklist to refer individuals for full consideration of eligibility for NHS CHC from the community, care home or hospital setting. Staff completing the Checklist must be familiar with, and have regard to, the Decision Support Tool

2. The Checklist must be completed with the full understanding of the process explained to the individual or their representative, who should be invited to fully participate in the process and to express their views. It should be explained to the patient and their family that the completion of a checklist may not result in eligibility for NHS CHC. A copy of the DH information leaflet should be given to patient and/or representative.

3. Informed consent should be obtained before the process of completing the Checklist begins. Consent for the process from the individual or a person with lasting power of attorney, or action taken due to lack of consent, 'best interests' meeting, should be recorded clearly on the Checklist. If it is not recorded the Checklist may be returned to the referrer for further completion.

4. In the acute hospital setting, NHS staff are required to consider someone's CHC needs before giving notice of an individual's case under the Delayed Transfer of Care regulations and should involve the Local Authority's Department of Adults, Health and Wellbeing in such an assessment. Given that a hospital setting can sometimes poorly represent an individual's capacity to funded therapy or rehabilitation elsewhere may be appropriate. All staff should be aware of this requirement, and if additional therapy or rehabilitation is arranged, NHS CHC needs should be assessed at the end of these interventions.

5. Where a Checklist has been completed and indicates that the individual does not require a full CHC assessment, the Checklist should still be forwarded to the Funded Care Team for monitoring purposes and for future reference should the individual be referred at a later date.

Procedure: Completion of the Checklist

The NHS CHC Checklist can be obtained from: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing- care

1. Process

1.1 Referrer
The referrer will ensure that consent is agreed and that the Checklist is completed fully in line with points 1 to 4 above. Clearly documenting their profession and contact details

1.2
If there is a concern that the individual may not have capacity to give consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice.

The referrer will email the completed Checklist, with consent/MCA/Best interests, to the NHS Funded Care Team on:

Secure email: cprccg.chc@nhs.net Secure email: SCCG.southendCHC@nhs.net

2. Team and timeline

2.1 NHS Funded Care Team

The NHS Funded Care Team will review the Checklist and enter receipt onto the CHC database. If the Checklist indicates the need for full consideration of eligibility for continuing healthcare, then the NHS Funded Care Team will notify the referrer that the completion of a Decision Support Tool indicating full social and health assessments needs to be completed and the individuals name will be added to the allocation list .

Timescale for completion of the full assessment is within 28 days from the NHS Funded Care team receiving the fully completed Checklist.
Full consideration against the eligibility criteria is indicated where:

- Two or more ticks in column A; or
- Five or more ticks in column B, or one tick in A and four in B; or
- One tick in column A which has an asterisked domain (*). Asterisked domains are those which carry a Priority level in the Decision Support Tool. (Behaviour; Breathing; Drug Therapies and Medication-symptom control; Altered States of Consciousness)

2.2 If the NHS Funded Care Team agrees a full consideration for NHS CHC is not required, this decision, together with the reasons for it will be communicated clearly to the referrer, individual and their carers and/or their representatives. A written copy of this communication from the assessor to the patient will be placed on file**.**

Timescale: for decision: 2 working days
for Communication: 2 working days

2.3 If the NHS Funded Care Team agrees a full consideration for NHS CHC is required the result and the reasons for it will be communicated clearly to the referrer, individual and/or their representatives. A written copy of this communication will be placed on file.

Timescale: for decision: 2 working days
for Communication: 2 working days

2.4 The NHS Funded Care Team leader will be responsible for ensuring that a full assessment by the multi-disciplinary team using the Decision Support Tool, takes place in line with the process set out within the guidance and within the timescales identified.

Appendix 2

NHS Continuing Healthcare
Procedure for completion of Decision Support Tool

1. The Decision Support Tool (DST)

1.1 The function of the DST is to summarise and collate key information from the Multidisciplinary Team (MDT) Health Needs Assessment (HNA) across the 12 domains and to consider the impact of the nature, intensity, complexity or unpredictability of health needs. The recommendation should also evidence the consideration of the primary health needs test; i.e. is the care being delivered greater than we could reasonably expect a local authority to provide?

The DST remains an aid to decision making and is not a substitute for professional judgment.

The MDT in the context of NHS CHC is described as;

- Two professionals who are from different healthcare professions or
- One professional who is from a healthcare profession and one person who is responsible for a assessing individuals for community care services under section 47 of the National Health Service and Care Act 2014 1990

1.2 As much as possible, CCG expects all DSTs to have Adult Social Care input and for the completed DST's to show this. The MDT recommendation should be signed by the social care practitioner involved in the assessment and if it is not for a written explanation to be provided as to why not.

1.3 Where Adult Social Care is unable to participate at the assessment, a copy of the HNA and DST, including the recommendation, will be shared with Social Care for comment within 2 working days.

1.4 The DST to be used by everyone is the national DST form, 2016; this is a DoH requirement.

1.5 The CHC lead will reject consideration of a DST if any of the following apply;

- where the DST is not completed fully (including where there is no recommendation)
- where there are significant gaps in evidence to support the recommendation
- where there is an obvious mismatch between evidence provided and the recommendation
- where the recommendation would result in either authority acting unlawfully

1.6 It is recommended that the MDT initially consider each domain in turn and agree the statements, throughout before considering tentative levels of need on the DST. The MDT should then consider the impact of nature, intensity, complexity or unpredictability (see 1.11 below) and then review the levels on the DST, amending these where necessary prior to completion.

1.7 The DST must contain all of the information used to decide on the scoring of each 'domain', clearly recorded within each section. This information must correlate with the MDT recommendation completed and signed on behalf of the MDT, including the rationale for the recommendation. If there is no signed recommendation and rationale it will be automatically rejected by the CHC lead and returned to the MDT for further work.

1.8 The NHS Funded Care Team is available to provide support and guidance with CHC assessments and DST completion.

1.9 It is expected that the person signing the DST on behalf of the MDT will be available to discuss the

case should this be necessary.

Nature, Intensity, Complexity and Unpredictability

1.10 These four elements continue to be an important part of the guidance and descriptors are included in the national framework.

1.11 Completion of the DST requires consideration of the four characteristics of need, Nature, Intensity, Complexity and Unpredictability. Guidance on the application of these characteristics are outlined below:

Nature	**Intensity**
This is about the characteristics of the individual's needs. Ask yourself questions like: • How would you describe the needs (rather than the medical condition leading to them)? • What adjectives would you use? • What is the impact of the need on overall health and wellbeing? • What types of interventions are required to meet the need? • Is there particular knowledge/skill required to anticipate and address the need? • Could anyone do it without specific training? • Is the individual's condition deteriorating or improving? • Is this greater than we would expect a Local Authority to provide?	This is about quantity, severity and continuity of needs. Ask yourself things like: • How severe is this need? • How often is intervention required? • How much care? • How many carers are required? • For how long is the care needed for each time? • Can the patient be left unattended in between interventions? • Does the care relate to needs over several domains? • Is this greater than we would expect a Local Authority to provide?
Complexity	**Unpredictability**
This is about the level of skill/knowledge required to address an individual need or the range of needs. Ask yourself things like: • How difficult is it to manage the need(s)? • Are the needs interrelated? • Do they impact on each other to make the needs even more difficult to address? • How much knowledge is required to address the need(s)? • How much skill is required to address the need(s)? • How does the individual's response to their condition make it more difficult to provide appropriate support?	This is about the degree to which needs fluctuate and There by create challenges in managing them. Ask yourself things like: • Are you able to anticipate when the need(s) might arise? • Does the level of need often change? • Is the condition unstable? • What happens if you don't address the need when it arises? • How significant are the consequences? • To what extent is professional knowledge or skill required to respond spontaneously and appropriately? • What level of monitoring/review is required?

1.12 The MDT having considered fully these characteristics as part of their discussions, determine whether someone is recommended eligible for CHC due to having a primary health need, or not eligible as no primary health need is evidenced.

1.13 Once completed the DST and all supporting evidence must be sent to the NHS Funded Care Team for review and quality check.

2. Time frame for completion of the Decision Support Tool.

2.1 The National Framework for NHS Continuing HealthCare and Funded Nursing Care states the following:

"The time that elapses between the Checklist (or were no Checklist is used, other notification of potential

eligibility) being received by the CCG and the funding decision being made should, in most cases, not exceed 28 days. In acute services, it may be appropriate for the process to take significantly less than 28 days if an individual is otherwise ready for discharge. CCGs can help manage this process by ensuring that potential NHS CHC eligibility is actively considered as a central part of the discharge planning process, and also by considering whether it would be appropriate to provide interim or other NHS-funded services.

Where there are valid and unavoidable reasons for the process taking longer, timescales should be clearly communicated to the person and (where appropriate) their carers and/or representatives". The CHC nurse assessor must clearly log any delays on the database

2.2 The timeline for completion of a CHC assessment is described for guidance only below. Different phase times may apply to individual cases; however the 28 day timeline is the specified target;

Phase of the continuing care process	**Stage of care pathway**	**Summary of key actions**	**Timescales/28 day target**	**Local Authority input were appropriate**
Assessment phase	Identify	Adult with potential CHC needs. Referred using Fast Track Tool (set up care) or Checklist to CHC Team.	**1 day**	Notify the Local Authority of need for assessment
	Assess	If full eligibility assessment is indicated a care coordinator is identified and commences gathering information for inclusion in the DST.	**8 days**	If no Local Authority input, notify on day 7.
Decision phase	Recommend	MDT considers the information gathered and makes a recommendation which is recorded in the completed DST. The completed DST is sent to the CHC Team for review quality check.	**21 days**	If no Local Authority input by day 14, send DST to local Authority
	Decide	The CCG considers the MDT recommendation and Validates	**28 days**	
Provision phase	Inform	Patient/referrer/family notified of decision verbally then in writing	**3 working days**	
	Deliver the package of care	CHC team identify provider/s for package of care based on care plan to meet needs and ensure care package is in place	Dependent on complexity of package this may take time, of which the patient should be kept informed.	

*completed within this time frame requires joint working across the whole system of health and social care. The timeframe identified is a performance indicator for NHS CHC and therefore is not optional. Delays and the reasons for delays in meeting this target will be required to be presented at when the eligibility consideration takes place and will be closely monitored and recorded.

Appendix 3

CCG Referral Procedure for Continuing Healthcare Assessment

Fast Track Pathway Tool

The process for referral for CHC assessment is identified within the National Framework for NHS Continuing HealthCare and NHS-funded Nursing care, 2018 (revised).

The use of the Fast Track Pathway Tool for NHS CHC and the NHS CHC Checklist will be the **only** acceptable routes into the CHC service.

The Fast Track Pathway Tool.

The Fast Track Pathway Tool is used to request the CCG commissions a package of care and support, for an individual who has a rapidly deteriorating condition and needs to be discharged as a matter of urgency. This Tool bypasses the need for the Checklist and should only be used for individuals who may have a primary care need through a rapidly deteriorating condition that may be entering a terminal phase.

Completion of the Fast Track Tool

The Framework makes it clear that the Fast Track Pathway Tool can only be completed by an 'appropriate clinician', and the Responsibilities Directions define an 'appropriate clinician' as a person who is:

i. ***Responsible for the diagnosis, treatment or care of a person in respect of whom a Fast Track Pathway Tool is being completed***
ii. ***Diagnosing, or providing treatment or care to, that person under the 2006 Act, and iii. A registered nurse or is included in the register maintained under section 2 of the Medical Act 1983.***

Thus those completing the Fast Track Pathway Tool could include consultants, registrars, GPs and registered nurses. This includes relevant clinicians (registered nurses and doctors) working in end of life care services within independent and voluntary sector organisations if their organisation is commissioned by the NHS to provide the service.

Whoever the clinician is, registered nurse or doctor, completing the Fast Track Pathway Tool, they should be knowledgeable about the individual's health needs, diagnosis, treatment or care and be able to provide reasons why the individual meets the conditions required for the fast tracking decision.

The use of the Fast Track Pathway Tool and Care Plan is compulsory when an individual requires an urgent package of CHC due to a rapidly deteriorating condition that may be entering a terminal phase. No variations on the Tool should be used. It is only when the Fast Track Pathway Tool has been used that a CCG is required by the Responsibilities Directions to decide immediately that the person is eligible for NHS Continuing Healthcare.

Procedure: Fast Track Pathway Tool

1 Process

1.1 **Referrer**

Where a patient has a **rapidly deteriorating condition** which may be entering into the terminal phase and **<u>requires an urgent care package to be set up</u>** then the following must happen:

- The 'Appropriate clinician' (registered nurse or doctor) completes the Fast Track Pathway Tool setting out how their knowledge and evidence about the patient's needs leads them to consider

that the patient has **a rapidly deteriorating condition,** which may be entering a terminal phase**.**

- Any necessary evidence should be included and must include **diagnosis, prognosis and current condition,** together with a completed care plan developed as part of the individual's end of life care pathway that describes the immediate needs to be met, and the patient's preferences, including those set out in any advance care plan.

- The completed Fast Track Pathway Tool should then be sent by secure emailed to the NHS Funded Care Team Secure email

1.2 **NHS Funded Care Team**

The NHS Funded Care Team is responsible for ensuring the Fast Track Tool is completed correctly and that there is sufficient evidence that the patient meets eligibility for CHC funding.

- CHC clinician notifies the referrer of decision re; eligibility
- If the patient requires a hospital or hospice placement the CHC clinician will assist with arrangements in a Case Management/Coordination function.
- If the patient requires a Community placement, the NHS Funded Care Team will arrange the package of care to commence as soon as possible
- If Registered Nurses or Health Support Workers with additional skills, e.g. management of nebulisers, external ventilation, and/or complex medication regime is required, the NHS Funded Care Team will ensure this is arranged as soon as possible.

1.3 **Out of Hours**

Currently, there is not provision for CHC decision-making outside normal office hours. In exceptional circumstances the DCO can discharge to an agreed limited otherwise they would need on-call management approval.

1.4 **Review**

All patients placed on CHC following the application of a Fast Track Pathway Tool will be reviewed no later than 3 months, and preferably within 3-6 weeks, from the start of the care package by the NHS funded care team.

All Fast Track applications will be monitored to ensure compliance with the guidance and appropriate use of the Fast Track Tool

Appendix 4: Cessation of Continuing Healthcare Funding Policy

Purpose of policy

This policy sets out our approach to dealing with the ending of continuing healthcare funding. This policy should be read in conjunction with the National Framework for NHS Continuing Healthcare (Department of Health 2012), the Care and Support Guidance (Department of Health 2014) and the Care Act 2014.

Approach

When ceasing continuing healthcare funding we will balance the need of the adult to have their ongoing healthcare and any associated social care needs met, with our wider duty to ensure that public funds are spent appropriately and best value is obtained for public money.

Decision making

Continuing healthcare funding will only cease after a formal review has been conducted with a recommendation from the MDT that continuing healthcare funding is no longer appropriate, which has been validated by the CCG. The review and decision making process will be conducted in conformity with the NHS Framework for Continuing Healthcare.

All timeframes for the cessation of funding are highlighted in the '**NHS CHC INTERAGENCY PROCESS & TIMELINE BETWEEN LA/CCG'** document.

Appeals

All appeals shall be in writing and must contain an outline of the grounds based on assessed need, for appeal.

In the event that the adult or family appeals against the decision to end their NHS Continuing Healthcare funding the CCG will continue funding until completion of local resolution process (see '**NHS CHC INTERAGENCY PROCESS & TIMELINE BETWEEN LA/CCG'** document). In the event that the appeal is unsuccessful, funding will cease as identified in the '**SCCG NHS CHC APPEALS'** document.

Should the individual/family request NHS England to review the matter the CCG will not will not continue to fund while the matter is under review, as identified in the '**SCCG NHS CHC APPEALS'** document. It will then exercise its discretion when deciding what action to take on the outcome of the IRP review.

Disputes with Southend Borough Council

The disputes protocol in place between the CCG and Southend Borough Council shall apply. In this case the CCG will continue to fund the adult's care until the matter has been resolved in line with disputes protocol. In the event that the matter is decided in favour of the CCG the Local Authority will reimburse the CCG for the cost of the adult's care in line with the disputes protocol.

Appendix 5: Equity & Choice Policy

Below is the Equity & Choice Policy sets out the principles and practice related to supporting adults who are eligible for NHS Continuing Healthcare:

1. **INTRODUCTION**

This policy describes the way in which NHS both CCG will provide support for people who have been assessed as eligible for fully funded NHS Continuing Healthcare (CHC). The policy describes the ways in which we will commission and provide care in a manner that reflects the choice and preferences of individuals and balances the need for the CCG to commission care that is safe and effective and makes best use of the resources available.

Individuals receiving NHS Continuing Healthcare have some of the most clinically complex and severe needs within the local population. The majority of cases have little or no potential for rehabilitation and many are receiving end of life care; although in some situations, a person's condition can improve to the extent that they are no longer eligible for CHC funding. In the delivery of CHC has to ensure consistency in the application of the national policy whilst implementing and maintaining good practice and ensuring quality standards are met and sustained. The aim of this policy is to always work towards a patient-led outcome and to ensure that family/carers and other interested 3rd parties feel that their opinions are fully considered. Furthermore, the principle of transparency is paramount to any commissioning consideration.

1.1 Purpose

This policy ensures that individuals who are in receipt of NHS Continuing Healthcare receive care in line with the following core principles listed below:

- The CCG has the duty to consider the best use of resources for their population whilst meeting the healthcare needs of an individual. Therefore, options will always be considered to meet the identified health needs of an individual who is eligible for CHC, and the CCG will always consider the most cost effective option to meet the individual's needs.

- This policy is for adults aged 18 years onwards, following on from the Children's Continuing Care Policy and guidance for Essex.

- Equality of individuals will be upheld and any agreements will not be discriminatory. The CCG has a key responsibility to ensure that services it commissions are safe, and the safety, welfare and any potential risks to the individual are taken into account in the care purchased.

- Personalisation is part of the process of support and care for an individual is central to decision making.

- The NHS Constitution states that individuals have the right to make choices about their care and to be able to access information to support these choices. As such the CCG will take into consideration an individual's views and preferences. However, there may be situations where an individual's choices cannot be agreed.

1.2 Definitions

'NHS Continuing Healthcare' means care provided over an extended period of time to a person aged 18 or over, to meet physical or mental health needs which have arisen as a result of disability, accident or illness. It may require services from the NHS and/or social care and can be provided in a range of settings. To assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the National Health Service Act 2006, and to distinguish between those and the services that Local Authorities may provide under section 21 of the National Assistance Act 1948 (now the Care Act 2014), the Secretary of State has developed the concept of a 'primary health need'.

Where a person's primary need is a health need, they are eligible for NHS Continuing Healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs. Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, the NHS is responsible for providing all of that individual's assessed needs – including accommodation, if that is part of the overall need' (DH, 2012).

A practical approach to eligibility is required considering certain characteristics of need and their impact on the care required to manage them, may help determine whether the 'quality' or 'quantity' of care required is more than the limits of a Local Authorities' responsibilities and as outlined by Coughlan (DH, 2012):

- Nature
- Intensity
- Complexity
- Unpredictability

Each of the above characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual's needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered. 'NHS Continuing Healthcare' means a package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need. It can be provided in any setting. Where a person lives in their own home, it means that the NHS funds all the care and support that is required to meet their assessed health and care needs.

Such care may be provided either within or outside the person's home, and includes primary healthcare and community nursing services, as appropriate to their assessment and care plan. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the person's accommodation, board and care (National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, Department of Health 2012.

2 ROLES AND RESPONSIBILITIES

The CCG has an ongoing responsibility to fund the care for individuals outside hospital settings whose primary need is for healthcare. Anybody can qualify for NHS Continuing Healthcare as long as their assessed needs meet the eligibility criteria. This care can be provided in any setting and includes funding for personal, nursing, medical care and, if within a care home, reasonable accommodation costs. The CCG holds responsibility and accountability for making the final decision on eligibility.

The CCG has the duty to commission services that offer quality, efficiency and value for the whole population they serve. The Framework (2018) highlights that 'the process of assessment and decision making should be person-centred. This means placing the individual, their perception of their support needs, and their preferred models of support at the heart of the assessment and care-planning'. A Multi-Disciplinary Team (MDT), usually from health and social care, carry out the assessment for eligibility for CHC using the Decision Support Tool (DST) in accordance with the National Framework (2018). Following assessment the CHC clinical team confirms eligibility against the decision support tool criteria and work within the national framework for continuing healthcare and funded nursing care (DH 2018) and the NHS continuing healthcare practitioner guidance (DH 2012).

Appeals and disputes relating to eligibility are held within the CHC eligibility panel which is an independent panel, made up of senior health and social care leads from partner organisations *e.g.* the local authority, community services, acute hospital trusts, who confirm eligibility against the Decision Support Tool Criteria and operate within the national guidance. The CHC management team are responsible for ensuring that the CHC team work to and within the NHS Continuing Healthcare Framework, service specifications and CCG policies related to CHC and for ensuring the delivery of best possible health and wellbeing outcomes, as well as working to promote equality, and achieving this with the best use of available resources.

3 The provision of services for adults who are eligible for NHS Continuing Healthcare

The CHC team has developed this policy in light of the need to balance personal choice alongside safety and effective use of finite resources. It is also necessary to have a policy which supports consistent and equitable decisions about the provision of care regardless of the person's age, condition or disability. These decisions need to provide transparency and fairness in the allocation of resources.

Application of this policy will ensure that decisions about care will:

- be robust, fair, consistent and transparent;
- be based on the objective assessment of the person's clinical need, safety and best interests;
- have regard for the safety and appropriateness of care to the individual and staff involved in the delivery;
- involve the person and their family/representative wherever possible;
- take into account the need for the CCG's to allocate its financial resources in the most cost effective way;
- support choice to the greatest extent possible in view of the above factors.

The CCG has a duty to provide care to a person with continuing healthcare needs in order to meet those assessed needs. An individual or their family / representative cannot make a financial contribution to the cost of the care identified by the CHC team as required to meet the individual's health and social care needs. An individual however, has the right to decline NHS services and make their own private arrangements.

Access to NHS services depends upon clinical need, not ability to pay. The CCG will not charge a fee or require a co-payment from any NHS patient in relation to the assessed needs. The principle that NHS services remain free at the point of delivery has not changed and remains the statutory position under the NHS Act 2006. The CCG are not currently able to allow personal top up payments into the package of healthcare services under NHS CHC, where the additional payment relates to core services assessed as meeting the needs of the individual and covered by the fee negotiated with the service provider (e.g. the care home) as part of the contract.

However, where service providers offer additional services which are unrelated to the person's health and social care needs as assessed under the NHS CHC framework, the person may choose to use personal funds to take advantage of these services. Examples of such services falling outside NHS provision include hairdressing, a bigger room or a nicer view within a care home. Any additional services which are unrelated to the person's primary healthcare needs will not be funded by the CCG's as these are services over and above those which the service user has been assessed as requiring, and the NHS could not therefore reasonably be expected to fund those elements. In these circumstances the provider must be able to clearly separate the associated cost of these additional services.

In instances where more than one suitable care option is available (i.e. a nursing home placement and a domiciliary care package) the total cost of each package will be identified and assessed for the overall cost effectiveness. While there is no set upper limit on the cost of care, the expectation is that the most cost effective option will be commissioned that meets the individual's needs. Any assessment of a care option will

include the psychological and social care needs and the impact on the home and family life as well as the individual's care needs. The outcome of this assessment will be taken into account in arriving at a decision.

The setting in which continuing healthcare is provided is ultimately a matter for CCG; however the CCG will take into account reasonable requests from the individual and their family in relation to particular settings. In addition to a person's assessed needs, the CCG may have to take into account its own resources when deciding upon which package of care to commission.

4 Continuing Healthcare Funded Care Home Placements

Where a person has been assessed as needing placement within a care home, the expectation is that the CHC team will make this placement with a provider that has no significant quality or safeguarding concerns, and can deliver the assessed need in a cost effective manner and as far as reasonably practicable (as above).

The person may wish to move into an alternate provider outside of that arranged by the CHC team. As long as the fee for the bed is comparable to the fee agreed with the provider, the provider can meet the patients care needs and this alternate provider would not significantly delay commencement of the care package, the CHC team will consider this option. If the fee is higher than the fee charged by the provider arranged by the CHC team, the CHC team would anticipate subject to clarification that the extra fees are for non-core care costs or for a higher level of accommodation. The provider will only be able to invoice the CCG's for the core care costs and reasonable accommodation costs and will have to invoice the client separately for the non-core care costs and extra accommodation costs. The invoices will detail what CCG and the patient are being charged for.

The provider must be able to separate out NHS and privately funded care arrangements, the financial arrangements for the privately funded care entirely a matter between the individual and the relevant provider and it should not form part of any service agreement between CCG and the provider. If the provider refuses to do this the CCG will not be able to purchase the care at this home and the family will be advised that they will need to consider other homes that fulfil the criteria as above.

5 Continuing Healthcare Funded Packages at Home

Patients who are eligible for NHS Continuing Healthcare funding have a complexity, intensity, frequency and unpredictability in their health needs which means it is less common for care to be safely delivered at home. The CHC team will take account of the following issues (this list is not exhaustive) before agreeing to commission a care package at home:

- Care can be delivered safely and without undue risk to the person, the staff or other members of the household (including children);

- Safety will be determined by a written assessment of risk undertaken by an appropriately qualified professional in consultation with the person or their family. The risk assessment will include the availability of equipment, the appropriateness of the physical environment and the availability of appropriately trained care staff and/or other staff to deliver the care at the intensity and frequency required;

- The acceptance by the CHC team and each person involved in the person's care of any identified risks in providing care and the person's acceptance of the risks and potential consequences of receiving care at home.

- Where an identified risk to the care providers or the person can be minimised through actions by the person or their family and carers, those individuals agree to comply and confirmed in writing with the steps required to minimise such identified risk;

- The person's GP agrees to provide primary care medical support;

- The suitability and availability of alternative care options;

- The cost of providing the care at home in the context of cost effectiveness;

- The relative costs of providing the package of choice considered against the relative benefit to the person;

- The psychological, social and physical impact on the person;

- The willingness and ability of family, friends or informal carers to provide elements of care where this is part of the care plan and the agreement of those persons to the care plan.

Many persons wish to be cared for in their own homes rather than in residential care, especially people who are in the terminal stages of illness. A person's choice of care setting should be taken into account but there is no automatic right to a package of care at home. The option of a package of care at home should be considered, even if discounted, with documented reasons. It may be necessary to pay more to meet an individuals assessed needs in a way that does not discriminate against them but the NHS does not have to provide a home care package if it is more expensive than providing care in a residential setting.

When a person is discharged into the community from hospital the CHC team as commissioners takes on the responsibility for the care. Home care packages in excess of eight hours per day would indicate a high level of need which would be more appropriately met within a residential placement. These cases would be carefully considered and a full risk assessment undertaken. Likewise, patients who need waking night care might generally be more appropriately cared for in a residential placement. The need for waking night care indicates a high level of supervision day and night.

Residential placements may be deemed more appropriate for persons who have complex and high levels of need. Residential placements benefit from direct oversight by registered professionals and the 24-hour monitoring of patients. If the clinical need is for registered nurse direct supervision or intervention throughout the 24 hours the care would normally be expected to be provided within a nursing home placement. This would include the requirement for 1-2 hourly intervention/monitoring for turning, continence management, medication, feeding, manual handling, and other clinical interventions or for the management of significant cognitive impairment.

There are specific conditions or interventions that it may not be appropriate to manage in a home care setting. These would include but are not restricted to: the requirement for sub-cutaneous fluids, continual invasive or non-invasive ventilation or the management of grade 4 pressure areas. In each case a comprehensive risk assessment would be completed to determine the most appropriate place for care to be provided. Each assessment will consider the appropriateness of a home based package of care, taking into account the range of factors and principles as listed in previous areas of this policy.

6 Exceptional Circumstances

The CHC team will seek to take account of the wishes expressed by patients and their families when making decisions as to the location(s) of care packages and residential placements to be offered to satisfy the obligations of SCCG to provide continuing healthcare. The CCG accepts that many patients with complex medical conditions wish to remain in their own homes and to continue to live with their families, with a package of support provided to the person in their own homes. Where a patient or their family expresses such a desire the CHC team will investigate to determine whether it is clinically feasible and cost effective to provide a clinically sustainable package of continuing care for a person in their own home.

Packages of care in a person's own home are bespoke in nature and thus can often be considerably more expensive for the CCG's than delivery of an equivalent package of services for a patient in a care home. Such

packages have the benefit of keeping a person in familiar surroundings and / or enabling a family to stay together. However CCG need to act fairly to balance the resources spent on an individual patient with those available to fund services to other persons. CCG has resolved that, where it is determined that supporting a package of continuing care for a person in their own home is clinically sustainable and in line with the wishes of the person or their family this will usually be supported as the preferred option. A package of continuing care for a person in their own home will normally be considered to be cost effective if it is the same (or less) than the anticipated maximum cost of a care package delivered in an alternative appropriate location.

CCG has resolved that, in exceptional cases and in an attempt to both balance these different interests, it will be prepared to support a clinically sustainable package of care which keeps a person in their own home provided the anticipated cost to CCG is no more than 10% higher than the anticipated cost of a care package delivered in an alternative appropriate location such as a care home.

Exceptionality will be determined on a case by case basis and requires senior management approval (Head of Service/Chief Nurse). The basis for determining exceptionality would include (but not necessarily be limited to):

- Are the patient's needs significantly different to other patients with the same or similar conditions and;

- Will the patient benefit significantly more from the additional or alternative services or placement than other patients with the same or similar conditions?

The senior management approval referred to above will be convened as required and will consist of the following: at least one of executive level representative or deputy (Chief Nurse/Head of Complex Case Management) and one representative from the CHC team (CHC Clinical Lead/Senior CHC Nurse).

7 Capacity

If a person does not have the Mental Capacity to make a decision about the location of their commissioned care package and suitable placement, the CHC team will commission the most cost effective, safe care available based on an assessment of the patients 'best interests' (Mental Capacity Act, 2005). This will be carried out in consultation with any appointed advocate, Attorney under a Lasting Power of Attorney (LPA)or a Court Appointed Deputy or the Court of Protection directly, relevant family member or other person who should be consulted under the terms of the Mental Capacity Act 2005.

The authorisation for the commissioning and funding of packages of care at home lies with CCG. There will be a process for the authorisation of eligibility and the authorisation of care packages and placements. Once a package of care at home has been agreed by the CHC team the person may be given a notional weekly personal health budget which is the cost of the care package. Patients and their families will be able to have some flexibility in the delivery of the care (for example, times) as long as the person's assessed care needs are being met.

8 Review

Individuals and their families need to be aware that there may be times where it will no longer be appropriate to provide care at home. For example, deterioration in the person's condition may result in the need for clinical oversight and 24-hour monitoring.

The care package will be reviewed three monthly and then annually as a minimum requirement alongside the continuing healthcare review to ensure that it is still meeting the person's needs at that time. If the weekly cost of the care increases, apart from a single period of up to two weeks to cover either an acute episode or for end of life care to prevent a hospital admission, the care package will be reviewed and other options (for example a nursing home placement) will be explored following consideration of the issues outlined in paragraph

9 Right of Appeal

The appeal process set out in the National Framework and local policies are applicable if the individual wishes to dispute a decision about their eligibility for NHS Continuing Healthcare. If the individual wishes to challenge

the package of care provided by SCCG, any complaint should be made via the local NHS Complaints Procedure. Where local complaints procedures have failed to resolve the dispute, the patient or family/3rd party representative has recourse to complain to the Health Ombudsman.

Appendix 6 - The Local Resolution Procedure.

The up-to date structures are available from Corporate Services on request.

Appendix 7- The Local Resolution Procedure

Requesting a Review of an Eligibility Decision regarding NHS Continuing Healthcare

How do I request a review of an eligibility decision?
If you and/or your representative, which could be your family, friend or advocate, has had an NHS Continuing Healthcare assessment and you do not agree with the eligibility outcome you have the right to request a review of the eligibility decision.

The CCG adheres to the core values and principles of the NHS Continuing Healthcare Framework (2018) and will ensure that you and/or your representative are fully and directly involved in the review of an eligibility decision process and that the final decision made by the CCG will be fully explained.

You and/or your representative will need to lodge your request for a review of the eligibility decision no later than six months from the date of the letter informing you of the eligibility decision made by the CCG. When you and/or your representative request a review, you will need to write a letter clearly evidencing the reasons for the review.

Your reasons for a review of the eligibility decision should be based on;

- The procedure followed by Castle Point and Rochford CCG or Southend CCG in reaching its decision on eligibility for NHS Continuing care and/or
- The application of the criteria of eligibility for NHS Continuing Healthcare (Primary Health Need)

You and/or your representative will need to send the reason for your request for a review of the eligibility decision to the CCG who undertook the assessment and made the eligibility decision; you will find the addresses below:

The NHS Funded Care Team
NHS Castle Point and Rochford CCG
Pearl House,
12 Castle Road,
Rayleigh,
SS6 7QF

Or

The NHS Funded Care Team
NHS Southend CCG
Floor 5 Civic Centre
Victoria Avenue
Southend on Sea
SS2 6ER

Once the full reasons for requesting a review of the eligibility decision has been received from you and/or your representative the CCG is required to complete a local review of your case within three months.

Can I request a review of the decision on behalf of a relative or friend?
Yes, you can. You will need to provide evidence that you are the individual's representative and you are able to act on their behalf. You may have already provided us with this information. Examples of authority would be:

- The individual's written consent to act on their behalf in this matter; or if the individual lacks the capacity to consent please provide one of the following documents as evidence of authority to act:

    - Lasting Power of Attorney (LPA) for Welfare or Finance.

    - Enduring Power of Attorney (EPA) registered with the Office of Public Guardian (showing the seal of the Office of Public Guardian).

    - Court Appointed Deputy for Welfare or Finance.

Please note that if your authority is for finances only, this may limit the information that can be shared, this is due to patient confidentiality.

To avoid delay in us being able to speak or correspond with you about your request it would be helpful to provide the evidence of authority as soon as possible.

If you do not have formal authority to act on their behalf, please contact us to discuss this. It may be possible to proceed on a 'best interests' basis. The information provided may be generic as patient confidentiality may limit what information can be shared.

If the individual has since passed away, the above documents will no longer apply. You will need to provide evidence that you are responsible for dealing with their estate.

Do I need a solicitor or specialist claim firm to help me request a review of an eligibility decision?
No, this is not a legal process and we aim to keep the process as simple as possible. If you and/or your representative feel you that additional support is required the CCG can provide you with the contact details of independent advocacy services which may provide support free of charge.

If you ask a solicitor, claims firm, independent advocate or other third party to act on your behalf or their authorised representative, we will need written authority for them to act in addition to the consent form. If you and/or your representative choose to involve a solicitor or claims firm you will be responsible for the payment of any fees they charge.

What happens after I request a review of the eligibility decision?
Your request for a review of the eligilbity decision will be acknowledged by the CCG within 10 working days of receipt and once your full grounds for appeal have been received a Lead Nurse will then review your case. You will then be invited to an Informal Local Resolution meeting which will involve a two-way discussion with the Lead Nurse.

In some situations you and/or your representative may wish to move straight to a Formal Local Resolution meeting and this request will be considered by the CCG.

What is an Informal Local Resolution meeting?
This may involve either a face to face informal meeting or a telephone discussion between you and/or your representative and a Lead Nurse from the CCG. At this meeting the Lead Nurse will endeavour to explain our process, answer any questions and document any additional information that you provide us with.

A Lead Nurse will also explain how the CCG has arrived at the decision regarding eligibility, including reference to the completed Decision Support Tool and primary health need assessment.

What are the possible outcomes from the Informal Local Resolution meeting?
There are three possible outcomes from the Informal Local Resolution meeting:

- The original decision made by the CCG regarding eligibility can be changed.
- If may be agreed that a further assessment of your needs is required.
- The original decision made by the CCG regarding eligibility is unchanged.

Are there minutes taken at the Local Resolution meeting?
Formal minutes will not be taken at the meeting. Notes of the key action points and outcome/agreements made at the meeting will be taken and you and/or your representative will be provided with a copy for your reference.

What happens if I decide not to continue with the appeal following the local Informal resolution meeting?
If following the Informal Local Resolution meeting you and/or your representative choose not to proceed with the appeal, the process will stop.

However if you and/or your representative remain dissatisfied regarding the outcome of this meeting you and/or your representative will be invited to attend a Formal Local Resolution meeting which will enable you to put forward your reasons why you remain dissatisfied with the CCG's decision.

Prior to the Formal Local Resolution meeting the CCG will also gather the relevant Health and Social Care records to support the identification of your care needs.

The Formal Local Resolution meeting will consist of a Lead Nurse and Social Worker.

What is the remit of the Formal Local Resolution meeting?
The Formal Local Resolution meeting will consider the following:

- That the process that has been followed in reaching a decision regarding eligibility is robust and compliant with the NHS Continuing Healthcare Framework (2018)
- Whether the eligibility criteria has been robustly applied in accordance with the NHS Continuing Healthcare Framework (2018)

The meeting will be unable to consider any challenges against the actual content of the criteria as this is a national document.

What do I need to do before the Formal Local Resolution meeting?
If you and/or your representative have any additional information you wish the meeting to consider, this must be submitted at least 14 days before the date of the meeting. This allows the attendees to fully review the information prior to the meeting.

What happens at the Formal Local Resolution meeting?
You will be invited to attend the first part of the meeting to give your views regarding any procedural issues that have arisen during the assessment process and completion of the Decision Support Tool and also of your or the individuals care needs. The meeting will consider needs as described in the Decision Support Tool and will want to know from you and/or your representative where there is disagreement with the information that has been documented.

At the meeting you and/or your representative will have the opportunity to express any views and to discuss the levels of need in each of the care domains as documented within the Decision Support Tool.

You and/or your representative will also be invited to give an opinion regarding the level of needs in each of the care domains.

Once the first part of this meeting has been concluded, you and/or your representative will be invited to leave. The second part of the meeting will then proceed to consider the information that has been provided in the first part of the meeting and also any additional information that has been gathered prior to this meeting to enable a decision to be reached regarding your or the individuals eligibility for NHS Continuing Healthcare.

What are the possible outcomes from the Formal Local Resolution meeting?
There are three possible outcomes from the Formal Local Resolution meeting:

- The CCG will uphold the original eligibility decision
- The CCG will change the original eligibility decision

- The meeting will request additional information and defer the decision regarding eligibility until this has been considered

Will I be informed of the Formal Local Resolution meeting's decision on the same day?
You will not be informed of the decision on the day of the meeting but you will receive a full written record of the Formal meeting which will be clear and comprehensive with an explanation of the rationale for the decision within 21 days of the meeting date.

What can I do if I don't agree with the Formal Local Resolution meeting's decision?
Where it has not been possible to resolve your concerns at a local level then you may apply for an independent review of the CCG's decision.

Details of how to do this and how to contact NHS England will be included with the information sent to you following the local resolution process.

However NHS England has the discretion to agree that your or the individuals case could proceed direct to an independent review without completion of the local resolution process.

If you disagree or remain unhappy with the outcome of the NHS England Independent review, you may request a further review by the Parliamentary and Health Service Ombudsman.

Where can I find further information about NHS Continuing Healthcare?
The current eligibility criteria are set out in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. You can find the policy and the Decision Support Tool at the following website www.gov.uk search Continuing Healthcare.

Appendix 8 – Refreshed Redress Guidance

Executive Summary

This Guidance

1. This guidance is a refresh of "NHS Continuing Healthcare: Continuing Care Redress Guidance" published by the Department of Health on 14 March 20071 in response to the Parliamentary and Health Service Ombudsman's report "Retrospective Continuing Care Funding and Redress" published 13 March 2007. This guidance follows the principles set out in the Parliamentary and Health Service Ombudsman's "Principles for Remedy"2.

2.The purpose of this guidance is to assist Clinical Commissioning Groups (CCGs) when settling claims for individuals arising from NHS Continuing Healthcare eligibility decisions or where an eligibility decision has been reached on a previously un-assessed period of care in respect of NHS Continuing Healthcare and the need for redress has been identified.

3.NHS England has responsibility for NHS Continuing Healthcare for specified groups, for example prisoners and serving members of the Armed Forces and their families. Throughout this document where CCG is referred to, the guidance will also apply to NHS England in relation to these specified groups.

4.This guidance also retains the previously established principle that "where maladministration has resulted in financial injustice, the principle of redress should generally be to return individuals to the position they would have been in but for the maladministration which occurred."

5. This guidance does not remove the requirement for CCGs to consider the specific circumstances of each individual case when determining the appropriate level of redress.

6.The guidance recommends that the Retail Price Index is the appropriate interest rate to apply to redress.

7. The guidance applies with immediate effect from the date of publication where:

- an eligibility decision for NHS Continuing Healthcare has been made on or after the date of publication of this guidance; **and**
- the need for redress has been identified by the CCG.

8. The Parliamentary and Health Service Ombudsman is aware that this guidance has been developed.

Background

1. NHS Continuing Healthcare is a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness. Where an individual has both health and social care needs, but they have been assessed as having a 'primary health need' under the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care3* (the National Framework), the NHS has responsibility for providing for all of that individual's assessed health and social care needs. This care can be provided in a number of settings, including at home. Further information on the policy can be found in the National Framework**.**

2. This guidance has been developed to reflect the new NHS framework and structures which came into effect on 1 April 2013. This guidance details the appropriate interest rate which should generally apply to NHS Continuing Healthcare redress. This approach aims to achieve an outcome that is fair and reasonable to the individual and will demonstrate an appropriate use of public funds.

3. The Parliamentary and Health Service Ombudsman's report "Retrospective Continuing Care Funding and Redress"4 was published on 14 March 2007. Subsequently, the Department of Health issued the *NHS Continuing Healthcare: Continuing Care Redress5* Guidance in 2007 to help Primary Care Trusts review the approach they had taken, and were taking, to settle cases arising from continuing care reviews since 1996.

4. The purpose of redress is solely to restore the individual to the financial position they would have been in had NHS Continuing Healthcare been awarded at the appropriate time. As set out in "Principles for Remedy" "remedies should not lead to a complainant making a profit or gaining an advantage". This principle also applies to the NHS.

Redress Guidance
Action
1. The guidance applies with immediate effect from the date of publication where:

- an eligibility decision for NHS Continuing Healthcare has been made on, or after, the date of publication of this guidance; **and**
- The need for redress has been identified. This is irrespective of the period of care for which NHS Continuing Healthcare funding is being paid.

Therefore if the CCG is in the process of undertaking an assessment of a case and the decision on eligibility is made after publication of the guidance then, if appropriate for redress, this guidance applies.
Redress
2. CCGs are independent decision-making bodies. When making redress payments they should employ a transparent rationale and ensure they fully consider the individual circumstances of each case, taking legal advice where necessary. CCGs have the discretion to consider making ex-gratia payments, over and above the care costs and interest, however, these are expected to be exceptional and would need to be made in accordance with a CCG's own Standing Financial Instructions and any other pre-requisite guidance.

Interest rate
3. Redress is about placing individuals in the position they would have been in had NHS Continuing Healthcare been awarded at the appropriate time and not about the NHS or the public profiting from public funds.

4. CCGs are advised to apply the Retail Price Index for calculation of compound interest when considering redress cases. The index is calculated monthly, with an average for each calendar year. CCGs are advised to apply the average rate for the year for which care costs are being reimbursed. The rates of the Retail Price Index are available from the Office of National Statistics at: http://www.ons.gov.uk/. The contact details for the Office of National Statistics are available here http://www.ons.gov.uk/ons/site-information.

5. It is important that once an eligibility decision for NHS Continuing Healthcare is reached, CCGs should promptly pay any redress sums owed to individuals or their representatives. Disputes about aspects of the redress payment or other aspects of a case should be dealt with subsequently.

Legal costs and complaints
6. The Parliamentary and Health Service Ombudsman has indicated that it is rarely appropriate to receive a refund of legal and professional costs in bringing forward an NHS Continuing Healthcare dispute.

7. Individuals do not need to seek legal advice in order to request an assessment of eligibility for NHS Continuing Healthcare and there is also a mechanism to request a review of a decision on eligibility. CCGs and third sector services will help and advise individuals or their representatives on the process that will be followed in line with the '*National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care'*.

8. If an individual is dissatisfied with the CCG's redress offer, they can pursue the matter via the CCG's complaints process. However, CCGs should not delay payment in respect of undisputed elements.