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NHS
Mid Essex
Clinical Commissioning Group

NHS Continuing Healthcare Standard Operating Procedure

Mid Essex CCG (MECCG) Policy Reference:
MECCG126

Brief Description (max 50 words)	This document outlines the CCG's Standard Operating Procedure for NHS Continuing Healthcare in Adult patients only.
Target Audience	Health & Social Care Professionals; Patients and their representatives; Care Providers; Mid Essex Hospital Services NHS Trust, Mid Essex CCG Staff, Essex County Council (ECC)
Action Required	For approval and distribution

Document Information

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Accountable Director	Director of Nursing & Quality
Responsible Officer/ Policy Owner	Continuing Healthcare Operational Lead Nurse
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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 MECCG.
Quality Impact Assessment	This document has been assessed for quality impact.
Consultation	

Amendment History

Version	Date	Reviewer Name(s)	Comments
3.0	17th May 2017	Sharon Cooper John White	
5.0	9th June 2017	Sharon Cooper	

5.1	19th July 2017	Sara O'Conner	Amendments made to format of policy
5.2	26th July 2017	Sharon Cooper	Amendments made following reformatting guidance
5.3	8th August 2017	Vivienne Barker	Review of document content with minor amendments made
6.0	4th February 2020	Alyson Taylor	Review and update of all contents, including cross check with Thurrock CCG's policy to align practices.

This policy progresses the following Authorisation Domains and Equality Delivery System (tick all relevant boxes):

Clear and Credible Plan		Collaborative Arrangements	
Clinical Focus and Added Value	✓	Engagement with Individuals/Communities	
Commissioning processes	✓	Leadership Capacity and Capability	
Equality Delivery System		NHS Constitution ref	

Associated Policy Documents

Reference	Title
MECCG016	Safeguarding Children and Adults at Risk Policy
MECCG007	PALS and Complaints Policy
MECCG021	Individual Funding Requests Policy
MECCG135	Continuing Healthcare Cessation of Funding Policy
MECCG136	Continuing Healthcare Disputes Agreement Policy
MECCG027	Continuing Healthcare Appeals and Panel Policy
MECCG124	Equity in Choice Policy
MECCG143	Safe Observation CHC Policy
MECCG	PHB policy

Glossary

Term	Definition
BIA	Best Interests Assessment
CHC	NHS Continuing Healthcare
COD	Clinician of the Day
FNC	Funded Nursing Care
IRP	Independent Review Panel
MCA	Mental Capacity Assessment
MDT	Multidisciplinary Team
DST	Decision Support Tool
LA	Local Authority

Table of Contents

1 INTRODUCTION

This is the Standard Operating Procedure (SOP) of Mid Essex Clinical Commissioning Group (hereafter known as "the CCG") for governing the processes surrounding NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments and eligibility decisions.

CCGs assumed statutory responsibility for NHS Continuing Healthcare from 1st April 2013.

The CCG will deliver the service in line with the National Framework for Continuing Healthcare and NHS Funded Nursing Care (revised October 2018; in this document referred to as the 'National Framework'), ensuring they are fully compliant with the legislation and promoting best practice.

1.1 Legislative Framework

'Continuing Healthcare' 'CHC' and 'PHN' (Primary Health Need) are not presently addressed in primary legislation; however, the NHS Act 2006 amended by the Health and Social Care Act 2014 requires the Secretary of State to promote a comprehensive health service, designed to secure improvement, having regard to the NHS Constitution.

The Health and Social Care Act 2014 also establishes the need to reduce inequalities, establishing the NHS Commissioning Board (NHS England) and CCGs and requiring them to provide care/after care for people who are/have suffered from illness, if considered appropriate (i.e. having identified a primary health need), as part of the NHS.

The Health and Social Care Act 2014 also places a duty on every NHS Trust to take reasonable steps to ensure that an assessment of eligibility for NHS CHC is carried out in all cases where it appears to the Trust that the patient may have a need for such care, in consultation, where if considers it appropriate, with the relevant social services authority.

2 SCOPE AND PURPOSE

2.1 Purpose

This document is intended to advise practitioners and managers in relation to NHS CHC and FNC and sets out the roles and responsibilities for the process of referring, assessing and agreeing eligibility for NHS CHC as well as the commissioning and provision of that care.

2.2 Scope

CHC Team, patients aged 18 years and over for whom the CCG are the responsible commissioner and their representatives, NHS and private care providers including acute general hospitals in Mid and South Essex and other acute hospitals caring for Mid Essex CCG patients.

This policy does not cover:

- Under 18s (children); a child in receipt of Children's Continuing Care should be reassessed for their eligibility for Adult NHS CHC as part of the agreed transition process
- Previously Unassessed Periods of Care (PUPOC)
- Personal Health Budgets (PHB)

- Joint Funding: funding shared between a local authority and the CCG is only applicable to patients found after assessment to not be eligible for NHS CHC, but with nursing needs that may be outside of the local authority's legal remit to provide, or a shared NHS/LA responsibility
- Appeals against CHC eligibility decisions; this is a separate policy
- Cessation of CHC funding; this is a separate policy

3 DEFINITIONS

NHS Mid Essex Clinical Commissioning Group (MECCG) is responsible for commissioning health services for the population of Mid Essex.

Fully funded 'NHS Continuing Healthcare' (CHC) is a term used to describe a package of ongoing care, including accommodation if in a care home, arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need.

'NHS Funded Nursing Care' (FNC) is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS Funded Nursing Care has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS Continuing Healthcare before a decision is reached about the need for NHS Funded Nursing Care.

Eligibility for funding via NHS Continuing Healthcare is based on an individual's assessed needs. The diagnosis of a particular disease or condition is not in itself a determinant of eligibility for NHS Continuing Healthcare.

NHS Continuing Healthcare (CHC) CHC applies to care provided to persons aged 18 or over to meet their physical or mental health needs which have arisen as a result of disability, accident or illness. It may require the provision by the NHS of health services and social care services and can be provided in a range of settings. CHC is not awarded indefinitely, but is subject to regular eligibility reviews.

Local Resolution Panel the Local Resolution Panel considers appeals of the Multidisciplinary Team's decision by the individual or their representative.

Regional Independent Review Panel (IRP) IRP is hosted by NHS England. The Independent Review Panel (IRP) process has been set up to enable individuals and/or their representatives to look at:

- the primary heath need decision by a Clinical Commissioning Group (CCG)
- or the procedure followed by a CCG in reaching a decision about their eligibility for NHS Continuing Healthcare; and to make a recommendation to NHS England in the light of its findings on the above matters

Multidisciplinary Team (MDT) A Multidisciplinary Team is a group of professionals who are members of different clinical disciplines (Therapists, Nurses, Doctors, Social Workers etc.). The minimum requirement for an MDT is a clinician and a social care professional.

Personal Health Budget (PHB) is an amount of money to support a person's individual health care and wellbeing needs, planned and agreed between the individual and their local NHS team.

4 ROLES AND RESPONSIBILITIES

Role	Responsibility
CCG Board	The CCG has the lead responsibility for NHS Continuing Healthcare in the CCG locality, there are also specific requirements for Local Authorities to cooperate and work in partnership with the CCG across a number of key areas.
Accountable Officer (AO)	The AO must ensure MECCG meets its responsibilities as set out in the National Health Service (Commissioning Board and Clinical Commissioning Groups Standing Rules) Regulations 2012.
Director of Nursing	The Director of Nursing leads the Continuing Healthcare Team and assumes a consultative and advisory role in the clinical and operational aspects of the CHC team. The Director of Nursing must ensure MECCG meets its responsibilities as set out in the National Health Service (Commissioning Board and Clinical Commissioning Groups Standing Rules) Regulations 2012.
Local Resolution Panel Chair	The Independent CHC Panel Chair is responsible for ensuring that the local panel decision-making process is equitable and due process is followed as per the National Framework for the NHS Continuing Healthcare 2018. The Chair's responsibilities include ensuring families and carers are given clear information about the panel procedures and decisions are communicated appropriately.
CHC Senior management Team	Are responsible for ensuring that the CHC Team work to the National Framework 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.
CHC Staff	All members of CHC staff have a responsibility to familiarise themselves with the content of the Policy.

5 POLICY PROCEDURAL REQUIREMENTS

5.1 Eligibility

Eligibility for NHS CHC is based on an individual's assessed needs and is not disease or diagnosis-specific, nor determined by either the setting where the care is provided, or who delivers the care. Access to consideration and assessment is non-discriminatory; it is not based on age (except for being for adults aged 18 years and over), condition or type of health need diagnosed.

The principles underlying this policy support the provision of a consistent approach, and fair and equitable access to NHS CHC and NHS FNC.

In order to achieve this, the implementation of the criteria and local application for NHS CHC, in conjunction with the Local Authority, provider organisations, NHS Trusts and other agencies, should meet the following principles:

- Health and Social care professionals will work in partnership with the individual and their family/representatives throughout the process.
- All individuals and their families will be provided with information to enable them to participate in the process.

- Where an individual lacks capacity, all professionals will act in accordance with the Mental Capacity Act 2005.
- The process for decisions about eligibility for NHS CHC will be transparent for individuals and their families and for partner agencies.
- Assessments and decision making about eligibility will be undertaken in a timely manner (as set out within this policy and the National Framework) to ensure that individuals receive the care they require in the most appropriate environment, without unreasonable delays.

5.2 Core values and principles of CHC

The process of assessment and decision making should be person-centred, taking into account the individuals preferred model of support, their wishes and expectations (which should be documented).

Access to assessment, decision making and provision should be fair and consistent. NHS England and CCGs are responsible for auditing and monitoring to ensure that there is no discrimination in the CHC process.

Individuals and their representatives should be supported during the assessment process so that they understand and have sufficient advice and information to promote informed decision-making about their future care. This includes ensuring access to relevant information in a language and format that the individual can understand. In addition to addressing the needs of people who do not read or speak in English, the CHC team will ensure that it meets the Accessible Information Standard (2016), which aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand, and with support, so they can communicate easily with health and social care services.

5.3 Consent

As with any NHS assessment, examination, treatment or service, the individual's informed consent should be obtained in writing before the process begins of determining eligibility for NHS CHC.

If an individual does not consent to consideration of eligibility for NHS CHC, the potential effects on the ability of the NHS and Local Authority to provide appropriate services should be carefully explained to them.

Where there are concerns that an individual may have significant on-going needs and the level of appropriate support could be affected by their decision not to consent, the appropriate way forward should be considered jointly at a senior management level in the CCG and Local Authority.

5.4 Lack of capacity

If there is concern that the individual may not have the capacity to give their consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated Code of Practice and in line with the five principles of the Act.

If the person lacks the mental capacity either to refuse or to consent, a 'best interests' assessment (BIA) and decision should be taken as to whether or not to proceed with assessment of eligibility for NHS CHC. A third party cannot give or refuse consent for an assessment of eligibility for NHS CHC on behalf of an adult who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney or they have been appointed a Welfare Deputy by the Court of Protection.

The Mental Capacity Act 2005 requires Local Authorities and the NHS to engage Independent Mental Capacity Advocates (IMCAs) in certain circumstances where individuals are assessed as lacking capacity to make specific decisions at the time that the decision needs to be made and where there is absence of appropriate representative. The Act defines the circumstances in which a referral should be made to an IMCA.

5.5 Best interests decisions

Where a 'best Interests' decision needs to be made, any relevant third party who has a genuine interest in the person's welfare must be consulted; this will include family and friends.

5.6 Request for CHC assessment

A request for screening to consider the need for a full assessment of eligibility for NHS CHC may take the form of direct contact from an individual or their relative and can be received by telephone, letter, fax (via internet only) or email to the CHC team:

CHC Team
NHS Mid Essex CCG
Wren House
Hedgerows Business Park
Colchester Road
Springfield
Chelmsford
Essex, CM2 5PF
Tel: 0300 123 8095
Email: meccg.chc@nhs.net

The request will be checked to ensure all relevant details are available and correct such as CCG responsibility and valid consent (or MCA/BIA) is provided. This will be completed within 5 working days of receipt of the request. Where MECCG is not the responsible commissioner, the request will be returned to the individual with relevant information as to where responsibility lies, where known. All requests need to be progressed to a checklist within 14 days of receipt of the original request.

On receipt of a referral, or request for a CHC, or a completed Checklist, the details in relation to the case will be recorded on the Broadcare (CHC management system) and SystmOne (clinical record).

5.7 Checklist screening

The first step in the process for identifying individuals who may be eligible for NHS CHC will be a screening process using the NHS CHC Checklist, unless it is deemed appropriate for the Fast Track Pathway Tool to be used.

Before applying the Checklist, and in line with the framework guidance, all referrers should have explored and considered whether the patient has any further rehabilitation or reablement potential. NHS Continuing Healthcare is only considered when any rehabilitation needs have been met and a period of rehabilitation and/or reablement is completed.

The aim is that a variety of health and social care practitioners can complete the Checklist in a variety of settings. These could include NHS registered nurses, GPs, other clinicians or Local Authority staff

(such as social workers, care managers or social care assistants) completing them in the most appropriate environment. Professionals undertaking Checklists should be able to evidence training in this area, to assure consistent quality of the screening exercise and document completion. An individual or their representative cannot complete a checklist themselves.

Completion of the Checklist does not mean that an individual is automatically eligible for NHS CHC. The threshold for a 'positive' Checklist outcome is set deliberately low to ensure that there is full consideration of needs where required.

Financial issues are not considered as part of the decision on an individual's eligibility for NHS CHC, and it is important that the process of considering and deciding eligibility does not result in any delay to treatment or to appropriate care being put in place.

Referrals in the form of completed Checklists will be checked to ensure that they are robust, make appropriate reference to supporting evidence and that the individual and/or their representative have been involved.

Where there are concerns about the quality of the Checklist received or where there is a significant amount of missing or conflicting information the referrer will be contacted within 1 working day from receipt of the completed Checklist to respond to the queries. Any completed Checklists received should be verified, once any quality issues have been resolved, within a maximum 2 working days.

5.8 Mental Health referrals

Responsibility for the provision of Section 117 (care after discharge from detention under the Mental Health Act 1983) services lies jointly with Local Authorities and the NHS. Where an individual is eligible for services under Section 117 these must be provided under Section 117 and not under NHS Continuing Healthcare. It is important for CCGs to be clear in each case whether the individual's needs (or in some cases which elements of the individual's needs) are being funded under Section 117, NHS Continuing Healthcare or any other powers. However, patients on Section 117, who may also have physical health requirements outside of those mental health needs associated with their Section 117 after-care plan, may be entitled to consideration for NHS CHC subject to the usual assessments and decision making processes.

Where an individual is receiving services under Section 117 of the Mental Health act 1983 they will nonetheless be eligible for FNC as a universal service discreet from any Section 117 provision if they meet the relevant criteria.

If the CHC Team have questions relating to any mental health patients and Section 117 services they should discuss this with the EPUT Mental Health Act Office (epunft.mhaoffice@nhs.net).

5.9 Referrals not meeting eligibility criteria

Where the outcome of the Checklist is not to proceed to full assessment of eligibility, the CHC Team will write to the individual, providing them with a copy of the completed Checklist and details on how to request a review of the decision if they disagree with it.

Such requests should be given due consideration, taking account of all the information available, including additional information from the individual and/or their representative. A full Multidisciplinary Team assessment and DST may need to be completed if there is evidence to suggest it should. If not, then a clear and written response should be given to the individual or their representative as soon as

possible. The response should also give details of the individual's rights under the NHS complaints procedure, which includes referral to the Parliamentary and Health Service Ombudsman.

The individual and/or their representative will be advised to request the completion of a further Checklist should the individual's needs change.

If the individual is to be admitted to care home with Nursing, a determination for FNC must be considered.

5.10 Full assessment of need & decision making process

The National Framework makes clear recommendations for the decision-making process to sit as closely to the individual as possible, with local multidisciplinary teams collating the relevant assessments and supporting evidence, considering the health and social care needs of the individual using the Decision Support Tool (DST) and making recommendations regarding eligibility.

The National Framework outlines that there is a clear timetable for the decision making process, having regard to the expectation that decisions ***should usually be made within 28 days*** of the CCG receiving the referral.

5.11 Setting up the MDT

The CCG is responsible for coordinating the assessment processes and the convening of relevant members of the MDT in order to make a recommendation of eligibility.

The CCG should identify the appropriate professionals to comprise the MDT. For example:

- **Learning disabilities** - where the individual has a learning disability it will be important to involve professionals with expertise in learning disability in the assessment process as well as those with expertise in NHS CHC.
- **Local Authority (LA)** - The involvement of LA colleagues as well as health professionals in the assessment process will streamline the process of care planning and will make decision making more effective and consistent. It is expected that there is one representative from the local authority as a member of the MDT. The CCG, as far as is reasonably practicable, should consult with the relevant LA before making any decision about an individual's eligibility for NHS CHC.
- **Individual/Representative** - The individual and/or representative should be invited to be present, and reasonable notice should be given to an individual and/or their representative to be present and fully involved in the assessment process and the completion of the DST. The CCG should explain the DST process to the individual or representative and support them in playing a full role in contributing their views on their needs. If the MDT is to reach its final recommendation privately it is best practice to give the individual/representative an opportunity before they leave the meeting to state their views.

Each MDT will be individual to the needs of the patient. However, there must be a minimum of at least two professionals, usually from both the Health and Social Care disciplines who are knowledgeable about the individual's health and social care needs.

The DST should only be used following comprehensive assessments of the individual's health and social needs.

5.12 Decision Support Tool (DST)

The purpose of the DST is to help identify eligibility for NHS CHC, it is not designed as an assessment tool in its own right, but should draw upon such assessments as is appropriate (defined in the National Framework) to enable a decision to be made in a consistent manner.

Assessment documentation should be contemporaneous, signed and dated. Evidence supporting the decision making process should also be provided and can take the form of:

- Verbal statements from witnesses
- Written statement from witnesses
- Audio evidence
- Video evidence – which requires patient consent or a 'best interest' decision.

Referring to the MCA or consent as appropriate. Note this is not an exhaustive list and other appropriate evidence can be provided.

Evidence should be the minimum required to evidence the health needs, and ensure the safeguarding the patient's confidentiality and dignity. Evidence should demonstrate the type, intensity, complexity and unpredictability of any care needs of the individual.

The DST is designed to ensure that all relevant factors to be taken into account in determining eligibility. Twelve 'care domains' or 'generic areas of need' are set out to enable a decision to be made as follows:

1. Breathing
2. Nutrition
3. Continence
4. Skin Integrity
5. Mobility
6. Communication
7. Psychological and emotional needs
8. Cognition
9. Behaviour
10. Drug therapies and medication: symptom control
11. Altered states of consciousness
12. Other significant care needs (not covered by domains 1-11)

Throughout the DST meeting each care domain is allocated a weighting which best describes the level of need in that domain. At the end of the DST, the MDT completes the DST summary sheet to provide an overview of the weightings chosen and a summary of the person's needs, along with the application of the Primary Health Needs (PHN) Test. Whilst the recommendation should make reference to all four concepts of nature, intensity, complexity and unpredictability, any one of these could individually or in combination with others be sufficient to indicate a Primary Health Need.

The MDT's recommendation of eligibility or ineligibility must always be included alongside the Primary Health Needs Assessment.

The MDT should then send the completed DST and associated assessments/documents/evidence to the respective CHC Team, taking into consideration the confidential nature of the documents and appropriately secure transfer methods.

On receipt of the completed DST and supporting evidence, the CHC Team will ensure that all supporting evidence is included to enable the MDT's recommendation regarding eligibility to be validated.

The CHC Team may ask an MDT to carry out further work on a DST if it is not completed fully or if there is a significant lack of, or missing, evidence to support the weightings allocated to the care domains within the DST, the PHN and the MDT's recommendation. The application will be returned to the MDT with a full explanation in order that appropriate action can be taken to provide the CCG with the relevant documentation to enable verification of the MDT recommendation.

5.13 Decisions

The CCG CHC Team undertakes a ratification process whereby the recommendation from the MDT is considered and a decision taken as to eligibility status. The CHC Team should not fulfil a gate-keeping function, and nor should it be used as a financial monitor. Only in exceptional circumstances, and for clearly articulated reasons, should the MDT recommendation not be confirmed.

If the MDT recommends non-eligibility for CHC, the MDT should consider FNC if the individual is in a Care Home with Nursing.

A decision not to accept the MDT recommendation should be made by two members of the CHC Team at management level.

Exceptional Circumstances and referral back to the MDT may occur when:

- the DST is not fully completed and/or no recommendation is made
- there are significant gaps in evidence to support the DST

- there is obvious inconsistency between the evidence provided and the recommendation made
- the recommendation would result in either authority acting unlawfully

However a case cannot be referred back, or decision made not to accept a recommendation, simply because the MDT has made a recommendation that differs from the one that those who are making the final decision would have made.

There is no requirement in the National Framework for the CCG to use a formal panel as part of their decision making processes. Panels may be used in a selective way to support decision making. For example, this could include panels considering:

- Cases where the individual or their representative is disputing the recommendation of the MDT
- Cases where there is a disagreement between the CCG and the LA over the recommendation

The role of the panel is to:

- Verify and confirm the recommendation made by the MDT
- Apply the Primary Health Needs test as part of the verification process.
- Agree required actions where issues or concerns arise They do not have the role of:
- Financial gatekeeping
- Completing or altering DSTs
- Overturning recommendations (although they can refer back to the MDT in exceptional circumstances)

The main principles of the decision making process applies to any out of panel verifications, but the process would not be applied to:

- Cases where there is disagreement between the CCG and the LA – this could form part of the disputes process
- Cases where the individuals do not agree with the MDT recommendation or are appealing the decision
- Cases where individuals who were previously eligible, and on review, no longer meet the eligibility criteria

Where an individual dies whilst awaiting a decision on NHS CHC eligibility, and has received services prior to their death that could have been funded through NHS CHC, then the eligibility decision making process should be completed. Where no such services were provided it is not necessary to continue with the eligibility decision making process.

Where a decision is made that the individual would have been eligible for NHS CHC funding then payments should be made in accordance with national guidance.

The CHC Team will communicate the decision following verification of the MDT recommendation to the individual (or their representative) and relevant professional agencies in writing within 10 working days of the decision. A copy of the verification panel record or formal CHC Panel minutes and the DST will be sent to the individual, with information regarding the Local Resolution Process and timescales, should they wish to appeal the decision.

5.14 Care planning and case management

Once an individual has been found eligible for NHS CHC, the CCG is responsible for their case management, including monitoring the care they receive and arranging regular reviews. The CCG should ensure arrangements are in place for an ongoing case management role for all those eligible for NHS CHC funding. The CCG will assign a named case manager or named of point of contact for anyone in receipt of NHS CHC.

Where an individual, who is in receipt of NHS CHC, becomes the subject of a safeguarding concern, this must be addressed by the responsible CCG using the local safeguarding procedures (i.e. where the individual is currently living). CCGs have a duty under the Care Act 2014 to co-operate with the local authority, who in turn have a responsibility to make enquiries and to ensure, where appropriate, that an individual subject to a safeguarding enquiry has access to independent advocacy.

Where an individual is eligible for NHS CHC, the CCG has a responsibility to ensure that effective case management is commissioned, which includes monitoring the care received and arranging regular reviews. Case management involves management of the whole package of care and not just the healthcare aspects. The key elements of case management, which in any given case might be undertaken by more than one professional, include:

- ensuring that a suitable personalised care plan has been drawn up for, and with, the individual
- ensuring that the agreed care and support package continues to meet the individual's assessed health and associated care and support needs and agreed outcomes
- where the care plan includes access to non-NHS services, ensuring that the arrangements for these are in place and are working effectively
- monitoring the quality of the individual's care and support arrangements and responding to any difficulties/concerns about these in a timely manner

- acting as a link person to coordinate services for the individual
- ensuring that any changes in the person's needs are addressed
- initiating/undertaking reviews

Where a person qualifies for NHS CHC, the package of care to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health, associated care and support needs. The CCG has responsibility for ensuring this is the case and determining what the appropriate package should be.

In doing so, the CCG should have due regard to the individual's wishes and preferred outcomes.

Although the CCG is not bound by the views of the Local Authority on what services the individual requires, any Local Authority assessment under the Care Act 2014 will be important in identifying the individual's needs and in some cases the options for meeting them. Whichever mechanism is used for meeting an individual's assessed needs; the approach taken should be in line with the principles of personalisation.

5.15 Personal Health Budgets

A Personal Health Budget (PHB) is an amount of money that is allocated to an individual to allow them to meet their health and well-being needs in a way that best suits them. At the heart of a PHB is a care/support plan which sets out the individual's health (and social care) needs and includes the desired outcomes, the amount of money in the budget and how this will be spent. The care/support plan has to be agreed between the individual and the health care professional, before being checked and signed off by the CCG.

PHBs do not alter the legal obligations to assess for NHS CHC, nor do they alter the eligibility criteria or the assessment of the level of need. PHBs should only be considered as a way of planning and delivering NHS CHC once the level of care has been agreed.

PHBs are governed under a separate CCG Policy.

5.16 Fast Track Pathway

There may be circumstances where an individual, *not previously awarded NHS CHC*, on the basis of need does have a rapidly deteriorating condition and the condition may be entering a terminal phase.

The person may need NHS CHC funding to enable their needs to be urgently met (e.g. to provide appropriate end of life support to be put in place either in their own home or in a care setting), where that support is not already available from appropriate locally commissioned services such as District Nursing and Hospice services. The Fast Track Pathway Tool should be used by an appropriate clinician to outline the reasons for the Fast Track decision.

The process for Fast Track applications ensures that decisions about eligibility for NHS CHC can be made, where appropriate, to support the preferred priorities of the individual for their end of life care as soon as is reasonably practicable.

The Fast Track Tool should not be used instead of a full assessment because of service pressures and staff shortages.

The Fast Track Tool bypasses the Checklist and DST. The National Framework is clear that it can only be completed by an appropriate clinician. The National Framework defines appropriate clinician as follows:

- responsible for the diagnosis, treatment or care of the individual under the 2006 Act in respect of whom a Fast Track Pathway Tool is being completed
- and a registered nurse or a registered medical practitioner

When completing the Fast Track Pathway Tool, clinicians should sensitively explain to the individual that their needs may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review**.**

The CCG must accept and immediately action a Fast Track Pathway Tool where the Tool has been properly completed and is evidenced by relevant documentation such as a Do Not Attempt Resuscitation (DNAR) form and an anticipatory end of life symptom control medicines prescription.

The referrer will be informed at the time of decision to minimise the delay in arranging and commissioning care. This will be confirmed in writing to both the referrer and the individual or their representative.

Exceptionally, there may be circumstances where the completed Fast Track Tool appears to show that the individual's condition is not related to a rapidly deteriorating condition which may be entering the terminal phase. In these circumstances the CHC Team should urgently ask the relevant clinician to clarify the nature of the individual's needs and the reason for the use of the Fast Track Pathway Tool. Where it then becomes clear that the use of the Fast Track Tool was not appropriate, the clinician should be asked to submit a completed Checklist for consideration through the wider eligibility process.

It is 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 CHC. The CCG will make any decisions about reviewing eligibility in Fast Track cases with sensitivity.

Where an individual, who is receiving services from use of the Fast Track Pathway Tool, is expected to die in the very near future, the CCG should continue to take responsibility for the care package until the end of their life.

No individual identified through the Fast Track Pathway Tool who is eligible for NHS CHC should have this funding removed without their eligibility being re-considered through the completion of a DST by a MDT, including this MDT making a recommendation on eligibility for NHS CHC.

5.17 Commissioning and funding

To enable the CHC Team to commission safe and appropriate packages of care, the following principles need to be identified:

- A holistic personalised care plan identifying all needs and how these needs can be best met including who will be meeting these needs i.e. family members, community nurses
- Unmet needs within the holistic care plan which need to be commissioned by the CHC Team need to be clearly identified within the care plan, supported by relevant risk assessments, such as manual handing and behaviour risk assessments

The CHC Team needs to be assured that the following information has been sourced for all care providers:

- CQC registration and latest inspection report
- Insurance certificate (liability)
- Statement of purpose
- Contingency plans

The CHC Team will commission the provision of NHS CHC in a manner that reflects the choice and preference of individuals based on their assessed needs and balance the need for the CCG to commission care that is safe and effective, equitable and makes best use of resources. This is referenced in more detail within the Equity in Choice Policy.

The CHC Team have delegated authority to commission care provision on behalf of the CCG with an escalation process in place for approval of high cost packages of care.

Each provider receives a funding agreement and contract setting out the terms and conditions of the care provision, including agreed costs and invoicing procedures.

CHC funding will commence from the date of when an individual is determined eligible by the MDT. However if there is a delay of over 28 days between referral and the decision, the CCG should consider funding from the 29th day of receipt of referral, except in cases where the delay is due to circumstances beyond the CCG's control, which will include:

- Evidence (such as assessments or care records) essential for reaching a decision on eligibility have been requested from a third party and there has been a delay in receiving these records
- The individual or their representatives have been asked for specific information or evidence of participation in the process, and there has been a delay in receiving a response from them
- There has been a delay in convening an MDT due to the lack of availability of a non-CHC practitioner, whose attendance is key to determining eligibility, and it is not practicable for them to give their input by alternative means such as written communication or via telephone

5.18 NHS Continuing Healthcare funding cessation

Refer to separate policy: MECCG135 – Continuing Healthcare Cessation of Funding Policy.

5.19 Joint Funding

There is not currently a formal agreement with the Local Authority regarding a process for Joint Funding of patients.

Joint Funding can only occur where a person has been assessed for Continuing Healthcare and has been found ineligible for fully funded CHC or FNC.

5.20 Funded Nursing Care (FNC)

NHS Funded Nursing Care is the funding provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible for NHS Funded Nursing Care. Section 22 of the Care Act 2014 prohibits Local Authorities from providing or arranging

for the provision of nursing care by a registered nurse save in the very limited circumstances set out in Section 22 (4).

The registered nurse input is defined in the following terms:
"services provided by registered nurse and involving either the provision of care or the planning supervision or delegation of the provision of care other than any services which having regard to their nature and circumstances in which they are provided, do not need to be provided by a registered nurse."

When reviewing the need for NHS Funded Nursing Care, potential eligibility for NHS Continuing Healthcare must always be considered. This will normally be achieved by completing a Checklist and where necessary a full assessment for NHS Continuing Healthcare using the DST. However, where:

- a Checklist and/or DST has previously been completed (with the result that the individual was not found eligible for NHS Continuing Healthcare)

and

- it is clear that there has been no material change in need

then it will not be necessary to repeat the Checklist and/or DST and this should be recorded. The individual should be informed of this outcome and the reasons for it.

FNC will stop 5 days post admission to hospital, but will resume once the patient is re-admitted to the nursing home.

FNC payments stop at the date of death.

5.21 Appeals

Refer to separate policy: MECCG027 – Continuing Healthcare Appeals and Panel Policy.

5.22 CCH/Local Authority Dispute Resolution

Refer to separate policy: MECCG136 – Continuing Healthcare Disputes Agreement Policy.

5.23 NHS Continuing Healthcare Reviews

Where an individual has been found eligible for NHS Continuing Healthcare, a review should be undertaken within three months of the initial eligibility decision being made. After this, further reviews should be undertaken on at least an annual basis, although some individuals will require more frequent review in line with clinical judgement and changing needs.

These reviews should primarily focus on whether the care plan or arrangements remain appropriate to meet the individual's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility.

It is expected that the most recently completed Decision Support Tool (DST) will normally be available at the review and should be used as a point of reference to identify any potential change in needs. Where there is clear evidence of a change in needs to such an extent that it may impact on the individual's eligibility for NHS Continuing Healthcare then the CCG will arrange a full reassessment of eligibility for NHS Continuing Healthcare.

Where reassessment of eligibility for NHS Continuing Healthcare is required, a new DST must be completed by a properly constituted Multidisciplinary Team (MDT), as set out in the National Framework. Where appropriate, comparison should be made to the information provided in the previous DST. CCGs are reminded that they must, in so far as is reasonably practicable, consult with the local authority before making an NHS Continuing Healthcare eligibility decision, including any re-assessment of eligibility. This duty is normally discharged by the involvement of the Local Authority in the MDT process, as set out in the Assessment of Eligibility section of this National Framework. The CCG should ensure an individual's needs continue to be met during this reassessment of eligibility process.

If the Local Authority is responsible for any part of the care, both the CCG and the Local Authority will have a requirement to review needs and the service provided. In such circumstances, it would be beneficial for them to conduct a joint review where practicable.

Even if all the services are currently the responsibility of the NHS, it may sometimes be beneficial for the review to be held jointly by the NHS and the Local Authority where there is an indication of a possible need for a care and support assessment as part of the review process.

6 MONITORING COMPLIANCE

This policy will be electronically distributed to all relevant staff involved in CHC processes. In addition, the content of the policy will be reviewed with staff at an appropriate team meeting and the policy placed on the CCG's Internet site to ensure public access to this document.

The Continuing Healthcare Operational Lead, in conjunction with the CHC Team, is responsible for the monitoring, revision and updating of this document.

A suite of Key Performance Indicators (KPIs) will be used to monitor the effectiveness of the policy and service, and will be reported to the Finance and Performance Committee. Issues of quality and governance relating to this policy and CHC service will be reported to the Quality & Governance Committee.

The Continuing Healthcare Assurance Tool (CHAT) 'Key Lines of Enquiry' framework, which is monitored by NHS England, will be used to monitor the CCG progress in delivering CHC processes and this will be reported to the Quality & Patient Safety Committee.

7 ASSOCIATED DOCUMENTATION

- National Framework for NHS Continuing Healthcare (Department of Health 2018)
- Care and Support Guidance (Department of Health 2014) and the Care Act 2014
- Department of Health NHS Funded Nursing Care Best Practice Guidance

8 ARRANGEMENTS FOR REVIEW

This policy will be reviewed no less frequently than every three years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance.

9 REFERENCES

National Framework
https://www.gov.uk/government/publications/national-framework-for-nhs- continuing-healthcare-and-nhs-funded-nursing-care

Department of Health Decision support tool
https://www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool

Department of Health Checklist
https://www.gov.uk/government/publications/nhs-continuing-healthcare-checklist

Department of Health Fast Track Tool
https://www.gov.uk/government/publications/nhs-continuing-healthcare-fast-track-pathway-tool

Department of Health NHS Funded Nursing Care Best Practice Guidance
https://www.gov.uk/government/publications/nhs-funded-nursing-care-practice

The National Health Service Commissioning Board and clinical commissioning groups (Responsibilities and Standing Rules) Regulations 2012
http://www.legislation.gov.uk/uksi/2012/2996/pdfs/uksi_20122996_en.pdf

Who pays? Establishing the Responsible Commissioner
https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

Mental Capacity Act 2005
http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

NHS Continuing Healthcare Refreshed Redress Guidance 2015
https://www.england.nhs.uk/wp-content/uploads/2015/04/nhs-cont-hlthcr-rdress-guid-fin.pdf

Care and support statutory guidance, Updated 26 October 2018
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted