Calderdale Clinical Commissioning Group

and

Calderdale Council Metropolitan Borough Council

Operational Policy for NHS Funded Continuing Healthcare and NHS Funded Nursing Care

Policy Reference No 027

Version/Status:	1.0 / FINAL
Responsible Committee:	Quality Committee
Date Approved:	30 November 2017
Author:	Operational Manager, Continuing Health Care
Responsible Lead:	Head of Commissioning for Continuing Health Care, Mental Health and Learning Disabilities
Review Date:	November 2018

Version History

Version	Date	Author	Status	Commentary: (document development / approval)	Circulation
0.1		Operational Manager, Continuing Health Care	Draft	First draft	Head of CHC, MH and LD Project Advisor, Calderdale Metropolitan Borough Council
0.2		Operational Manager, Continuing Health Care	Draft	Amended	Quality Committee
1.0	30.11.17	Operational Manager, Continuing Health Care	**FINAL**	Approved by Quality Committee subject to dispute resolution pathway being approved by the Local Authority. (Dispute resolution pathway was subsequently approved by the	CHC Team Intranet Website

Version	Date	Author	Status	Commentary: (document development / approval)	Circulation
				Local Authority with a minor amendment which was agreed with CCG Quality Manager)	

Contents

1. Introduction

1.1 The CCG will operate Continuing Healthcare in accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised) and the Department of Health Responsibilities and Standing Rules. The National Framework sets out the principles and processes for the implementation of NHS Continuing Healthcare and NHS-funded Nursing Care and it provides national tools to be used for assessment, applications and for fast track cases.

1.2 The determination of eligibility for NHS-funded Nursing Care has been integrated into the National Framework so that the same framework for eligibility determination and care planning for NHS Continuing healthcare also applies for NHS-funded Nursing Care. Individuals should be considered for eligibility for NHS continuing healthcare before a decision is reached about the need for NHS Funded Nursing Care (FNC).

1.3 This policy should be read in line with the National Framework for NHS Continuing Healthcare and NHS Nursing Care, November 2012, the associated Practice Guidance, NHS – funded Nursing Care Practice Guide 2013, the Standing Rules Regulations and Responsible Commissioner Guidance, Who Pays, Determining Responsibility for Payment to Providers, August 2013 1.4 This policy should be read in line with the Fraud Act 2006, the Bribery Act 2010 and the Clinical Commissioning Group Anti-Fraud and Bribery Policy which is located on the intranet under the Policies, Strategies and Terms of Reference Section

2.0 Purpose

2.1 This policy sets out the roles and responsibilities for health and social care staff for the implementation of the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in Calderdale. It provides the process for determining eligibility for NHS-funded Continuing Healthcare and includes the procedures for this in the relevant appendices.

2.2 This policy describes the way in which the CCG will commission care in a manner that reflects patient choice and preferences of individuals, but balances the need for the CCG to commission care that is safe and effective and makes best use of resources.

2.3 The policy includes the following sections:

- eligibility for NHS-funded Continuing Healthcare
- fast track applications
- management of Appeals, Complaints and Disputes
- discharge planning
- Mental Health Act Section 117 Aftercare
- Retrospective Reviews of Care and Continuing Healthcare Redress
- Commissioning of Care Packages, Case Reviews, Contracting Arrangements and Choice
- Jointly Funded Packages of Care
- direct payments/Personal Health Budgets

3.0 Principles

3.1 **"NHS continuing healthcare"** means a package of on-going care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in the guidance. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery.

3.2 **"NHS-Funded Nursing Care"** 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 (FNC) 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 FNC.

3.3 There will be some individuals who, although they are not entitled to NHS continuing healthcare (because 'taken as a whole' their needs are not beyond the powers of a local authority to meet), but nonetheless have some specific needs identified through the Decision Support Tool that are not of a nature that an LA (Local Authority) can solely meet or are beyond the powers of an LA to solely meet. The CCG and the LA will work in partnership to agree respective responsibilities in a jointly funded package of care, including which party will take the lead commissioning role.

3.4 The National Framework aims to provide a consistent approach, and ease of understanding of NHS Continuing Healthcare, and to simplify the interaction between NHS Continuing Healthcare and NHS-funded Nursing Care.

3.5 The principles underlying this policy support the provision of a consistent approach, and fair and equitable access to NHS-funded Continuing Healthcare. These principles are as follows:

- The process of assessment and decision making will be person centred and underpinned by the principles of the Mental Capacity Act 2005 (MCA).
- The individual's informed consent will be obtained for completion of the CHC process including the completion of the Checklist, completion of the Decision Support Tool (DST), any appeal, the initial Review and the obtaining and sharing of assessment information.if the individual lacks the mental capacity either to give or refuse consent, unless it is known that there is a relevant Power of Attorney or a Deputyship Order in place, a 'best interests' decision will be taken and recorded in line with the Mental Capacity Act 2005 as to whether or not to proceed with assessment of eligibility for NHS continuing healthcare.
- A third party cannot give or refuse consent for an assessment of eligibility for NHS continuing healthcare on behalf of a person who lacks capacity

unless they have a valid and applicable Power of Attorney, or have been appointed as a Deputy by the Court of Protection.

- health and social care professionals will work in partnership with individual patients/clients and their families throughout the process
- all individual patients and their families will be provided with information to enable them to participate in the process
- the CCG will support the provision of advocacy to individuals through the process of application for NHS-funded Continuing Healthcare
- the process for decisions about eligibility for NHS-funded Continuing Healthcare will be transparent for individual patients /clients and their families and for partner agencies
- Once an individual has been referred for a full assessment for NHS continuing healthcare (following use of the Checklist or a direct referral); a multidisciplinary assessment of the individual's health and social care needs will be conducted, and the Decision Support Tool completed.
- The aim will be for assessments and decision making about eligibility for NHS-funded Continuing Healthcare to be undertaken within 28 working days of the completion of the Continuing Healthcare Checklist wherever possible so as to ensure that individuals receive the care they require in the appropriate environment, without unreasonable delays.

4.0 Continuing Healthcare section within the CCG

4.1 Aims and objectives of services provided:

- To establish and maintain operational and governance arrangements for NHS Continuing Healthcare that ensure consistency in the application of the National Framework.
- To work in partnership with a range of agencies to achieve standard procedures for assessing eligibility, decision-making and review for people with continuing care needs.
- To commission and procure appropriate care packages for eligible people that represent good quality and value for money

- To manage a system to address complaints, disputes and appeals relating to continuing healthcare

4.2 Service Description

- The service ensures that policy and legal guidance is correctly interpreted and implemented.
- It provides an assessment service and decision making processes in line with the National Framework and Standing Rules and Regulations.
- It offers a single point of contact and manages relationships between patients, relatives, health and social care professionals, other NHS organisations and the public sector.
- It provides on-going case management for people who are eligible for NHS continuing healthcare, some of which are complex because of the nature of the client group
- It oversees the procurement and provision of care to patients with a range of presenting conditions and provides contract and finance management to ensure quality services are provided that represent value for money.
- It provides training and development to health and social care professionals who assess patients' eligibility for NHS continuing healthcare.
- It manages complaints, disputes and independent reviews in line with Department of Health and the Health Service Ombudsman's requirements.

5.0 Eligibility for NHS Continuing Healthcare

5.1 The National Framework provides a consistent approach for 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 NHS Continuing Healthcare. Continuing Healthcare eligibility will usually be determined within 28 days.

5.2 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.

5.3 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 from the assessment process. Where an individual has a primary health need and is therefore eligible for NHS continuing care, the NHS is responsible for providing all of that individual's assessed needs (including accommodation) if that is part of the overall need.

5.4 The term "primary health need" does not appear, nor is defined, in primary legislation; although it is referred to in the Standing Rules where it sets out a person should be considered to have a primary health need when the nursing or other health services they require, when considered in their totality, are:

- where that person is, or is to be, accommodated in a care home, more that incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or
- of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide.

5.5 The LA can only meet nursing /healthcare needs when, taken as a whole, the nursing or other health services required by the individual are below this level. If the individual's nursing/healthcare needs, when taken in their totality are beyond the lawful power of the LA to meet, then they have a primary health need.

5.6 Consideration of primary health need includes consideration of the characteristics of need and their impact on the care required to manage them. In particular to determine whether the quantity or quality of care is more than the limits of responsibility of LAs (as outlined in the Coughlan judgment), consideration is given to the following:

- Nature is about the characteristics of both the individual's needs and the interventions required to meet those needs.

- Intensity - both extent ("quantity") and severity ("degree") of the needs, including the need for sustained care ("continuity")
- Complexity is about the level of skill/knowledge required to address an individual need or the range of needs and the interface between two or more needs.
- Unpredictability of need - the degree to which needs fluctuate, creating difficulty/challenges in managing needs.

5.7 The national Decision Support Tool (DST) 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 DST combined with the practitioners' own experience and professional judgement should enable them to apply the primary health needs test in practice in a way which is consistent with the limits on what can lawfully be provided by a Local Authority and in accordance with Coughlan and Grogan judgments.

5.8 Eligibility for NHS Continuing Healthcare is based on an individual's assessed health needs. The decision support tool provides the basis for decisions on eligibility for NHS-funded Continuing Healthcare. The DST should be completed by the multidisciplinary team which, as a minimum, should include a health professional and a social worker. Social care staff must always be invited to be involved in the completion of the DST. (See Appendix 1 for details of agreed timescales for allocation of social workers and completed documentation). The CCG reserves the right to arrange a multidisciplinary team without social care staff if the timescales are not adhered to. Specialist staff and mental health staff should be involved dependent on the individual's needs.

5.9 The multi-disciplinary team will make recommendations on eligibility of individual patients/clients for NHS-funded Continuing Healthcare to Calderdale CCG. The Continuing Healthcare Team, by means of the verification process or Decision Making Panel will review the assessments and DST and can make the following decisions with regard to recommendations about eligibility for NHS-funded Continuing Healthcare:

- approve the recommendation of the multidisciplinary team
- defer the decision and request further evidence to support decision making
- decline the recommendation of the multidisciplinary team where the evidence provided does not support the level of need indicated in the DST. This would only happen in exceptional circumstances.

6.0 Responsible Commissioner

The CCG is usually only responsible for NHS Continuing Healthcare and Funded Nursing Care for individuals who are registered with a G.P. whose practice is a member of Calderdale CCG and in accordance with Who Pays, Determining Responsibility for Payment to Providers August 2013 (or any superseding or amending guidance).

7.0 Application Process

7.1 Where it is identified that an individual may have a need for continuing healthcare then an NHS Continuing Healthcare Checklist should be completed.

7.2 The first step in the process for most people will be a screening process using the NHS Continuing Healthcare Checklist. The purpose of the checklist is to encourage proportionate assessments, so that resources are directed towards those people who are most likely to be eligible for NHS Continuing Healthcare.

7.3 Before applying the checklist, it is necessary to ensure that the individual and their representative where appropriate, understand that the checklist does not indicate the likelihood that the individual will be found to 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 do get this opportunity. However, there may also be circumstances where a full assessment for NHS continuing healthcare is appropriate even though the individual does not meet the indicated threshold set out at paragraph 21 of the checklist user notes.

7.4 Qualified healthcare professionals or social workers can apply the checklist to refer individuals for a full consideration of eligibility for NHS Continuing Healthcare from either a community or hospital setting. Whoever applies the checklist must be familiar with, and have regard to, the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH 2012) and the DST.

7.5 In a hospital setting, before an NHS body gives notice of an individual's case to a Local Authority in compliance with section 2(2) of the Community Care (Delayed Discharges) Act 2003, it "must take reasonable steps to ensure that an assessment for NHS continuing healthcare is carried out in all cases where it appears to the body that the patient may have a need for such care". The Checklist should therefore be applied, where relevant, as the first stage of that discharge process.

7.6 Assessments of eligibility for NHS Continuing Healthcare can take place in either a hospital or non- hospital setting. It is noted that eligibility assessments taking place in hospital may not always reflect an individual's capacity to maximise their potential. Anyone carrying out the assessment of eligibility should always consider whether there is potential for rehabilitation and for independence to be regained and how the outcome of treatment or medication may affect ongoing needs.

7.7 Where the Checklist has been used as part of the process of discharge from an acute hospital, and has indicated a need for full assessment of eligibility, a decision may be made at this stage first to provide other services and then to carry out a full assessment of eligibility at a later stage. This should be recorded. The CCG will ensure that full assessment of eligibility is carried out once it is possible to make a reasonable judgement about the individual's on-going needs. This full consideration will be completed in the most appropriate setting (NHS institution, individual's home, care home or other setting). In the interim the CCG retains responsibility for funding appropriate care.

7.8 If completion of the checklist indicates that the individual may be eligible for NHS funded Continuing Healthcare, the DST will be completed following the completion of the multi-agency assessment process. The DST provides the overall picture of need and interaction between needs which, together with the evidence from relevant assessments, supports the process of determining eligibility and ensures consistent and comprehensive consideration of an individual's health and social care needs.

7.9 Once an individual has been referred for a full assessment for NHS continuing healthcare, irrespective of the individual's setting, the CCG has responsibility for coordinating the whole process until the decision on eligibility has been made and any care plan agreed as appropriate. The CCG will identify an individual (or individuals) to carry out the coordination role, which is pivotal to the effective management of the assessment and decision-making process. The coordinator may either be a CCG member of staff or be from an external organisation.

7.10 The multidisciplinary assessment that informs completion of the Decision Support Tool should be carried out with the knowledge and consent of the individual, and they should be given every opportunity to participate in the assessment. The individual should be given the option of being supported or represented by a carer, relative or advocate, if they so wish. The assessment process should draw on those who have direct knowledge of the individual and their needs. It should also make use of existing specialist assessments, and should make referrals for other specialist assessments whenever that is appropriate in light of the individual's care needs.

7.11 The multidisciplinary team should use the Decision Support Tool to set out the evidence and enable them to consider not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments. Completion of the DST should result in an overall picture of the individual's needs that captures their nature, and their complexity, intensity and/or unpredictability and thus the quality and/or quantity (including continuity) of

care required to meet the individual's needs. The overall picture, and the descriptors within the domains themselves, also relate to the nature of needs.

7.12 Practitioners must use the DST to apply the primary health need test, ensuring that the full range of factors which have a bearing on the individual's eligibility are taken into account in making the decision. The process for application of NHS-funded Continuing Healthcare is set out in Appendix 1.

7.13 The DST cannot directly determine eligibility, but it provides the basis from which decisions are made exercising professional judgment and in consideration of the primary health need test. Once the multi- disciplinary team has reached agreement they make a recommendation on eligibility to the CCG.

8.0 Decision Making

8.1 A CCG Clinical Verifier will review the DST and the MDT recommendations and in most cases the recommendation will be accepted and verified. This review will ensure consistency and quality of decision making and will provide governance to the assessment and decision making process. This will ensure equity of access to NHS-funded Continuing Healthcare and consistent decision making for all applications.

8.2 In exceptional circumstances the MDT recommendation might not be accepted e.g. where the DST is not complete, where there are significant gaps in evidence to support the recommendation, where there is an obvious mismatch between the evidence and the recommendation or where the recommendation would result in either the CCG or the LA acting unlawfully. In such a case, the matter should be referred back to the MDT with an explanation of the issues needing to be addressed.

8.3 The ultimate responsibility for the eligibility decision rests with the CCG.

8.4 A person only becomes eligible for NHS continuing healthcare once a decision on eligibility has been made by the CCG, informed by a completed DST or Fast Track Pathway Tool. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment. This adjustment should be made by the agency responsible for the care package at the time.

8.5 Once the recommendation is validated by the CCG the individual will be informed in writing as soon as possible, giving the reasons for the decision and details of who to contact if they wish to seek further clarification or wish to request a review of the decision. This letter will be copied to the referrer and any other relevant parties.

8.6 Where individuals are found to be eligible for NHS-funded Continuing Healthcare arrangements will be made to provide the care package that is required based on the health needs assessment and the care plan. Funding will be agreed from the date that the decision is made to accept the recommendation or the date when the care provision commences.

9.0 Fast Track Applications

9.1 The eligibility criterion for a fast track application for NHS-funded Continuing Healthcare is defined within the National Framework for NHS-funded Continuing Healthcare (DH 2012). The framework states that a fast track application may be made by an appropriate clinician who is; **Registered nurse, or medical practitioner who is responsible for the diagnosis, providing treatment or care and is pursuant of the 2006 Act** for an individual with a rapidly deteriorating condition that may be entering a terminal phase. Where an individuals end of life needs are supported by either independent/ voluntary sector organisations who are familiar with their health including diagnosis, that organisation can contact the appropriate clinician responsible for the individual's healthcare to request Fast Track Tool be completed or alternatively approach Calderdale CHC Team.

9.2 Where a recommendation is made for an urgent package of care via the fast-track process, this should be accepted and actioned immediately by the CCG. The referrer must provide information as to how/why the person meets the criterion for fast track funding. In order for care packages to be commissioned promptly, fast track referrals must be accompanied by a detailed care plan outlining the patient's specific needs, following person centred and MCA .

9.3 NHS continuing healthcare assessments and care planning for those with end of life needs should be carried out in an integrated manner, as part of the individual's overall end of life care pathway, and should reflect the approaches set out in the national End of Life Care Strategy, with full account being taken of patient preferences, including those set out in advance decisions and directives provided by the patient and any opinion of an appointed attorney or deputy for health and welfare decisions.

9.4 The CCG will monitor use of the tool and raise any specific concerns with clinicians, teams and organisations. Such concerns should be treated as a separate matter from the task of arranging for service provision in the individual case.

9.5 The process for fast track applications is set out in Appendix 3.

10.0 Commissioning and care planning

10.1 For those identified as eligible for Continuing Healthcare funding the Multi-Disciplinary Team will provide information on the care package required by the patient but the responsibility for the commissioning of the care package is the responsibility of the Continuing Healthcare Team.

10.2 The care needs and the dependency level of the patient will be confirmed by the clinical verifier and a care package will be proposed in line with the Continuing Healthcare Commissioning policy. (Appendix 2)

10.3 All care packages in nursing and residential care will be commissioned using the NHS contract arrangements and fee structure that has been agreed. Where the individual has health needs that are of a degree of complexity and intensity that is more than can be provided through the standard contract, an individual care package will be negotiated in line with the Policy for the Provision of NHS Continuing Healthcare.

10.4 Domiciliary care packages will be commissioned from providers that have an NHS standard contract with Calderdale CCG. In exceptional circumstances, where there is no capacity within CCG contracted providers, domiciliary care may be procured from providers which have been approved by Calderdale Council; however the provider will be expected to enter into an NHS standard contract with the CCG with immediate effect.

10.5 The CCG will ensure that any proposed provider is suitably registered with CQC, has no out -standing quality/ safeguarding issues that will affect the care of the individual and that the provider agrees to the terms and conditions set by the CCG, (see paragraph 14).

11.0 Equipment

11.1 There individuals in receipt of NHS continuing healthcare require equipment to meet their care needs, there are several routes by which this may be provided:

- If the individual is, or will be, supported in a care-home setting, the care home may be required to provide certain equipment as part of regulatory standards or as part of its contract with the CCG. Further details of the regulatory standards can be found on the Care Quality Commission's website
- Individuals who are eligible for NHS continuing healthcare have an entitlement – on the same basis as other patients – to joint equipment services. The CCG will ensure that the availability to those in receipt of NHS continuing healthcare is taken into account in the planning, commissioning and funding arrangements for these services.

- Some individuals will require bespoke equipment (or other non-bespoke equipment that is not available through routes above) to meet specific assessed needs identified in their NHS continuing healthcare care plan. The CCG will make appropriate arrangements to meet these needs ensuring that there is clarity about which of the above arrangements is applicable in each individual case.

12.0 Reviews

12.1 If the CCG is commissioning, funding or providing any part of an individual's care, a case review will be undertaken to re-assess care needs and eligibility for NHS Continuing Healthcare and ensure needs are being met to the standard expected by the NHS.

12.2 Care reviews will be undertaken for individuals in accordance with the timesacales specified in the National Framework . The care review will also review the continuing eligibility of the individual patient for NHS Continuing healthcare.

12.3 An individual's needs might change and therefore so might their eligibility for NHS Continuing Healthcare. The review will be done in consultation with the person being reviewed and any other relevant people. The outcome of the case review will determine whether the individual's needs have changed and that will then determine whether the package of care may have to be revised or the funding responsibility altered. In such cases the Local Authority will be advised of this decision and will require a discussion regarding the implications. The patient's informed consent to the arranged care package is requested, should the patient lack capacity and does not have an attorney / deputy for health and welfare MCA processes will be applied. The outcome of the case review will be communicated to the individual in writing.

12.4 Some individuals will require more frequent review in line with clinical judgement and changing needs.

12.5 Neither the CCG nor the LA will unilaterally withdraw from any existing joint funding arrangement without a joint reassessment of the individual and without first consulting one another and the individual about the proposed change in the arrangement.

13.0 Review of Fast Track Decisions

13.1 Once the individual has an appropriate care package in place or for those already in 24 hour placement it is important to review the effectiveness. National Guidance recommends review at 3 months however in certain situations the needs may indicate it is appropriate to review the eligibility for NHS Continuing Health Care at a different period/s**.** The CCG also has the responsibility to audit and monitor the use of the Fast Track Tool. The CCG will address any concerns arising regarding the appropriate use of Fast Track Tool with relevant clinicians or organisations.

14.0 Contracting Arrangements

14.1 The Continuing Healthcare section contributes to the CCG's responsibility to plan strategically and specify outcomes for people who are eligible for NHS continuing healthcare.

14.2 The Continuing Healthcare section will manage provider performance for the services contracted by them to meet the needs of individuals who qualify for Continuing Healthcare.

14.3 The Continuing Healthcare section will contribute to the commissioning of services that include the on-going case management role from providers; e.g. community services; discharge planning; all those who may be entitled to NHS Continuing Healthcare; as well as commissioning the NHS elements of joint packages.

14.4 The Continuing Healthcare section will monitor quality and patient experience within the context of provider performance within the contracts it manages.

14.5 Care packages will be commissioned from care homes, from domiciliary care providers and from nursing agencies.Where an NHS contract for NHS-funded Continuing Healthcare is not already 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.

14.6 Care will only be commissioned from those care providers who have an adequate/satisfactory care rating from the Care Quality Commission. Where a care provider has an inadequate rating from the Care Quality Commission, care packages will not be commissioned until an action plan for improvement has been put in place and the care rating has improved.

14.7 Where care is already being commissioned for residents in the care setting which receives an inadequate rating from CQC, a risk assessment will be undertaken in partnership with the Local Authority and in consultation with the resident and their family to ensure appropriate controls are in place to assure the individual's safety and the quality of the care provided.

15.0 Choice

15.1 Provision of NHS-funded Continuing Healthcare will be commissioned in a manner which reflects the choice and preferences of individuals as far as possible, but balances the need to commission care that is clinically appropriate, safe and effective and represents value for money in line with the Continuing healthcare commissioning policy (Appendix 2).

16.0 Jointly Funded Packages of Care

16.1 There will be some individuals who, although they are not entitled to CHC NHS health care (because 'taken as a whole' their needs are not beyond the powers of a local authority to meet), but nonetheless have some specific health needs identified through a DST that are not of a nature that an LA can solely meet or are beyond the powers of an LA to solely meet. The CCG will work in partnership with its colleagues to agree their respective responsibilities in a

joint package of care, including deciding which party will take the lead commissioning role.

16.2 The Continuing Healthcare section will assist in identifying the range of health services commissioned and provided by the NHS that the patient may access, if these are identified and agreed as part of an assessment and care plan. The range of services that the NHS is expected to arrange and fund includes, but is not limited to:

- Primary healthcare
- Assessment involving doctors and registered nurses
- Rehabilitation/re-enablement and recovery (where this forms part of an overall package of NHS care, as distinct from intermediate care)
- Respite healthcare
- Community health services
- Specialist support for healthcare needs; and
- Palliative care and end of life healthcare

16.3 The CCG will fund the identified health care element of the jointly funded care package.

17.0 Funded Nursing Care

17.1 'NHS-funded Nursing Care' introduced in 2001, is the funding provided by the NHS to care homes providing nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible. If an individual does not qualify for NHS Continuing Healthcare, the need of care from a registered nurse should be determined. Once the need for such care is agreed, the CCG's responsibility to pay a flat rate contribution to the care home towards registered nursing care costs arises.

17.2 The registered nurse input is defined in the following terms:

17.3 ‘Services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any other services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse.’

17.4 Those in receipt of NHS-funded Nursing Care continue to be entitled to access to the full range of primary, community, secondary and other health services. The CCG will ensure that the contracting arrangements with the care homes that provide nursing care give clarity on the responsibilities of nurses within the care home and of community nursing services, respectively, so no gap in service provision should arise.

18.0 Out of Area Placements

18.1 Wherever possible, people should be supported to be cared for within their own homes and local communities. For a minority of people, the nature of their complex needs may mean they need specialist provision that is only provided outside of their local area. Alternatively the individual or their representative may ask for a placement outside of the CCG’s area as their preference.

18.2 In such cases the National Protocol for Notification of NHS Out of Area Placements for Individual Packages of Care will be used. This will ensure that both the receiving and the placing CCGs are aware of individuals who are placed in care homes and independent hospitals within their area. This means that both CCGs will be aware of any concerns about the standard of care provided by the provider and can be appropriately involved in any local multi-agency safeguarding procedures.

19.0 Links to Other Policies

19.1 Section 117 After Care

A patient liable to detention under certain sections of the Mental Health Act 1983 (for example Section 3) may be eligible to receive aftercare services funded under Section 117of that Act and those arrangements are separate and different from NHS funded Continuing Healthcare, so the two should not be confused. Only if an individual has additional health needs not related to their mental disorder that are not covered under the Section 117 might it be necessary to carry out consideration for NHS funded Continuing Healthcare. An example of this might be if there is a significant physical health need in addition to their mental health needs which may be the responsibility of health organisations and fall under the NHS Continuing healthcare framework. However, an individual's mental health and associated needs come under the Mental Health Act provision.

20.0 Deprivation of Liberty Safeguards

20.1 The Mental Capacity Act 2005 contains provisions that apply to a person who lacks capacity and who, in their own best interests, needs to be deprived of their liberty in a care home or hospital, supported living arrangements or their own home, in order for them to receive the necessary care or treatment. The fact that a person needs to be deprived of his liberty in these circumstances does not affect the consideration of whether that person is eligible for NHS continuing healthcare.

21.0 Transition from Child to Adult Services

21.1 The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care and the Supporting guidance and tools should be used to determine what ongoing care services people aged 18 years and over should receive from the NHS.

21.2 Legislation and the respective responsibilities of the NHS, social care and other services are different in child and adult services. The term ‘continuing care’ also has different meanings in child and adult services. It is important that young people and their families are helped to understand this and its implications right from the start of transition planning.

21.3 Entitlement to adult NHS continuing healthcare will initially be established using the decision-making process set out in this adult Framework, including the Checklist and the Decision Support Tool. The decision on eligibility will be made using the continuing healthcare decision-making processes. The health plans and other assessments and plans developed as part of the transition process will provide key evidence to be considered in the decision-making process. Any entitlement that is identified by means of these processes before a young person reaches adulthood will come into effect on their 18th birthday, subject to any change in their needs.

21.4 If the young person who receives children’s continuing care has been determined by the CCG not to be eligible for a package of adult NHS continuing healthcare in respect of when they reach the age of 18, they should be advised of their ineligibility and of their right to request review, on the same basis as NHS continuing healthcare eligibility decisions regarding adults. The CCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a package of care jointly funded by the CCG and the LA.

22.0 Personal Health Budgets

22.1 NHS Continuing Healthcare can also be provided via a Personal Health Budget. Since April 2014, Continuing Health Care (CHC) patients, both adults and children, have had the right to ask about a Personal Health Budget (PHB). Since October 2014 that has increased to the right to have a Personal Health Budget.

22.2 A personal health budget is an amount of money to support the patient's identified health and wellbeing needs, planned and agreed between them and the CCG. The aim is to give people eligible for continuing healthcare funding greater choice and control over the healthcare and support they receive.

22.3 Calderdale Clinical Commissioning Group has commissioned Calderdale Local Authority to provide information, advice and guidance for anyone who would like to have a Personal Health Budget. Please refer to **Appendix 6** for additional information regarding the process.

23.0 Management of Appeals

23.1 The formal responsibility for informing individuals of the decision about eligibility for NHS continuing healthcare and of their right to appeal or request a review lies with that CCG with which the individual is a patient for the purposes of NHS continuing healthcare, in line with current DH 'responsible commissioner' guidance.

23.2 The CCG will inform the individual, in writing, of the outcome of the decision regarding eligibility for continuing healthcare funding including the reasons for the decision and details of who to contact if they wish to seek further clarification, appeal or request a review of the decision.

23.3 If an individual is challenging a decision where a full assessment of eligibility has been undertaken using the Decision Support Tool (or by use of the Fast Track Pathway Tool, this should be addressed through the local resolution procedure. Where it has not been possible to resolve the matter through the local procedure the individual may apply for an independent review of the decision, if they are dissatisfied with:

a) the procedure followed by NHS England or the CCG in reaching its decision as to the person's eligibility for NHS continuing healthcare; or
b) the decision regarding eligibility for NHS continuing healthcare

23.4 The process for appeals is set out in **Appendix 7.**

24.0 Retrospective Reviews of Care and Continuing Healthcare Redress

24.1 The CCG will only consider requests for a retrospective review where it is satisfied that one or more of the following grounds for the review exist:-

- the CCG carried out an assessment of the individual but there is evidence that the criteria were not applied appropriately;

- it should have been reasonably apparent to the NHS that the individual may need NHS CHC but the CCG failed to carry out an assessment.24.2 In the absence of evidence of any of the above, the CCG is not obliged to undertake a retrospective review of the claimant's eligibility for such funding.

24.2 Where a retrospective review of eligibility for NHS funded Continuing Healthcare determines that an individual was eligible for NHS-funded continuing healthcare, appropriate arrangements will be made for financial recompense in line with the CCG's Redress Policy.

24.3 The process for appeals for NHS Continuing Healthcare Retrospective Review Process is set out in **Appendix 8**.

25.0 Complaints

25.1 If an individual has concerns in respect of an appeal or a review, they may submit a complaint through the CCG's complaints procedure (but see also the individual's rights to request an independent review referred to previously).

26.0 Disputes between the CCG and a Local Authority

26.1 Calderdale Council or other Local Authorities may dispute a decision that is made by the CCG in respect of an application for NHS-funded Continuing Healthcare.

26.2 Paragraph 6.83 of the Care and Support Statutory Guidance (DH 2014) makes it a statutory requirement for LAs and CCGs to have a disputes resolution process in place that deals with disputes between CCGs and LA, which must cover;

- eligibility for Continuing Healthcare , and/or,
- the apportionment of funding, and/or,
- operation of the refunds guidance.

26.3 The CCG and Calderdale Council subscribe to the principle that there should be no delay in the provision of services due to disagreements or disputes on the assessment recommendation or outcome of the decision on eligibility. Should such situations arise, the National Framework for NHS-funded Continuing Healthcare is explicit in stating that any existing funding arrangements cannot be unilaterally withdrawn and that agreement of the other funding party is required.

26.4 Therefore, anyone living in their own home, or in a care home whose care is funded by the local authority must continue to be financially assisted by the Council until the dispute is resolved.

26.5 Similarly, anyone in hospital, or whose care is funded by the CCG must remain funded by the CCG until the dispute is resolved. The CCG and Calderdale Council and neighbouring Local Authorities 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 original funding request. This means that if the Local Authority has continued to fund an arrangement that was subsequently decided to be the responsibility of the CCG, NHS Continuing Healthcare funding will be backdated to the date that the Local Authority gave

notification to the CCG of their dispute and either the individual or the Local Authority or both will be reimbursed for any healthcare and relevant other costs that they have paid during this interim period.

26.6 Similarly, where the CCG has continued to fund an arrangement that subsequently is decided to have been a Local Authority responsibility, Calderdale Council or the neighbouring Local Authority will reimburse the CCG to the date that the decision.

26.7 If a case cannot be resolved at a Local Resolution hearing or through escalation to relevant Directors the case will be referred to NHS England.

27.0 Delayed Transfers of Care

27.1 Completion of the checklist (and where relevant the DST) should be undertaken as part of the assessment and care planning process for discharge arrangements for individual patients.

27.2 In order to ensure there are no unnecessary stays in hospital, assessment of eligibility can be completed in non-hospital settings. To ensure discharges are not delayed a jointly agreed 'Discharge to Assess Pathway' has been formulated between the Local Authority and Continuing Healthcare Service.

27.3 See Appendix 1, 3.0 Discharge to Assess.

27.4 In order to progress discharge arrangements for individuals in these circumstances, where a decision has not yet been made on eligibility for NHS funded Continuing Healthcare, the CCG may agree to fund an interim placement whilst the assessment process is completed. This will be time-limited with clear plans for discharge in the event of the individual not being eligible for a care package funded by the NHS.

28.0 Training

28.1 The CHC department supports training for hospital and community staff and adult social care staff regarding the use of the national tools, the identification of primary health need and the application process for NHS Continuing Healthcare. Training is provided in the use of national tools, the identification of primary health need and the application process for NHS Continuing healthcare to support the CCGs in fulfilling their responsibility for governance in the CHC process.

28.2 All professionals within the CCG and other provider organisations have access to an e-learning programme that has been developed by the Department of Health

29.0 Governance and Quality of CHC Process (including Data Management)

29.1 Implementation of the National Framework for NHS funded Continuing Healthcare and NHS-funded Nursing Care (DH 2012) will be monitored through performance reports and quality assurance to the CCG, NHSE, DOH.

29.2 Peer review and audit will be undertaken by the CCG to ensure consistent decision making regarding eligibility aligned to the National Framework.

30.0 Data Management

30.1 The CHC section uses Electronic Database to record information, including personal and sensitive information about service users. This system acts as a patient record system and is able to produce financial and performance data and reports. It is also able to support invoice scheduling. The personal and sensitive information held within the Electronic database is governed by the requirements of the Data Protection Act 1998 as well as the CCGs own policies and procedures relating to Information governance. All CHC staff are expected to comply with the requirements of the Data Protection Act 1998 and

local CCG policies and procedures when accessing and sharing personal and sensitive information.

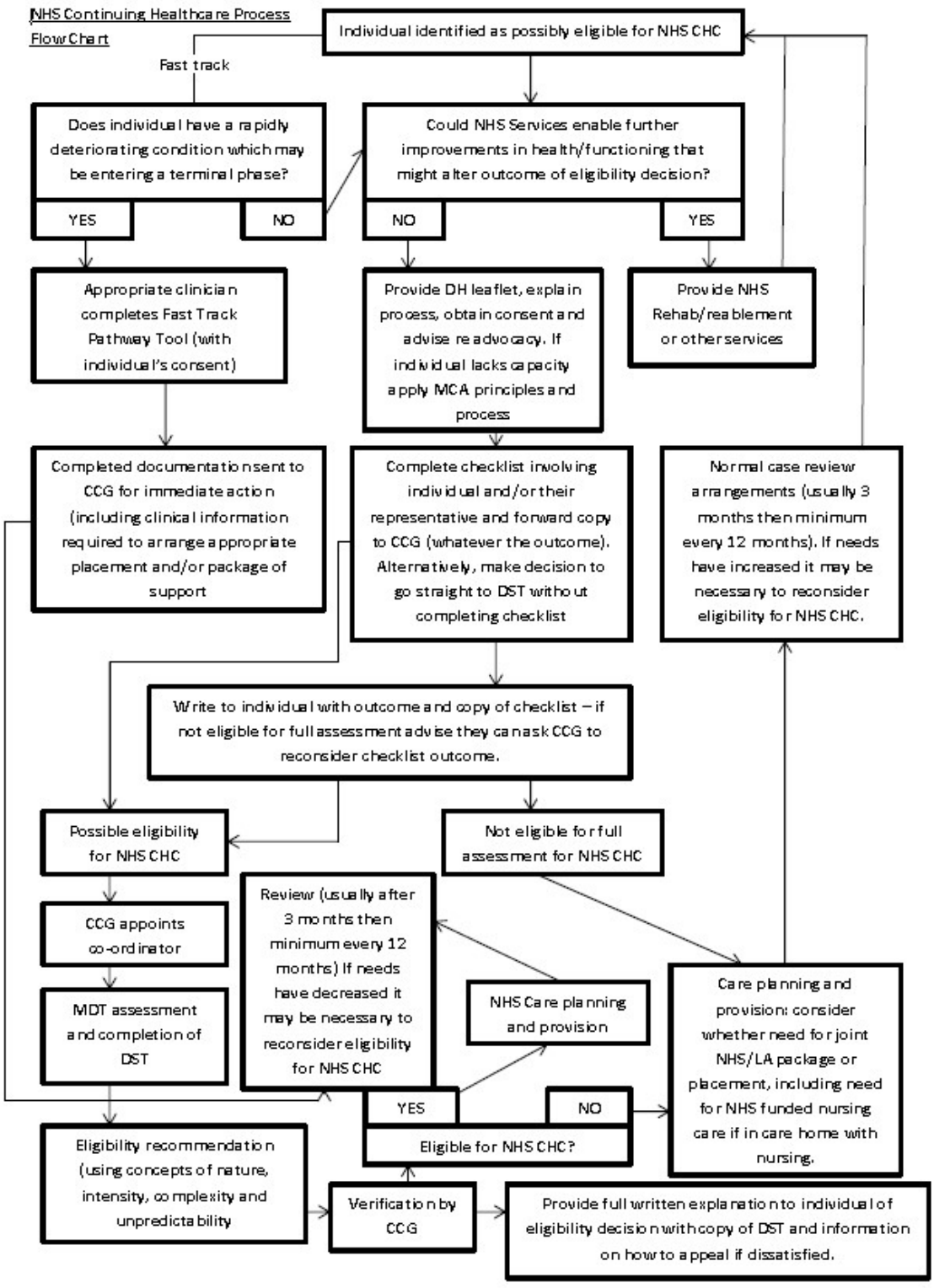
31.0 Records Management

31.1 All records pertaining to individuals request for continuing healthcare funding will be retained according to the CCGs policy and as follows:

- adults 18 years onwards retained for 6 years from the cessation of funding.
- discharge or any (final) Continuing Healthcare decision that an individual was not eligible for continuing healthcare after 8 years.

APPENDIX 1NHS CONTINUING HEALTHCARE PROCESS FLOWCHART

This flowchart shows the process to determine an individual's eligibility for Continuing Healthcare. These are outlined more fully in the following section of the document



CHC Process Chart (see CHC process flowchart) Referral, process, assessment, decision, commissioning and review of CHC

1.0 REFERRAL PROCESS FOR CONSIDERATION OF ELIGIBILITY FOR NHS CONTINUING HEALTHCARE

1.1 Continuing Healthcare Checklist

Prior to the completion of a checklist and commencement of the referral process informed consent must be obtained from the individual.

If the individual is deemed to lack capacity, Power of Attorney for Health and Welfare must be established from family/representative. If there is no POA, Mental Capacity Assessment must be completed and checklist completed in their best interest.

In an acute hospital setting a CHC checklist must only be considered once full potential for recovery has been established

A variety of health and social care practitioners in different settings can complete checklists, however, preferably a Nurse, Doctor, other qualified professional or social worker who are involved in assessing the individual needs on day to day basis and whom are familiar with CHC process should complete the checklist. All completed checklists, consent forms, MCA where appropriate should be sent to the CCG, CHC Team via secure email :- SHAVEN@nhs.net

Where referrals for clients with a physical/disability are received from a Healthcare professional with no LA involvement, Social Workers to be allocated within 5 working days of the request. Care Act Assessments can be provided at DST with the Social Worker and do not have to be provided prior to same.

1.2 Requests from an individual or their carer will be directed to Gateway to Care to initiate the process as appropriate.

1.3 It is essential that the consent form documentation has been discussed with the individual and is signed providing evidence of authority for the referring

professional to make an application for consideration of eligibility for Continuing Healthcare on the patient's behalf where relevant.

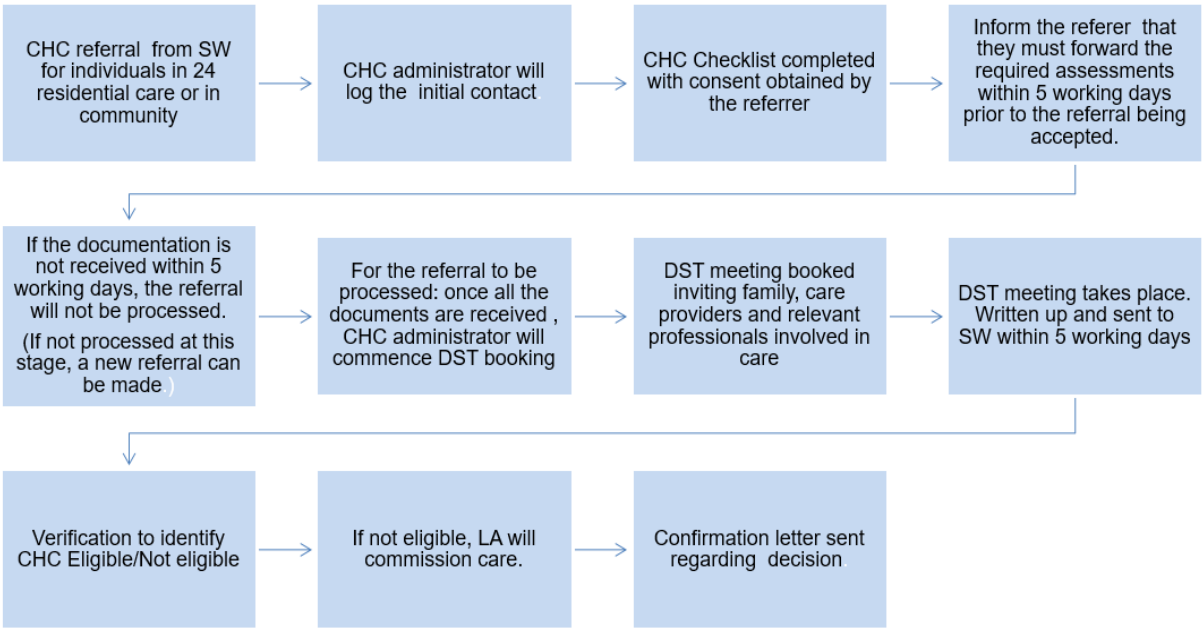
1.4 CHC will screen all checklists, those identified as positive will proceed to a DST. CHC will request the appropriate documentation as required. CHC will review electronic documents as part of their information gathering. CHC will communicate the outcome of the screening i.e. proceed to a DST following a positive checklist or send a letter regarding a negative checklist.

1.5 **Process for Learning Disability** referrals differs to the physical/disability referrals (in acknowledgement of the complexities attached to these cases)

- Information sent to shaven@nhs.net as above. On receipt of consent and positive checklist, this is logged by CHC administrator as an initial contact. The DST process does not start at this stage.
- The CHC administrator will request the Community Care Assessment (CCA) and Nursing Needs Assessment (NNA) and any other relevant information from the referrer to be provided within 5 working days.
- Within 5 working days, once the information has been received, it will be screened and the DST process will commence: DST will be booked
- If the information is not provided within 5 working days, the referral will not be processed.
- A new referral can be made as above.
- View flowchart pathway for LD referrals on next page which shows the process from from referral by the Social Worker up to a confirmation letter being issued with a decision.

Calderdale CHC Eligibility Pathway (Learning Disability)

The process should be completed within 28 days or less from the point ofacceptance of a positive checklist to panel verification



2.0 Assessment of Individual Needs

2.1 Note: Clients who are eligible for after care under care of Section 117 on the Mental Health Act do not require a checklist UNLESS their physical healthcare needs override their mental healthcare needs and they are eligible for consideration of full NHS CHC. See National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care, *November 2012 (Revised)*

2.2 CHC is responsible for the coordination, collation of the required documentation and completion of the DST process.

2.3 Checklist received – Negative

- Review of documents received, outcome communicated

2.4 Checklist received – Positive

- Review (screening) of documents received
- Nursing information will be gathered from electronic patient records inc. SystemOne
- For Learning Disability referrals, see 1.5 above
- If required request further information or documents as necessary i.e. Mental Capacity assessment, Best Interests decision
- Further information received - further review (screening) of additional documents
- Booking of DST with date confirmed with all parties (SW – 5 day notice)

3.0 DISCHARGE TO ASSESS

3.1 In acute care, in-patients who have a positive checklist and are eligible to be considered for NHS CHC, can be discharged on the Discharge to assess pathway with pragmatic funding.

3.2 Patients must be ready for discharge. See Discharge to Assess pathway table below:

Patient Identified	• Patient identified as meeting the eligibility criteria for consideration for CHC and DST required. • All paperwork to be sent to CHC and agreement sought for discharge to access funding for support package/24 hour placement. • FNC (nursing input) for nursing care home, residential placement cost initially to be funded by LA. Care package to be orginised and funded by LA. Self funders can arrange their own package if they choose to or LA to assist.

	• Funding for discharge to assess must be agreed in 24 hours. • Prior to discharge, placement/package, date of discharge must be shared with CHC.
Finance	• All patients must be informed of the funding arrangements and the possibility of charges should patient not meet eligability criteria for CHC. • All patients and family must be informed of the implications of placements where there is a top up fee should patient not meet eligibilty criteria for CHC • Self funders must be informed of finacial responsibility should they not meet eligibility of CHC. • Social Care staff must ensure that the funding request on check list is completed and received back form CHCT and the signed page is added to the customers file. • Social care staff to ensure that start date of placement/package of care is entered into CIS.
Discharge Planning	• SW/discharge co-ordinator to discuss with patient and family what is needed for them to return home if this is their perfered option. Worker must explain to patient/family that the package is a interim package of care and could be liable to change. • IF 24 Hour placement needed then homes with vacancies to be passed to patient and family. Worker to explain to patient that this is interim placement should they not want one

	with vacancies and home of choice to be sought following on from this placement. • Worker to book appointment with CHC coordinator for DST and date and time to be given to patient/family before discharge.
Ongoing Support planning	• Interim discharge care (package or placement) to be sourced and put in place by LA. Patient must be informed that the package or placement is a temporay solution and that both the package and provider might change, this will be determined by the outcome of the CHC eligibilty process. • CHC Nurse will visit on agreed date with Social worker. • If full CHC eligibility is agreed ongong support plan will be sourced by CHCT. This may mean that there is a change of provider if high cost provider has been used in the interim as we will need to ensure the package is cost effective. If a placement unless the customer wishes to chage placement the placement will stand. • Social Care Staff to inform LA finance status of funding(full chc, joint, LA funded or self funded) and date of start of service. • LA finance to bill CCG for CHC funded placements (including FNC) from start of placement/package. • patient and family to be given an aproximated review date. review to be conducted within 3 months.

	• CHCT to send notification of all full CHC funded , FNC funding and joint funding to LA (as per EDR process).

3.3 Discharge to assess pathway should ideally be activated on the day of referral: on the same day as the consent and checklist is sent. Within a 24 hour window is considered the maximum acceptable for the discharge to take place.

4.0 **DST MDT Process**

4.1 A multi-disciplinary Team (MDT) meeting will be convened with patient and patient representative where the DST will be completed. On completion of the DST, health and social care MDT professionals will sign the DST confirming agreement of the content: the DST can be submitted for verification (below)

4.2 If an electronic copy is not available for MDT attendees to review at that time then the CHC Lead Nurse will complete the electronic copy within one working day (may not be the same day, within 24 hours) and will send to the SW within the 24 hours for signature and agreement or signature and documentation of disagreement. The SW has one working day to sign and return. If unreturned, CHC nurse will contact the SW for the signed DST. If MDT SW unavailable, Lead Nurse will discuss with SW Team Leader. Another working day is agreed to chase up SW signature. Both parties will make best endeavour to resolve the situation.

4.3 In the instance when the MDT have a professional disagreement of the recommended eligibility outcome of the DST, this is documented on the DST in the area allocated for this. If the MDT disagree the outcome, this should be discussed at the DST and the reason why documented.

4.4 The DST will still be prepared and submitted for verification in the usual manner. The SW may have declined to sign the DST due to the professional disagreement with the Lead Nurse recommendation of eligibility. Timely verification ensures there are no delays with the timescale of 28 calendar days

for the Continuing Healthcare process as per the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

4.5 The Eligibility Decision Report is sent to LA with the verifier's decision. If the SW has a professional disagreement with the outcome, local resolution is sought: please see the pathway below.

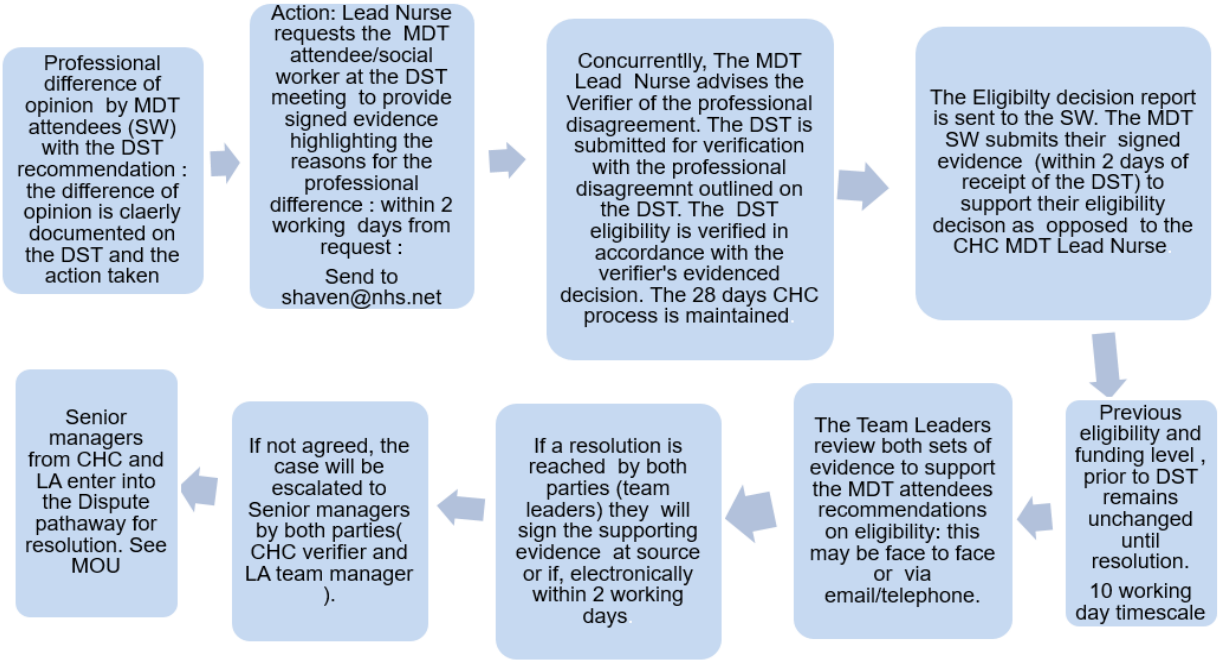
4.6 The resolution pathway should take no longer than 10 working days before escalation to senior management.

4.7 Resolution pathway followed as below

Calderdale Local Resolution for CHC Eligibility Process

This outlines the steps taken to prevent, resolve disputes and ensure timely completion of the CHC process for the interest of the individual underdoing the CHC eligibility assessment.

Note: In the exceptional event that the DST is completed for hospital in patients, discharge should not be delayed by waiting for a decision.



5.0 VERIFICATION PROCESS / ELIGIBILITY DECISION REPORT

5.1 On completion of the MDT DST, with signatures of health and social care MDT professionals confirming agreement of the content, the Clinical Verifier (CHC) will review the DST and the recommendation of eligibility.

5.2 The Verifier will review the domain levels achieved and the 4 key indicators for clarity as to how the recommendation outcome was achieved.

5.3 If the Verifier is satisfied that the evidence supports the recommendation, the Decision Report (EDR) and will be completed. The Verifier will complete an Eligibility Decision Report to advise AHSC of their agreement of the DST MDT recommendation. The verifier will sign same and send to AHSC via secure email address for attention of the social worker who was part of the MDT.

5.4 The DST is signed-off by inputting the date of the verification as per National Framework for NHS CHC and FNC Nursing Care (amended)

5.5 In the instance whereby the Verifier questions the recommendation, evidence in support of the recommendation will be requested from the MDT Lead Nurse and/or the Social worker who attended. The sign-off by the verifier of the DST is deferred until the supporting information is provided. **Note, this is in exceptional circumstances only.**

5.6 Once submitted and accepted, then the DST verification process is as step 5.2 to 5.4 above.

5.7 If the Verifier is still not satisfied with the evidence in support of the recommendation, the verifier will discuss with the Team Leader in AHSC and a decision may be agreed at this point. An early review of the client may be requested. If the Verifier and AHSC Team leader cannot resolve the matter, proceed to Dispute Process

5.8 Following verification, a letter with the DST outcome will be sent to the client/client representative. The letter will advise of the appeal process. A copy of the DST (as requested) will be sent with the letter. The letter will be sent within 14 working days.

5.9 In the case of the CHC Verifier agreeing the recommendation but AHSC Team Leader does not and they have been unable to find a resolution, the case will be escalated to senior management.

5.10 For cases which are verified with full NHS CHC eligibility, the verifier will contact the provider to advise that CHC are the responsible commissioners. CHC are the responsible commissioners for sourcing, managing and reviewing care provision/placements.

6.0 COMMISSIONING OF CARE PACKAGES

6.1 The Multi-Disciplinary Team will provide the CHC team with a care plan advising the appropriate care that is required to meet the individual's needs. It is the responsibility the responsibility of the Continuing Healthcare Team to commission care packages that are CHC funded.

6.2 Consent and agreement to the care package is required from the patient or a Best Interest decision is necessary for those who lack capacity prior to the Continuing Healthcare team agreeing to commission the package.

6.3 The care needs and the dependency level of the patient will be determined by the clinical verifier and a care package will be proposed in line with the Commissioning Policy (2017) for the provision of NHS Continuing Healthcare.

6.4 All care packages in nursing and residential care will be commissioned using the Continuing Healthcare contract arrangements and fee structure that has been agreed. Where the individual has health needs that are of a degree of complexity and intensity that is more than can be provided through the standard contract, the Continuing Healthcare Team will negotiate an individual care

package with the care provider using the standard contract as the basis for the care provision

6.5 Domiciliary care packages will also be provided through the standard contract arrangements with individual care packages negotiated in the same way as for residential care packages.

6.6 Refer to Commissioning Policy: Appendix 2: Policy Reference No 16, July 2017

7.0 **REVIEWS**

7.1 All individuals in receipt of FNC Contribution, jointly funded care package or fully funded care (for CHC Fast Track see Appx 3 6,2) package will have a review within 3 months of the date they were found eligible and annually thereafter. In complex cases reviews may be carried out more frequently and this will be agreed on individual need and circumstances.

7.2 The individuals and their representative will be invited to be fully involved in the process of review.

7.3 The provider will be informed of the review at least twenty-eight days prior to the review so they are able to ensure that a member of staff and/or documentation is available for the reviewing assessor.

7.4 The assessor will review the individual's eligibility. If it is clear that the individual's (who is fully funded) needs have not changed since the last review it is not necessary to complete a full assessment for NHS Continuing Healthcare. However, where there is a change identified and likely that the individual may not be eligible (i.e. Fast Track) please refer to point 1.1a.

7.5 Under usual circumstances the review will start with the completion of a Continuing Healthcare Checklist, proceeding to a full assessment as necessary.

7.6 The review will also take into account the suitability and quality of the care provision.

APPENDIX 2: CONTINUING HEALTHCARE COMMISSIONING POLICY

See Continuing healthcare commissioning policy

APPENDIX 3: FAST TRACK APPLICATION PROCESS FOR NHS FUNDED CONTINUING HEALTHCARE

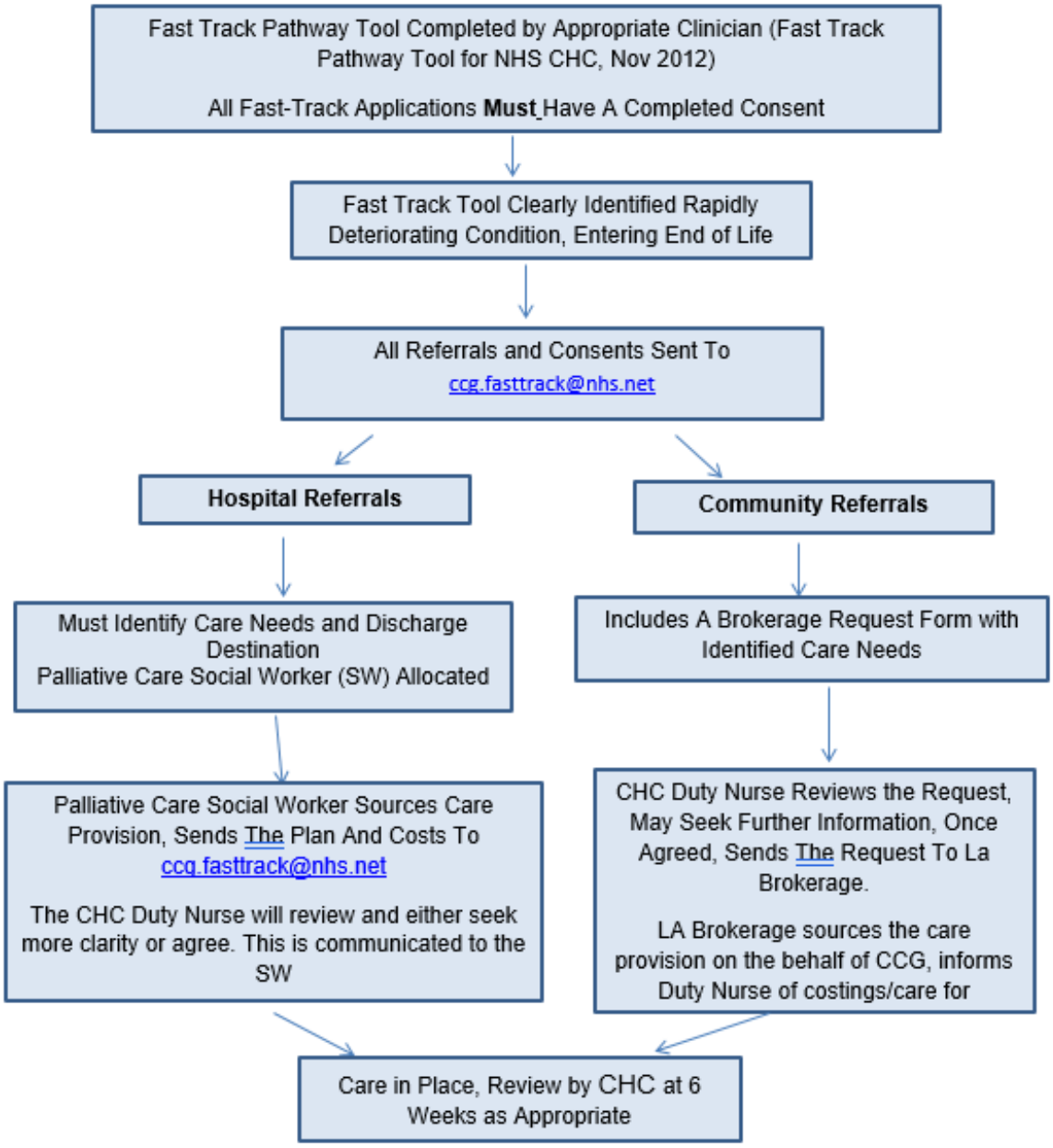
The intention of the Fast Track process is that the individual can access NHS CHC quickly with minimum delay without requirement for a DST. The completed fast track tool should be supported by prognosis and their condition deteriorated rapidly to a point where the referrer has determined the individual has a primary health need.

1.0 Fast Track Referral And Application for NHS fully funded Continuing Healthcare

1.1 The Fast track application tool is set by Department of Health in the National Framework

1.2 See flowchart below which details the fast track Pathway

This fast track pathway tool must be completed by the appropriate clinician and have completed consent.



There may be exceptions to the Pathway; patients should not stay in acute services while care is being sourced and an interim care provision / placement may be advised. Fast Track Funding is not in place of other NHS services.

2.0 Fast Track Reviews

2.1 All Fast track reviews are completed by the CHC nurse. Families will be invited to the review but if unable to attend the review may still go ahead. Patient and/or families can nominate a representative to be present (subject to informed consent).

2.2 Fast Track review outcome may result in the patient being referred for consideration of full NHS CHC eligibility.

APPENDIX 4: PROCESS FOR NHS FUNDED NURSING CARE

Eligibility for Funded Nursing Care (FNC) is determined once an individual has been assessed as not eligible for full Continuing Healthcare but it is determined they require placement in a care home with registered nursing care. A referral may be initiated as a result of the discharge planning process, as or as a review at a care home.

1.0 Assessment

1.1 In some cases an individual will have had a DST completed and the MDT have determined there is no primary health need. However, the multi-disciplinary team (MDT) has identified that the individual requires the services of a registered nurse and the individual is/will be resident in a care home. In such cases the individual will qualify for an FNC contribution.

1.2 This will be subject to verification by the CCG Verifying clinician/s and the individual will be notified of the decision, usually within 14 days.

1.3 For those individuals discharged to a nursing home from hospital, the CCG must be notified and the nursing home must send a notification to the CCG giving the date of admission, whether the individual is self-funded or local authority funded. Funding commences at the date of discharge to the home and will be added to the CHC database when notification is received.

1.4 The CHC Team will inform the care homes of any increase in the rate of FNC contribution

1.5 In certain circumstances, an individual who has been found not to be eligible for NHS continuing healthcare at the Checklist stage may still need an assessment of needs for NHS- funded nursing care. In such cases an appropriate assessment should be completed.

APPENDIX 5: JOINT FUNDING PROCESS

If a person is not eligible for NHS continuing healthcare, they may receive a package of health and social care (funded jointly by the CCG and the local Authority rather than being fully funded by the NHS).

“There will be some individuals who, although they are not entitled to NHS continuing healthcare (because ‘taken as a whole’ their needs are not beyond the powers of a local authority to meet), but nonetheless have some specific needs identified through the Decision Support Tool that are not of a nature that an LA can solely meet or are beyond the powers of an LA to solely meet. CCGs should work in partnership with their LA colleagues to agree their respective responsibilities in a joint package of care, including which party will take the lead commissioning role”.

1.0 Health Care Element

If the recommendation of the MDT at the DST is for a joint arrangement between LA and CCG, the Nurse and the SW must discuss the healthcare element needs of the client at the DST.

The healthcare need must be evidenced as a healthcare need and not a social care need.

1.1 The recommendation on the DST clearly states the joint arrangement need and that the client does not have a primary healthcare need.

1.2 The DST follows the process as Appendix 1

APPENDIX 6: PERSONAL HEALTH BUDGETS (PHB)

The CCG follows the National Policy and procedures for PHBs.

1.0 WHAT IS A PERSONAL HEALTH BUDGET

1.1 A personal health budget helps people to get the services they need to achieve their health outcomes, by letting them take as much control over how money is spent on their care/support as is appropriate for them. It does not necessarily mean giving them the money itself. Personal health budgets could work 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 to the individual (a 'healthcare direct payment').

1.2 Calderdale CCG PHB process:

This outlines the process for obtaining a personal health budget, once CHC eligibility has been established.

Calderdale PHB process: (CHC eligibility established)

1. Patient expresses an interest in having a PHB. (Information leaflet given to patient)
2. Patient indicates they wish to proceed with a PHB and consent gained
3. PHB application is discussed with the PHB clinical lead
4. Indicative budget agreed at panel
5. Referral made to the Direct Payments team (Local authority who the CCG commission to complete our PHB's)

6. Local authority to make an Initial appointment with the client, first visit inform of indicative budget, discuss options, payments, payroll, insurance, PA's, training and DBS etc.

7. Support planning commences

8. CCG receive signed support plan which is presented to panel for sign off

9. CCG receive Bank details, DP agreement if needed, liability insurance documents etc.

10. CCG to input information and start date given for the PHB

11. PHB audits completed at 3months post start of PHB, Risk assessments completed and audits reviewed as per level of risk.

12. PHB review undertaken by the local authority, at 6 months in the first year and then annually in order to measure health outcomes.

2.0 National Guidance

Refer to NHS England Guidance on Personal Health Budgets

A joint policy between LA and CCG is to be developed in 2018/2019. The Local Policy will be aligned to the National Policies.

APPENDIX 7: APPEALS PROCESS FOR NHS FUNDED CONTINUING HEALTHCARE

1.0 Right of appeal

1.1 If an individual disagrees with a CHC eligibility decision they have a right to appeal that decision in accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

2.0 Time limits and timescales

2.1 The individual/their representative must appeal within 6 months of the date of notification of the eligibility decision.

2.2 The appeal time limit may be extended if the CCG is satisfied that there was a good reason for the delay in appealing and it is still possible for the CCG to access all relevant information and records which informed the original decision.

2.3 The CCG should acknowledge receipt of an appeal within 5 working days of its receipt. The acknowledgement should include information on the appeal process.

2.4 The CCG should normally investigate and make a decision on an appeal within 3 months of its receipt.

2.5 The timescale for an appeal decision being made may be extended if there is good reason to do so, including:

- the individual or their representative have been asked for specific information or evidence or for participation in the process and there has been a delay in receiving a response from them;
- 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 delay in receiving these records from them;

- there has been a delay in convening a multidisciplinary team due to the lack of availability of a non-CCG 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 by telephone.

2.6 If the appellant/their representative disagrees with the appeal decision issued by the CCG then, within 6 months of notification of the CCG's decision, they may request an independent review of the decision by contacting NHS England.

3.0 **Appeal Process**

3.1 Documentation

The following documents will be required to enable an appeal to proceed: a completed Appeal Questionnaire or full grounds of appeal; a signed Consent Form to enable release of relevant clinical/care records; evidence of the appellant's identity and if the appeal is being made by a third party evidence of that party's authority to act and of their identity.

3.2 Initial consideration of appeal/screening

There will be an initial consideration of whether any evidence provided by the appellant/representative suggests that the eligibility decision may have been unsound from a clinical point of view or that there may have been a procedural irregularity which undermined the validity of the decision.

If there is no such evidence then the case will be closed and the appellant/representative will be advised of their right to submit a complaint under the CCG's complaints process.

3.3 Draft DST

If the initial consideration indicates the eligibility decision might not have been sound, a clinician (who had not been involved in the eligibility decision) will complete a new draft DST, which will be a historical document based upon available contemporaneous clinical/care records . The Draft DST will be sent to the appellant/representative for comment and they will be provided with contact

details of the clinician, to enable them to discuss any queries they may have upon it.

3.4 Appeal Panel hearing

An Appeal Panel hearing will be arranged and the appellant/representative will be invited to attend the first part of the hearing and make oral and/or written representations.

The Appeal Panel will sit as a multidisciplinary team and will comprise of 2 or 3 members. The Panel will be chaired by a senior member of staff from the CCG's CHC Team and Calderdale Council will be invited to nominate a social worker to serve on the panel. If no social worker is available, the Panel may include a clinician from a different discipline to the Panel chair (e.g. a mental health nurse).

The Panel will consider the Draft DST and any representations from the appellant/representative and will make a recommendation on eligibility.

3.5 Appeal Decision

The Appeal Panel's recommendation will be considered by a CCG Verifying Officer who will make the decision on eligibility. The appellant/representative will be informed of the decision in writing within 28 days of the Appeal Panel hearing.

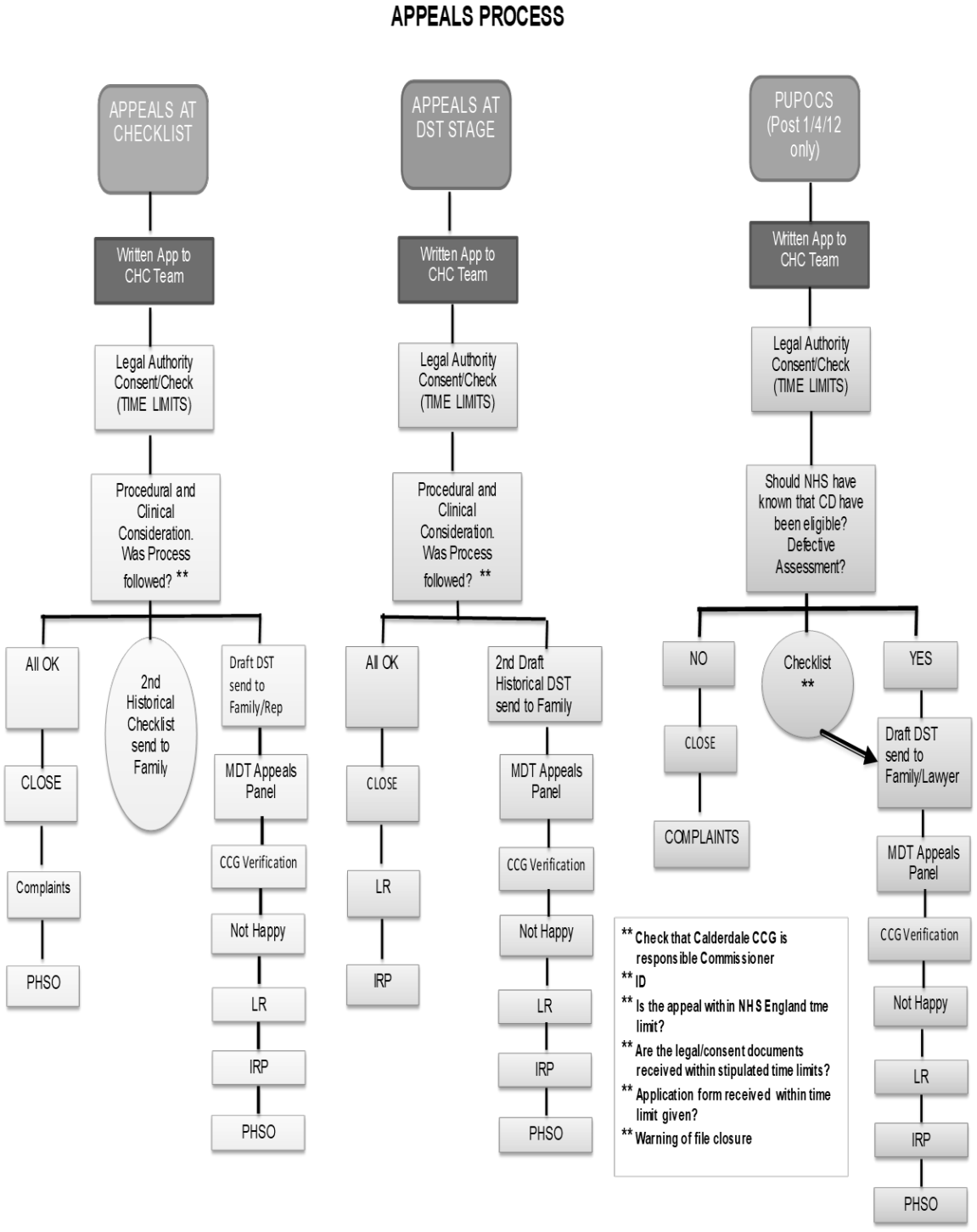
3.6 Local Resolution

If an appellant/representative is dissatisfied with the outcome of the appeal they make request a Local Resolution meeting with the CCG. The Local Resolution meeting will be conducted by a clinician who has not had any previous involvement in the appeal or the initial eligibility decision. The appellant/representative will be informed of the outcome of the Local Resolution meeting in writing within 28 days of the meeting and they will be informed of their right to request an independent review by NHS England if they remain dissatisfied with the CCG's decision.

A similar process to the above will be followed in respect of Retrospective Reviews/Previously Unassessed Periods of Care (see also Appendix 8)

Appeals Process flowchart

This details how the three types of appeal are processed (appeals at checklist, appearls at DST stage, PUPOCS (Post 1/4/12 only) This flow chart may not be accessible to all users please contact the continuing care team for assistance should this not meet your needs.



APPENDIX 8: NHS CONTINUING HEALTHCARE RETROPECTIVE REVIEW PROCESS

1.0 Aim

This process is to assist a CCG in determining whether an individual is eligible for a retrospective review in order to assess whether that individual has been wrongly denied funding for NHS Continuing Healthcare ("NHS CHC").

1.1 Duty

The duty is 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 NHS that there may be a need for such care. The purpose of such an assessment would be to establish whether there was a primary health need.

This duty of a CCG is set out in the NHS Continuing Healthcare (Responsibilities) Directions 2009, the NHS Continuing Healthcare (Responsibilities) Directions 2007 or the Continuing Care Directions 2004 depending on the relevant time period being considered.

The CCG's duty to fund continuing healthcare is found in Section 3 of the National Health Service Act 2006

Prior to 2007 the CCG's assessed an individual's eligibility for NHS CHC in accordance with the eligibility criteria of the relevant former Strategic Health Authority. The eligibility criteria were intended to be used to establish whether the individual's needs were such that the individual qualified for fully funded NHS care. In 2007 the Department of Health published the National Framework in order to standardise the assessment of eligibility for NHS CHC.

2.0 Responsibility

The CCG needs to check that they are the Responsible Commissioner for the relevant individual for all or part of the period being claimed.

The CCG does need to assess whether a retrospective review should be carried out.

The initial consideration can take place using the information provided by the families on the Application Form. Where the information provided suggests that there may be a need for retrospective review then the CCG may need to obtain additional information.

3.0 Grounds for a claim

An individual or their estate may seek a retrospective review to assess eligibility for NHS CHC in the following circumstances:

- the CCG carried out an assessment of the individual but there is evidence that the criteria were not applied appropriately;
- it should have been reasonably apparent to the NHS that the individual may need NHS CHC but the CCG failed to carry out an assessment.

4.0 Has a CHC assessment been carried out?

The CCG will need to consider whether the proper procedure was followed; i.e. were the relevant eligibility criteria lawful and were they correctly applied? The CCG is looking to assess whether the original decision demonstrates consideration of the totality of the individual's needs in order to consider whether their primary need was for healthcare (the "Primary Health Need Test").

In the event that the original CCG decision shows a failure to correctly apply the Primary Health Need Test then a retrospective review may need to be undertaken. The case of Green v South West SHA established that the eligibility criteria applied by South West SHA after 2006 were lawful.

Where a challenge is based on failure to consider the full evidence, then such challenge should have been brought at the time of the original assessment using the appeal process under the relevant eligibility criteria. In the event that additional evidence is provided, where the individual is still alive then this additional evidence can be considered by the CCG in relation to that individual's current eligibility for NHS CHC going forward but does not trigger a right to a retrospective review.

5.0 If a CHC assessment has not been carried out, should it have been reasonably apparent that a CHC assessment was required?

The NHS is not automatically liable to pick up the cost of previous funding unless the NHS should reasonably have been aware of a Primary Health Need. The CCG is not required to carry out a NHS CHC assessment if it was apparent that there was not a need for NHS CHC. The CCG should consider on the evidence it has available whether there was a Primary Health Need. The CCG should use the evidence submitted by families for the preliminary assessment in order to consider whether further investigation is required.

If a checklist exercise had previously been carried out or there is evidence to suggest that a CHC assessment was considered not necessary this would be good evidence to suggest that a CHC assessment was not required. In the absence of obvious error in the completion of the CHC Checklist, a full CHC Retrospective Review is unlikely to be required.

Where there has been a personal choice by the individual or their families not to accept NHS CHC funding (for example if this meant that they were unable to pick the home of their choice) then the NHS would not then be liable for this period of time if later they decide to claim retrospectively. In assessing whether a Primary Health Need should have been evident to the NHS, the CCG should consider the following:

6.0 Was the individual in receipt of RNCC/FNC

An RNCC assessment should have only taken place once it had been established that the individual was not eligible for NHS CHC. If there was a nursing assessment but no CHC assessment (or consideration of the need for a CHC assessment) then this indicates a system failure. The CCG should consider the nature of the health needs identified in the RNCC assessment in order to consider whether there is a possibility there was a Primary Health Need. RNCC/FNC funding should be reassessed annually. Therefore, NHS CHC eligibility should have been considered at these reviews.

Where there was no RNCC assessment but the application suggests that there were health care needs then the CCG should consider under paragraph 2.3 (below).

7.0 Was a CHC assessment requested at any point?

If there was a recommendation for a CHC assessment at any stage but this was not carried out (and no valid reason provided) then this is strong evidence that a retrospective review assessment should have been undertaken. The CCG should consider additional evidence in order to assess whether there may have been a Primary Health Need.

8.0 Is there any other evidence of a Primary Health Need

The CCG should initially consider the application submitted to assess whether that evidence suggests there may be evidence of a Primary Health Need. The CCG should consider whether the evidence provided is sufficient to carry out the CHC Checklist. If this suggests that there may be a Primary Health Need then a full retrospective review should be carried out

If there are NHS records (e.g. nursing, GP or hospital records) which suggest that there were complex, intense or unpredictable needs then it is likely that the CCG should have been aware that there may have been a need for CHC. The CCG is looking to see:

- whether there was regular contact with primary care professionals or community nurses; and
- whether the type of input and the nature of the individual's needs were such that it may suggest a Primary Health Need.

9.0 Claims for Periods after 2007

The National Framework was introduced in 2007. Therefore, after this date the Framework should have been applied to all NHS CHC decisions. Therefore, any CHC Assessment/Checklist following this date should comply with the National Framework. Failure to apply the National Framework correctly should be appealed using the appeal procedure set out within the National Framework. It may be necessary to consider the individual circumstances in the event of a request for a retrospective review for a period after 2007.

10.0 Was the individual in receipt of Funded Nursing Care?

The CHC Checklist or a full CHC Assessment should have been undertaken prior to the assessment for eligibility for Funded Nursing Care. Further, the eligibility for Funded Nursing Care should have been reviewed every year and at that point a CHC Checklist carried out.

The FNC Assessments for the full relevant period should be considered to assess whether the CHC Checklist was carried out. Where an individual was receiving Funded Nursing Care and there was no CHC Assessment or Checklist carried out then the CCG should consider the evidence provided to complete the CHC Checklist.

Where a Checklist indicates a full CHC Assessment should have taken place then a retrospective review should occur.

11.0 Was a CHC Checklist completed?

A completed CHC Checklist is good evidence that the CCG considered the individual's needs and have assessed whether or not that individual required a full CHC Assessment.

In the absence of obvious error in the CHC Checklist, a full CHC Retrospective Review is unlikely to be required.

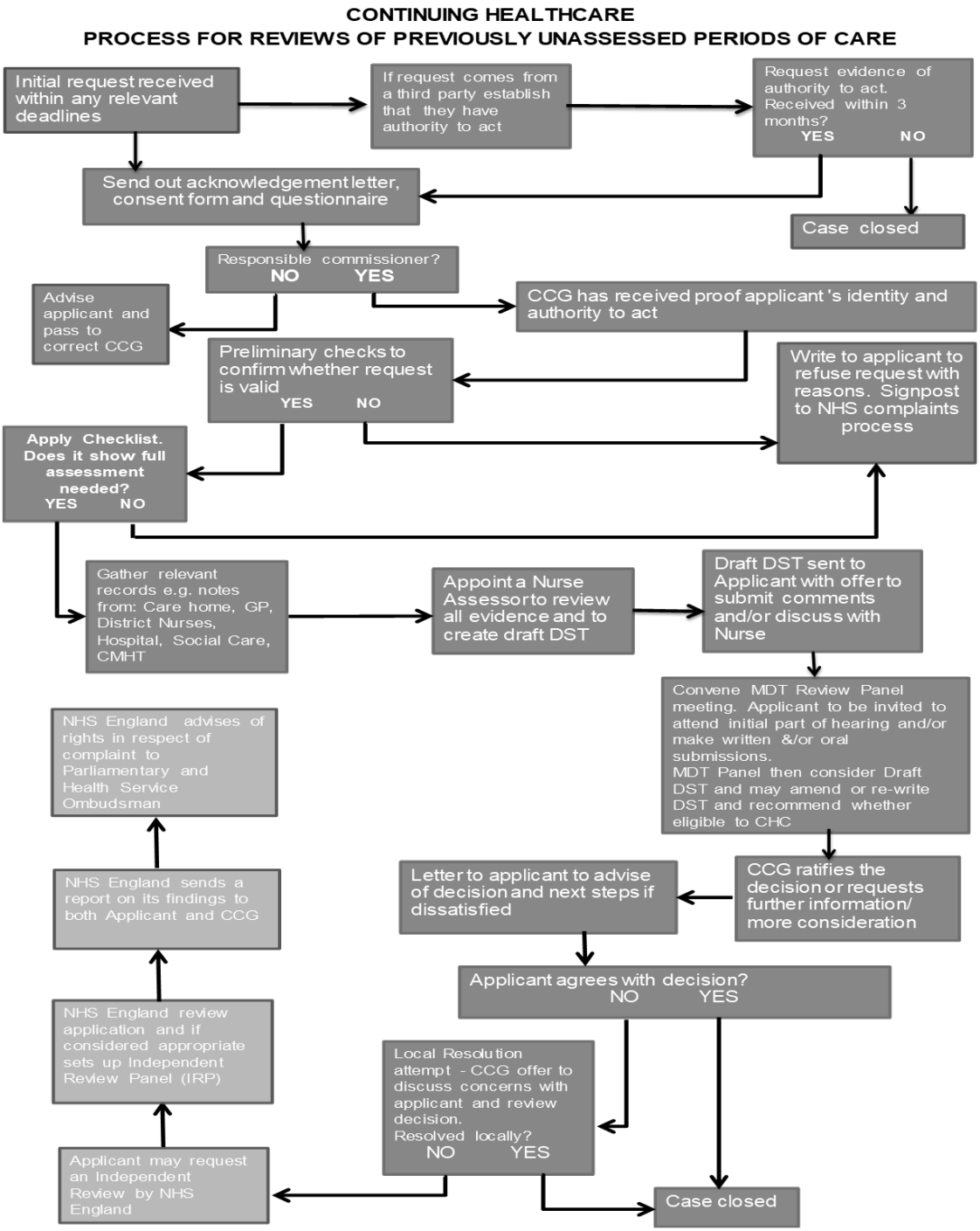
12.0 Is there evidence of a Primary Health Need?

Where the CHC Checklist or Assessment has not been completed and the individual has not received an assessment for Funded Nursing Care then the CCG should consider whether there is evidence that the NHS should have undertaken a CHC Assessment.

Where there has been a personal choice by the individual or their families not to accept NHS CHC funding (for example if this meant that they were unable to pick the home of their choice) then the NHS would not then be liable for this period of time if later they decide to claim retrospectively.

Continuing Healthcare Process for reviews of previously uassessed periods of care

See Flowchart below. This flow chart may not be accessible to all users please contact the Continuing Care team for assistance should you require the information in an accessible format.



In all cases where the LA is funding the adults care and support at the time the dispute arises it will continue such funding on a “without prejudice” basis until such a time as the dispute is resolved.

This policy has been jointly developed and agreed in partnership with Calderdale Council and will be the point of reference for discussions pertaining to Continuing Healthcare.