Thinking Differently

NHS
Dudley
Clinical Commissioning Group

NHS CONTINUING HEALTHCARE POLICY (ADULTS)

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REVIEWERS
This document has been reviewed by:

NAME	DATE	TITLE/RESPONSIBILITY	VERSION
Mrs A Price	01/12/2016	Office Manager	D1.0
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N.B: the version of this policy posted on the intranet must be a PDF copy of the approved version.

DOCUMENT STATUS
This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS
These documents will provide additional information.

NAME OF DOCUMENT	VERSION
The National Framework of NHS Continuing Health and Free Nursing Care (2018) revised	Department of Health Website https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care
NHS Continuing Healthcare Practice Guidance	
Who Pays? Establishing and Responsible Commissioner (Department of Health 2013)	
Continuing Healthcare Appeals Policy	
Choice and Resource Allocation Policy	

Contents

1.0 Introduction

1.0.1 This operational policy is for the delivery of the NHS Continuing Healthcare service across Dudley. The service will be delivered by Dudley Clinical Commissioning Group's, NHS Continuing Healthcare Team (CHC) in line with National Framework for NHS Continuing Healthcare.

1.0.2 The National Framework for NHS Continuing Healthcare (CHC) and Funded Nurse Care (FNC) sets out principles and processes for its implementation and provides national tools to be used in assessment applications and for Fast Track cases.

1.0.3 This policy describes the processes that Dudley CCG will follow and should be in conjunction with the following documents:

- The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (Department of Health 2018, revised).
- NHS Continuing Healthcare Practice Guidance
- Who Pays? Establishing The Responsible Commissioner (Department of Health 2013)
- This Policy applies to Adults (18+). A separate policy is in place for children and younger people.

1.1 Purpose

1.1.1 This policy applies to all NHS Continuing Healthcare application for adults aged 18 or older and who are registered with a Dudley General Practice.

1.1.2 This policy sets out the roles and responsibilities for health and social care staff in the delivery of the National Framework for CHC (included appeals process), FNC and Personal Health Budgets (PHBs)

1.1.3 The policy describes the way in which Dudley CCG will commission care in a manner that reflects patient choice and preferences, whilst keeping a set financial limit for the individual (please see choice and resource allocation policy for further detail)

1.2 Definitions

- ***Continuing Care*** – Care provided outside of a hospital to patients with long term health needs.

- ***NHS Continuing Healthcare (CHC)*** – Care solely funded by the NHS.

- ***Care Packages*** – suite of services (nursing, therapies, home care etc.) that are designed to match the assessed needs of a Patient.

- ***Care Plan –*** Plan drawn up by a clinician to meet the needs of a Patient centred around the Decision Support Tool which establishes the health needs.

- ***Decision Support Tool (DST) –*** a standardised needs assessment tool used by the clinicians to assess the needs of a Patient. The outcome of the Decision Support Tool is used to consider the eligibility of a patient.

- ***Verification–****All CHC Assessments will be verified by the Lead Nurse who will consider* the eligibility of Patients based on their DST recommendation and overall assessed level of need. Where there is any discrepancies the CCG may ask for further evidence to substantiate scores.

- ***Case Manager –*** Professional responsibility for drawing up a care plan; monitoring the needs of a patient receiving a care package and assessing the use of NHS resources.

- ***Budget Holder –*** Person responsible under the CCG scheme of delegation for authorising the release of NHS resource.

- ***Multi-disciplinary Team (MDT) -*** a group of health care workers and social care professionals who are experts in different areas with different professional backgrounds.

- ***Personal Health Budget –*** an amount of money to support an individual's identified health and wellbeing needs, planned and agreed between the person and their CCG representative.

1.3 Principles

1.3.1 Continuing Care means care provided over an extended period of time to a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness. NHS Continuing Healthcare means a package of continuing care arranged and funded solely by the NHS. (National Framework for NHS Continuing Healthcare & Funded Nursing Care, 2018 revised, Department of Health).

1.3.2 An individual who needs "continuing care" may require services from NHS bodies and/ or from Local Authorities. Dudley CCG has a responsibility to ensure that the assessment of eligibility for NHS Continuing Healthcare takes place within 28 days from the completion of the CHC checklist and in a timely and consistent fashion.

1.3.3 The principles underlying this policy are that the residents of Dudley have fair and equitable access to NHS funded continuing healthcare. These principles are:-

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

- if the individual lacks the mental capacity to refuse or consent, a 'best interests' decision should be taken and recorded in line with the Mental Capacity Act 2005 as to whether to proceed with assessment for eligibility for CHC. A third party cannot give or refuse consent for an assessment on behalf of a person that lacks capacity, unless they have a valid and applicable Lasting Power of Attorney for Health and Welfare or have been appointed as a Deputy by the Court of Protection for Welfare Only. Dudley CCG will act in the best interests of the individual;

- health and social care professionals will work in partnership with individual patients and their families thought the process;

- all individual patients and their family representatives will be provided with information to allow them to participate in the process. Dudley CCG has a code of conduct for families or their representatives (appendix 1);

- This code of conduct outlines expectations of involvement/ manner at CHC assessment. Whilst the CCG appreciate that a CHC assessment can have significant implications to individuals/ families at a difficult time, there is a zero tolerance to any abusive behaviour. Consequently anyone behaving in an aggressive, abusive or intimidating way towards the CCG staff will be immediately excluded from the assessment which will continue in their absence.

- the process for decisions about eligibility for CHC will be transparent for individual patients and their families and partner agencies;
- once an individual has been referred for a full assessment for CHC, following completion of a Checklist, all assessments will be undertaken by a Multiple Disciplinary Team (MDT) ensuring a comprehensive multi-disciplinary assessment of an individual's health and social care needs will be completed.. Dudley CCG has a code of conduct for MDT members (appendix 2);

- assessments and decision making about eligibility for CHC will be undertaken within 28 days of the completion of the CHC Checklist wherever possible to ensure individuals receive the care they require in the appropriate environment and without unreasonable delay.

2.0 Roles & Responsibilities

NHS Continuing Healthcare Team	• Receives and review all checklists and Fast Tracks Tools to ensure the standards required are met and that they indicate eligibility for further assessment. • Maintains the continuing healthcare allocation lists, patient files and database, ensuring all referrals are recorded and that all correspondence is kept for each individual patient. • Allocates a Case Co-ordinator who liaises with the referrer and arranges the Multi-disciplinary Team (MDT) meeting. • Allocation of a Nurse Assessor who ensures evidence is collected prior to the meeting. They facilitate the DST and recommendation ensuring the case is ready for verification.. • Verification ensures the DST is completed fully, in accordance with the National Framework, supported by robust clinical evidence and completed in an appropriate manner. Ensures that the DST has a clearly stated recommendation from the MDT and seeks further clarification as required. • Ensures a social care practitioner has been involved in the assessment where possible and in line with the CCG code of conduct. • Ensures triage of Checklists within 48 hours and complete Fast Track assessments within 24 hours. • Communicates the outcome to the patient or their representative in writing including how to appeal if not eligible. • For the cases that meet eligibility criteria the team is responsible for arranging packages of care and seeking funding approval from the Commissioning Manager. • Records all eligibility decisions in individual case records and ensures all communication of decisions is undertaken in a timely manner. • Ensures patient case management arrangements are in place. • Ensures reviews are undertaken in line with national policy and at other times as required.
NHS Continuing Healthcare Manager.	• Ensures that an appropriate selection of care packages is offered to each patient based on their individual care plan. • Reviews all complex packages of care ensuring value for money. • Approves packages of care in accordance to their delegated authority.

	• Seeks assurances that providers are fit and proper organisations to provide care

2.1 Procedures

2.1.1 The National Framework for CHC and FNC provides a consistent approach to establishing eligibility for CHC. This is achieved through the use of the National Tools and Guidance developed to assist in making decisions about CHC eligibility.

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

2.1.3 Where a person's "primary need" is a health need, they are eligible for CHC.

2.1.4 Considering a primary need for health, needs to include consideration of the characteristics of need and their impact on the care required to manage the needs. In particular to determine whether the quantity and quality of care is more than the limits of the Local Authority. Consideration is given to the following areas:

- **Nature** and type of need – the particular characteristics of an individual's needs and the overall effect of those needs on the individual, including the type of interventions required to manage them
- **Intensity** of need – both extent and severity of the needs, including the need for sustained care
- **Complexity** of need – how the needs present and interact to increase the skill required to monitor and manage the care. This may arise with a single condition or the interaction between a number of conditions.
- **Unpredictability** – the degree to which needs fluctuate, creating difficulty/ challenges in managing a need.

2.1.5 Eligibility for CHC is based on the individual's assessed health and social care needs. The DST provides the basis for decisions of eligibility for CHC. The DST must be completed by the MDT, which should include a health professional and a social care practitioner. Social care staff should always be involved in the completion of the DST where possible. Specialist staff should be involved dependant on the individual's needs.

2.1.6 The MDT will make recommendations on eligibility of the patient for CHC to the CCG. The CCG will consider the MDT recommendations and can make the decisions about eligibility by:

- Verifying the recommendations of the MDT.
- Deferring the decision and requesting further evidence to support a recommendation and consequently decision on eligibility
- Where the CCG feels the evidence provided does not support the level of need indicated in the DST and/ or the eligibility decision, a full written detailed explanation of the decision will be provided to the applicant or representative
- Verifying the removal of CHC funding from a patient who is currently in receipt of it, where the MDT recommend that the patient is no longer eligible for CHC.

3.0 Application for CHC

3.0.1 Before applying the checklist, it is necessary that the individual or representative understand the checklist does not indicate the likelihood of eligibility for CHC, only that they are entitled to be considered for eligibility. At this stage the threshold is set deliberately low to ensure that all those who require full consideration have the opportunity for an assessment.

3.0.2 There are a variety of health and social care practitioners that can complete a checklist (See appendix 3) in a community or hospital setting. The person completing the checklist must be familiar with the National Framework for CHC and have undergone appropriate training. The Patient or their representative should also be present at the completion of the checklist where possible or have given consent for it to be completed without them being present.

3.0.3 All appropriately completed Checklists with a consent or MCA and best interests assessment, should be sent to the Continuing Healthcare Team at:

Continuing.care@dudleyccg.nhs.uk

3.0.4 Receipt of the completed checklist and consent is the start of the 28 day target for eligibility decisions.

3.0.5 Where a checklist is used as part of the discharge process from an acute hospital, and a need for a full CHC assessment is indicated, consideration must be given to the person's further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect on-going needs.

3.0.6 If the completed checklist indicates the patient is entitled to a full assessment a decision support tool (DST) will be completed. The DST provides practitioners with a framework to bring together and record the various needs in the domains specified in the tool. The MDT 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 their recommendation.

3.0.7 The DST cannot directly determine eligibility, but it provides the basis from which decisions are made exercising professional judgement and in consideration of the primary health need issue. Once the MDT has reached agreement they make their recommendation on eligibility, recorded on the DST, to the CCG.

3.0.8 A Person only becomes eligible for CHC once verification of the recommendation has been completed by the CCG, informed by the completed DST or Fast Track Tool. Prior to the decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment.

3.1 Fast Track Applications

3.1.1 The Fast Track Application ensures that individuals who have a **"rapidly deteriorating condition, which may be entering a terminal phase"** get the care they require as quickly as possible. No further test is required.

3.1.2 The National Framework the CHC and FNC Framework (2018 revised, Department of Health) provides the Fast Track Tool for use in these circumstances. The Fast Track Tool (See appendix 6) needs to be completed by an 'appropriate clinician' described by the National Framework as:

"Someone who is responsible for an individual's diagnosis, treatment or case as a registered medical practitioner or registered nurse. These can include senior clinicians employed in the voluntary and independent sectors that have a specialist role in the end of life needs and the organisation's services are commissioned by the NHS".

3.1.3 The CCG supports the direct involvement of hospital staff in this process to ensure timely

discharge for these patients, supporting end of life care decision's and providing clear accountability for decision making.

3.1.4 A DS1500 is a form issued by GPs to patients assessed as suffering from a potentially terminal illness. Although this may indicate healthcare needs it does not necessarily mean the patient is in the end stages of this terminal disease.

3.1.5 The completed Fast Track Tool should clearly state the patient's diagnosis, prognosis and current condition. Once completed please send to:

Continuing.care@dudleyccg.nhs.uk

3.1.6 Upon receipt the CHC Team will make contract with the Patient or the Representative to make arrangement for an assessment to take place.

4.0 Management of Appeals – Please refer to the CHC Appeals Policy for detailed information

4.0.1 The eligibility decision of the CCG is communicated to the individual patient, or their representatives, and to lead health and social care professionals making the application. The decision is communicated in writing within 5 working days of the decision. The Patient, or their representative, and the lead health and social care professionals making the application can be informed verbally of the decision, if they are not present and pending the receipt of the formal correspondence.

4.0.2 Where an application has been found ineligible, individual patients can appeal to the CCG in writing within **6 months** of the notification of the decision. When an appeal is received this is acknowledged and a meeting is arranged with the Lead Nurse and the Nurse Assessor to discuss the areas of contention. If the appeal is not resolved at this stage an offer of an informal resolution meeting with the individual patient or their representative is made to go through the process of decision and rationale for the decision.

4.0.3 Appeals in the first instance should be sent to:

CHC Lead Nurse
NHS Dudley CCG
CHC Department
Tiled House
200 Tiled House Lane
Brierley Hill
DY5 4LE

Email: continuing.care@dudleyccg.nhs.uk

4.0.4 If following the informal resolution meeting the patient or their representative remains unhappy with the CCG's decision a hearing will be arranged of the Dudley CCG Local Review Panel (LRP). The members of the Review Panel will be independent of the initial decisions makers that reviewed the eligibility application.

4.0.5 The Patient or their representatives will be asked to submit evidence on why they disagree with the CCG's decision and to specify those areas of disagreement. Families and individuals are encouraged to attend the Local Review Panel meetings to present their case and participate in the discussions.

4.0.6 Where an individual remains dissatisfied by the Local Review Panel (LRP) outcome they can request an Independent Review Panel (IRP) by writing to NHS England at:

CHC Appeals
NHS Continuing Healthcare
NHS England
St Chad's Court
213 Hagley Road
Birmingham
B16 9RG

4.0.7 An Independent Review Panel's key tasks are, at the request of the CCG Board, to conduct a review of the following:

a) the procedure followed by the CCG in reaching a decision as to that person's eligibility for CHC; and /or

b) the primary health need decision by the CCG.

4.0.8 The Panel will make a recommendation to the Board in the light of its findings on the above matter.

4.0.9 Before an Independent Review Panel (IRP) can be convened, all appropriate steps must have been taken by the CCG to resolve the case at a local level.

4.0.10 The Terms of Reference of the IRP (Independent Review Panel) are to consider and determine any appeal against a decision regarding eligibility for NHS Continuing Healthcare and to ensure that due process has been followed in line with the National Framework for NHS Continuing Health Care (CHC) and NHS Funded Nursing Care (2018).

4.0.11 The Local Authority and their employees are not able to appeal against the decision made by the CCG on behalf of a client. Appeals may only be made by an individual applicant themselves or their representatives. There is a separate dispute resolution process for the Local Authority – details of which are outlined in the next section.

4.1 Disputes raised by the Local Authority

4.1.3 The procedure described below cannot be used to make an appeal on the individual's behalf.

4.1.4 If the individual (their representative or an independent advocate) makes a formal appeal at the same time or subsequent to a dispute registered by the Local Authority, the appeal by the individual, their representatives or independent advocate will take precedence and will follow the appropriate Appeals Procedure.

4.1.5 The key objective of both the CCG and the LA is to ensure that an individual's eligibility for NHS Continuing Health Care is correctly determined based on the assessment of their care needs and that the assessment of these needs has followed due process, as outlined in the NHS National Framework.

4.1.6 The following key principles apply:-

- To encourage a culture of problem solving, collaboration and close partnership working that demonstrates openness, consistency and transparency throughout the CHC process.

- Formal disputes should be the last resort and should seldom be necessary if the NHS National CHC Framework is adhered to;

- The Multi-Disciplinary Team members involved with each patient should endeavour to work together to undertake the CHC Assessment and consider the evidence to support decision making. The outcome of the CHC assessment should be agreed by the professionals and

other people involved with the individual who have the best knowledge and understanding about the individual's care needs;

- If the MDT is unable to reach a decision on the outcome of the CHC Assessment then this will be recorded on the DST (Decision Support Tool) with the views of the MDT members, including noted disagreements.

- The individual should not be involved in the dispute in any way. In such cases they should be informed of the CCG's decision on eligibility in the normal way, giving them the opportunity to formally appeal if they wish to in their own right;

- Individuals should always be cared for in an appropriate environment throughout the process and any dispute in relation to funding should not interfere with the support provided to them.

The Disputes Process

4.1.7 The process of considering and deciding eligibility for NHS Continuing Care must not delay treatment or appropriate care being put in place. The agreed arrangements therefore are based on the following principles:-

- Neither the CCG nor the LA will unilaterally withdraw from funding an existing package until the dispute is resolved;

- The individual will be discharged from hospital as soon as they are ready to their home, nursing/residential care etc. The dispute process must not delay discharge of a patient if support can be arranged prior to the dispute being resolved;

- The LA and CCG will work together to agree case management arrangements to ensure the individual continues to receive the best and most appropriate support to meet their needs at all times;

- In the event of a dispute between the CCG and the LA, the placement will be funded without prejudice pending a final decision. Reimbursement will be made as required from the date that the dispute was registered.

4.1.8 For disputed cases the placement / care package will be funded for the duration of the dispute by:-

- The current funding body (e.g. if individual was funded by the CCG as NHS Continuing Health Care before admission, the CCG would fund on discharge. Likewise for the LA if a comparable package of care was funded by the LA);

- If there was no funding responsibility before admission or no comparable care package the CCG will fund on discharge for patients who require care in a nursing home and the LA will fund care at home, in residential care or supported living without prejudice;

- The LA will undertake a full Community Care Assessment for disputed cases and provide a copy of the assessment to the CCG, without delay;

- The LA must send a formal notice of dispute to the CCG's CHC Manager, setting out the reasons why it is considered that the CHC assessment is incorrect or has not followed due process in line with the NHS National CHC Framework (2018).

Dispute Panel Arrangements

4.1.9 The arrangements for resolving disputes via a dispute panel should be on an exceptional basis. Every effort should be made for the dispute to be resolved by discussion between the

CCG CHC Assessment Co-ordinator, Social Worker and other members of the MDT who have direct knowledge of the individual and are conversant with his / her health care and support needs.

4.1.10 The dispute process must not delay discharge of a patient if a care package is ready prior to the dispute being resolved.

4.1.11 The stages for resolving the dispute are as follows:

Dispute Stage	**Process**	**Timescale**
Stage 1	The CHC Manager / Lead Nurse and Adult Social Care Manager to meet with CHC Assessment Co-ordinator and Social Worker / Community Nurse Learning Disabilities to discuss the assessment, process followed and evidence to support the completion of the DST (Decision Support Tool). Progress to Stage 2 if not resolved.	Within working 5 days
Stage 2	CCG and Social Care Leads for CHC to meet with CHC Manager and Adult Social Care Manager to try to agree a resolution. Progress to Stage 3 if not resolved.	Within 10 working days
At Stage 2, The respective CHC Leads can elect to resolve the matter by arbitration, mediation or independent review if considered appropriate.		
Stage 3	Independent Review panel to be convened consisting of: ▪ Head of Partnership Commissioning CCG. ▪ Assistant Director, or Head of Service - Adult Social Care ▪ A Consultant in Public Health Medicine (Independent Person) ▪ A Senior Manager from Social Care (Team Manager) ▪ CHC Manager. Progress to Level 4 if not resolved.	Within 28 working days
At Stage 3, the respective Directors / Chief Officers can elect to resolve the matter by arbitration, mediation or independent review if considered appropriate.		
Stage 4	Discussion between Chief Executive of the CCG and the Director of DACHS	Within 10 days
At Stage 4, the Chief Executive and the Director of Social Care can elect to resolve the matter by arbitration, mediation or independent review if considered appropriate. This can include a "Peer Review" of the process, evidence and decision making process from another CCG.		

4.1.12 The dispute process does not affect the legal rights of either party to take further action or to pursue the concerns via a formal complaint to NHS England.

4.1.13 There will be agreement that any learning from IRP (Independent Review Panels) and the Dispute Process will be taken positively to inform future and best practices for the benefits of individuals and support cohesive working relationships across the LA and CCG.

4.1.14 If at the end of the dispute process NHS Continuing Healthcare funding is agreed it will be payable from the date that the assessment was undertaken and not from the date of the conclusion of the dispute process.

4.1.15 It is the responsibility of the LA and CCG to provide updated full information at each stage of the dispute process so that decision making is not delayed by absence of information or evidence.

5.0 Commissioning of Care Packages

5.0.1 When a Patient is deemed eligible for CHC funding they will be allocated a case manager who will help the Patient or their Representative to find an appropriate placement or package. The service commissioned will include on-going case management and this will include review of an individual patient's needs.

5.0.2 Care packages will be commissioned for care homes, domiciliary care providers and from nursing agencies, where a NHS contract is in place for CHC provision. Care will not be commissioned from those care providers where there are concerns raised about the quality of the care provided or where they are known not to meet the Care Quality Commission minimum standards for care homes.

5.0.3 Depending on the package commissioned in some circumstances a 'top up' fee may be requested. This is only applicable for non-care costs and in this instance the patient, or their representative, will be responsible for this charge. Where a top fee is requested this will be discussed with the patient or their representatives prior to the CCG commissioning the service.

5.1 Care Costs– refer to choice and resource allocation policy

5.1.1 Individual preferences for care provision are supported wherever possible but the CCG considers this alongside quality assurance, risk management and financial indicators. The importance of ensuring value for money and the efficient use of public money has been established by using a resource allocation tool.

5.1.2 Within Dudley the 'budget' for an individual's continuing healthcare needs will be established by 3 mechanisms:

1) receipt of a costed care plan for that individual from care homes deemed appropriate for that individual. An average costing would be taken from at least two homes;

2) individual costed care plans from domiciliary care providers for support in a person's own home. Dudley CCG recognises that domiciliary care packages are normally more expensive than residential care placements (because there are no economies of scale to be had) and consequently a 20% enhancement is applied on top of the equivalent care home costs to reflect this. However in order to ensure appropriate use of public money an individual's package of care at home will not be considered beyond this 20% threshold for a care home placement;

3) for individuals wishing to consider a Personal Health Budget the nationally recognised budget tool is applied to provide a resource allocation.

5.2 Case Reviews

5.2.1 Case reviews will be undertaken for individuals no later than three months following the initial eligibility decision and thereafter on an annual basis, unless indicated earlier. This will ensure that individual patients are receiving the care they need and that they remain eligible for CHC funding. Continuing Healthcare funding may be withdrawn should a review show that the patient no longer meets the criteria and is therefore no longer eligible for funding.

5.2.2 It is the responsibility of the assessor and the case manager to ensure the Patient or their representatives are aware that these reviews occur and that CHC funding may be removed should a Patient's level of health need change and they no longer meet the criteria.

5.3 De-commissioning of care packages

5.3.1 The CHC Team will notify the Local Authority where a patient is no longer eligible for funding and may require a social care assessment. The patient or their representative will be informed of this decision following the review process. The CCG will fund for a maximum of 4 weeks after notification that the patient is no longer eligible for CHC funding.

6.0 Personal Health Budgets (PHB)

6.0.1 CCGs are required to offer a PHB to people in receipt of CHC funding, in order to give patients better flexibility, choice and control over their care. A PHB helps people to get the services they need to achieve their agreed health and wellbeing outcomes (agreed between the patient and clinician). Financially, PHBs can be managed in a number of ways, including:-

- a notional budget held by the CCG Commissioner
- a budget managed on the individual's behalf by a third party, and
- a direct payment to the individual

6.0.2 People who are newly in receipt of CHC funding for home care packages will be introduced to the concept of PHBs during their 3 month CHC review. If they would like to investigate this option an indicative budget will be produced and shared with the Patient or their representatives during an introductory meeting to explain the PHB process.

6.0.3 The CHC Case Manager or the Nurse Assessor will work with the patient or their representatives to agree health and wellbeing outcomes and form a support plan. The Case Manager or Nurse Assessor will then create a final budget and care plan which will be reviewed by a PHB Panel for approval.

6.0.4 Support services will be provided to help people with direct payments, and support and advice will be provided for those wishing to employ a personal assistant directly.

6.0.5 Care plans will be reviewed as per the National Framework Guidance, every three months after the care package has been started and a minimum of 12 months thereafter.

7.0 Transition from Children's services to Adult Continuing Healthcare Services

7.0.1 Once a young person reaches the age of 18 years, they are no longer eligible for continuing care for children but may be eligible for Adult NHS Continuing Healthcare, which is subject to its own legislation and specific guidance.

7.0.2 It is important that young people and their families are helped to understand that eligibility to Children's Continuing Care does not automatically imply eligibility to Adult NHS Continuing Health Care and the implications of this will be made clear right from the start of transition planning:-

- at 14 years of age, the young person will be brought to the attention of the CCG's Adult NHS Continuing Healthcare Team using the Continuing Care Transition Notification Form (appendix 7);

- at 16 years of age, screening for Adult NHS Continuing Healthcare will be undertaken using the adult screening tool;

- at 17 years of age, an agreement in principle for Adult NHS Continuing Healthcare will have been made;

- at 18 years of age, full transition to Adult NHS Continuing Healthcare or to universal and specialist services will have been made, except in instances where this is not appropriate.

7.0.3 Where the young person has an allocated Children's Disability Team Social Worker, they will lead the transition process, working alongside the identified Transition Team Social Worker.

Code of Practice relating to attendance at a CHC assessment meeting

This is a Code of Practice for family members and their advocates or representative when attending CHC assessments. Any page numbers referred to within it are references to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2018 (revised) which includes the Practice Guidance (PG).

1 CHC assessments are conducted by the CCG in accordance with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 and the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2018 (revised) which includes the Practice Guidance (PG).

2 The CCG will ensure that there is a multi-disciplinary team (MDT) as defined by the Regulations available in order to carry out the CHC assessment. The CCG will inform the individual and the advocate who is part of the MDT at the start of the assessment.

3 The CCG supports and encourages individuals who wish to involve an advocate during the CHC assessment process in order to assist them in putting their views across to the MDT team. If the individual chooses to have a legally qualified person to act as their advocate, that person would be acting with the same status as any other advocate nominated by the individual concerned (Page 146, PG 58.2). To be clear, the individual or advocate or legal representative acting on behalf of the individual, is not part of the MDT.

4 The CCG expect the individual involved (or their representative if they do not have capacity) to inform the CCG who will be the advocate before the assessment meeting begins. The CCG would usually only expect one advocate to be nominated to attend the assessment (Page 145, PG57.1). If an individual wishes more than one advocate to attend the assessment the CCG will consider this request if it is made in writing with reasons explaining why more than one advocate is required. The assessment meeting is to allow the MDT to assess an individual's needs while ensuring that the individual is able to put their views about their care to the assessors. The CCG fully recognises the importance of representation for the individual however, the guidance is clear that the assessment is not a legal or an adversarial process and its focus should be on assessing an individual's needs (Page 146, PG 58.1). It is only in exceptional circumstances that the CCG envisage agreeing to a request for more than one advocate to be involved in the assessment meeting.

5 The CCG envisages that most CHC assessments will take approximately 2-3 hours and it is only in exceptional circumstances that assessments should take longer than this. If a longer time period is required the individual and their advocate will be informed about the likely duration of the assessment. If the timeslot allocated is not adequate then a further appointment will be arranged to conclude the assessment process after the initial meeting.

6 The individual's views of their needs, directly or through their advocate, will be documented by the MDT at each stage of the assessment process on the Decision Support Tool. This can include a view on the scoring of the completed domain levels if a view is given by the individual or their representative or advocate.

7 The CHC assessors will not take part in extensive debate about the scoring or their clinical judgement once the views of the advocate/representative and the individual have been expressed and documented. The reason for this is that this is not an adversarial process and this debate would be an inappropriate use of the assessment time. If the CHC assessors consider that the advocate involved is becoming adversarial and the focus is moving away from the individual's assessment of needs, the meeting will be drawn to a close by the CHC assessors and will be re-arranged.

8 Once all the information has been gathered (and depending on agreed local protocols) it is acceptable for the MDT to have a discussion without the individual and/or their representative present in order to come to an agreed recommendation. MDTs should be aware that the DST contains a section at the end of the domain tables for the individual and/or the representative to give their views on the completion of the DST that have not already been recorded elsewhere in the document, including whether they agree with the domain levels selected. It also asks for reasons for any disagreement to be recorded. Therefore the MDT meeting

should be arranged in a way that enables that individual to give his/her views on the completed domain levels before they leave the meeting. (Page 117, PG 24.2)

9 Once the MDT has made a decision relating to the recommendation the individual and the advocate will be invited back into the room in order to hear the recommendation. Alternatively the recommendation will be communicated to them as soon as possible by the CCG.

10 Any issues not relating to the question of eligibility and an individual's needs should be raised by advocates with the CCG separately and outside the assessment meeting. This will ensure that the time allocated for the meeting is used as it should be and the meeting is not prolonged dealing with legal queries (Page 146, PG 58.2).

11 Details of members of the MDTs experience will be given at the start of the assessment meeting. If there are queries relating to the MDTs experience these queries can be raised with the CCG outside the meeting.

12 The CCG adopt the Framework guidance relating to when there is a disagreement about the scoring within the MDT. In a situation like this, the MDT practitioners will adopt the higher level of a domain if there is a clear and reasoned evidence to support this (Pages 124, PG 33). For the avoidance of doubt the individual and their advocate are not part of the MDT and their views on scoring will be recorded on the DST but a higher score will only be adopted if there is a disagreement relating to scoring within the MDT itself.

Code of Practice relating to Multi-Disciplinary Team

This is a Code of Practice for the MDT when attending CHC assessments. Any page numbers referred to within it are references to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (revised) which includes the Practice Guidance (PG).

1 CHC assessments are conducted by the CCG in accordance with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 and the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (revised) which includes the Practice Guidance (PG).

2 The CCG will ensure that there is a multi-disciplinary team (MDT) as defined by the Regulations available in order to carry out the CHC assessment. The CCG will inform the individual and the advocate who is part of the MDT at the start of the assessment.

3 The CCG supports and encourages individuals who wish to involve an advocate during the CHC assessment process in order to assist them in putting their views across to the MDT team. If the individual chooses to have a legally qualified person to act as their advocate, that person would be acting with the same status as any other advocate nominated by the individual concerned (Page 61, PG 10.2). To be clear, the individual or advocate or legal representative acting on behalf of the individual, is not part of the MDT.

4 The CCG expect the individual involved (or their representative if they do not have capacity) to inform the CCG who will be the advocate before the assessment meeting begins. The CCG would usually only expect one advocate to be nominated to attend the assessment (Page 60, PG 9.1). If an individual wishes more than one advocate to attend the assessment the CCG will consider this request if it is made in writing with reasons explaining why more than one advocate is required. The assessment meeting is to allow the MDT to assess an individual's needs while ensuring that the individual is able to put their views about their care to the assessors. The CCG fully recognises the importance of representation for the individual however, the guidance is clear that the assessment is not a legal or an adversarial process and its focus should be on assessing an individual's needs (Page 61, PG 10.1). It is only in exceptional circumstances that the CCG envisage agreeing to a request for more than one advocate to be involved in the assessment meeting.

5 The CCG envisages that most CHC assessments will take approximately 2-3 hours and it is only in exceptional circumstances that assessments should take longer than this. If a longer time period is required the individual and their advocate will be informed about the likely duration of the assessment. If the timeslot allocated is not adequate then a further appointment will be arranged to conclude the assessment process after the initial meeting.

6 The individual's views of their needs, directly or through their advocate, will be documented by the MDT at each stage of the assessment process on the Decision Support Tool. This can include a view on the scoring of the completed domain levels if a view is given by the individual or their representative or advocate.

7 The CHC assessors will not take part in extensive debate about the scoring or their clinical judgement once the views of the advocate/representative and the individual have been expressed and documented. The reason for this is that this is not an adversarial process and this debate would be an inappropriate use of the assessment time. If the CHC assessors consider that the advocate involved is becoming adversarial and the focus is moving away from the individual's assessment of needs, the meeting will be drawn to a close by the CHC assessors and will be re-arranged.

8 Once the assessment information has been gathered, the MDT may wish to discuss the recommendation without the individual and their advocate present. At this point the MDT will ask the individual and the advocate to leave the room (Page 74, PG 30.3) so that this discussion can take place.

9 Once the MDT has made a decision relating to the recommendation the individual and the advocate will be invited back into the room in order to hear the recommendation. Alternatively the recommendation will be communicated to them as soon as possible by the CCG.

10 Any issues not relating to the question of eligibility and an individual's needs should be raised by advocates with the CCG separately and outside the assessment meeting. This will ensure that the time allocated for the meeting is used as it should be and the meeting is not prolonged dealing with legal queries (Page 61, PG 10.2).

11 Details of members of the MDTs experience will be given at the start of the assessment meeting. If there are queries relating to the MDTs experience these queries can be raised with the CCG outside the meeting.

12 The CCG adopt the Framework guidance relating to when there is a disagreement about the scoring within the MDT. In a situation like this, the MDT practitioners will adopt the higher level of a domain if there is a clear and reasoned evidence to support this (Pages 77 – 78, PG 35.1). For the avoidance of doubt the individual and their advocate are not part of the MDT and their views on scoring will be recorded on the DST but a higher score will only be adopted if there is a disagreement relating to scoring within the MDT itself.

13 If members of the MDT disagree about the scoring then the CCG requires that each MDT member makes a full record, on the DST, which accounts for the reason why that MDT member has recommended that score. Without a full record of the individual MDT's reasoning, the panel will not be able to take account of that recommendation and will need to request further information before a decision is taken.

14 The guidance is clear that the moving to a higher level where there is disagreement within the MDT should not be used to artificially steer individuals towards a decision that an individual has a primary health need (Page 78, PG 35.2). The CCG will monitor the use of this practice as suggested by the guidance (Page 78 PG 35.3) and where regular patterns are identified the issue will be raised with the relevant organisation in order to address any practice issues.

Appendix 3

Department of Health & Social Care

NHS Continuing Healthcare Checklist

October 2018 (*Revised)*

Published March 2018

DH ID box
Title: NHS Continuing Healthcare Decision Support Tool
Author: **SCLGCP-SCP 25370**
Document Purpose: Guidance
Publication date: March 2018
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Contact details: NHS Continuing Healthcare and NHS-funded Nursing Care team Department of Health and Social Care 39 Victoria Street London SW1H 0EU

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October 2018 (revised)

What is the Checklist and why is it used?

1. The Checklist is a screening tool which can be used in a variety of settings to help practitioners identify individuals who may need a referral for a full assessment of eligibility for NHS Continuing Healthcare.
2. All staff who complete the Checklist should be familiar with the principles of the National Framework for Continuing Healthcare and NHS-funded Nursing Care and also be familiar with the Decision Support Tool for NHS Continuing Healthcare.
3. The Checklist threshold at this stage of the process has intentionally been set low, in order to ensure that all those who require a full assessment of eligibility for NHS Continuing Healthcare have this opportunity.
4. There are two potential outcomes following completion of the Checklist:
   - a negative Checklist , meaning the individual does not require a full assessment of eligibility and they are not eligible for NHS Continuing Healthcare; or
   - a positive Checklist meaning an individual now requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean the individual is eligible for NHS Continuing Healthcare.

Note:
All these tools are available electronically (as Word documents) and pages or boxes can be expanded as necessary.
It is important to note that these are national tools and the content should not be changed, added to or abbreviated in any way. However, CCGs may attach their logo and additional patient identification details if necessary (e.g. adding NHS number, etc.).

When should the Checklist be completed?

5. Where there may be need for NHS Continuing Healthcare, the Checklist should normally be completed.
6. There will be many situations where it is not necessary to complete the Checklist. See paragraphs 91 of the National Framework and page 7 below.
7. Screening and assessment of eligibility for NHS Continuing Healthcare should be at the right time and location for the individual and when the individual's ongoing needs are known. This may be in a variety of settings, although the full assessment of eligibility should normally take place when the individual is in a community setting, preferably their own home. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and ongoing needs. This will help practitioners to correctly identify individuals who require a full assessment of eligibility for NHS Continuing Healthcare.
8. To understand how NHS Continuing Healthcare interacts with hospital discharge, please refer to paragraphs 109-117 of the National Framework.

Who can complete the Checklist?

9. The Checklist can be completed in by a variety of health and social care practitioners, so long as they have been trained in its use.

What is the role of the individual in the screening process?

10. The individual should be given reasonable notice of the intention to undertake the Checklist and have the process explained to them. They should normally be given the opportunity to be present when the Checklist is completed, together with any representative they may have, so that they can contribute their views about their needs.

11. Where the individual concerned has capacity, their informed consent should be obtained before completion of the Checklist. It should be made explicit to the individual whether their consent is being sought specifically for the completion of the Checklist and the sharing of information for this, or for the full process, including the completion of the DST (where the Checklist is positive). It is generally good practice to obtain consent that is valid for the whole process, bearing in mind that the individual must be told that they can withdraw their consent at any time. Please refer to paragraphs 72-72 of the National Framework which gives detailed guidance on what is required for consent to be valid.

12. If there is a concern that the individual may not have capacity to give consent to the assessment process or to the sharing of information, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. It may be necessary for best interests decisions to be made, bearing in mind the expectation that all who are potentially eligible for NHS Continuing Healthcare should have the opportunity to be considered for eligibility. Guidance on the application of the Mental Capacity Act in such situations is provided in paragraphs 74-81 of the National Framework.

How should the Checklist be completed?

13. Completion of the Checklist is intended to be relatively quick and straightforward. It is not necessary to provide additional detailed evidence along with the completed Checklist.

14. Practitioners should compare the domain descriptors to the needs of the individual and select level A, B or C, as appropriate, choosing whichever most closely matches the individual. If the needs of the individual are the same or greater than anything in the A column, then ‘A’ should be selected. Practitioners should briefly summarise the individual’s needs which support the level chosen, recording references to evidence as appropriate.

15. A full assessment for NHS Continuing Healthcare is required if there are:

- two or more domains selected in column A;
- five or more domains selected in column B, or one selected in A and four in B; or
- one domain selected in column A in one of the boxes marked with an asterisk (i.e. those domains that carry a priority level in the Decision Support Tool), with any number of selections in the other two columns.

16. There may very occasionally be circumstances where a full assessment of eligibility for NHS Continuing Healthcare is appropriate even though the individual does not apparently meet the indicated threshold as set out above. A clear rationale must be given in such circumstances and local protocols followed.

17. The principles in relation to 'well-managed need' (outlined in the Assessment of Eligibility section of the National Framework, paragraphs 142-146) apply equally to the completion of the Checklist as they do to the Decision Support Tool.

What happens after the Checklist?

18. Whatever the outcome of the Checklist – whether or not a referral for a full assessment of eligibility for NHS Continuing Healthcare is considered necessary – the outcome must be communicated clearly and in writing to the individual or their representative, as soon as is reasonably practicable. This should include the reasons why the Checklist outcome was reached. Normally this will be achieved by providing a copy of the Checklist.

What happens following a negative Checklist?

19. A negative Checklist means the individual does not require a full assessment of eligibility and they are not eligible for NHS Continuing Healthcare

20. Where it can reasonably be anticipated that the individual's needs are likely to increase in the next three months (e.g. because of an expected deterioration in their condition), this should be recorded and a decision made as to whether the checklist should be reviewed within a specified period of time.

21. If an individual has been screened out following completion of the Checklist, they may ask the CCG to reconsider the Checklist outcome. The CCG should give this request due consideration, taking account all of the information available, and/or including additional information from the individual or carer, though there is no obligation for the CCG to undertake a further Checklist.

What happens following a positive Checklist?

22. A positive Checklist means that the individual requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean that the individual will be found eligible for NHS Continuing Healthcare (refer to paragraphs 104-107 of the National Framework).

23. An individual should not be left without appropriate support while they await the outcome of the assessment and decision-making process.

NHS Continuing Healthcare Needs Checklist

Date of completion of Checklist _____

Name | **D.O.B.**

NHS number and GP/Practice:

Permanent address and telephone number	**Current location (e.g. name of hospital ward etc.)**

Gender ___ _____

Please ensure that the equality monitoring form at the end of the Checklist is completed

Was the individual involved in the completion of the Checklist? Yes/No (please delete Yes/No as appropriate)

Was the individual offered the opportunity to have a representative such as a family member or other advocate present when the Checklist was completed? Yes/No (please delete as appropriate)

If yes, did the representative attend the completion of the Checklist? Yes/No (please delete as appropriate)

Please give the contact details of the representative (name, address and telephone number).

Did you explain to the individual how their personal information will be shared with the different organisations involved in their care, and did they consent to this information sharing? Yes/No (please delete as appropriate)

When not to screen

There will be many situations where it is not necessary to complete the Checklist.

Practitioners should review the statements below on when it may not be appropriate to screen for NHS Continuing Healthcare before they start the process of completing the Checklist.

The situations where it is not necessary to complete the Checklist include:

a) It is clear to practitioners working in the health and care system that there is no need for NHS Continuing Healthcare at this point in time. Where appropriate/relevant this decision and its reasons should be recorded. If there is doubt between practitioners the Checklist should be undertaken.

b) The individual has short-term health care needs or is recovering from a temporary condition and has not yet reached their optimum potential (although if there is doubt between practitioners about the short-term nature of the needs it may be necessary to complete the Checklist). See paragraphs 109-117 of the National Framework for how NHS Continuing Healthcare may interact with hospital discharge.

c) It has been agreed by the CCG that the individual should be referred directly for full assessment of eligibility for NHS Continuing Healthcare.

d) The individual has a rapidly deteriorating condition and may be entering a terminal phase – in these situations the Fast Track Pathway Tool should be used instead of the Checklist.

e) An individual is receiving services under Section 117 of the Mental Health Act that are meeting all of their assessed needs.

f) It has previously been decided that the individual is not eligible for NHS Continuing Healthcare and it is clear that there has been no change in needs.

If upon review of these statements, it is deemed that it is not necessary to screen for NHS Continuing Healthcare at this time, the decision not to complete the Checklist and its reasons should be clearly recorded in the patient's notes.

Name of individual		Date of completion	
	C	**B**	**A**
Breathing*	Normal breathing, no issues with shortness of breath. **OR** Shortness of breath or a condition, which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Shortness of breath or a condition, which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not consistently respond to management and limit some daily activities. **OR** Requires any of the following: - low level oxygen therapy (24%); - room air ventilators via a facial or nasal mask; other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to therapeutic treatment and limits all daily living activities. **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (non-invasive positive airway pressure, or non-invasive ventilation)

Brief description of need and source of evidence to support the chosen level		**Write A, B or C below:**

Name of individual		Date of completion	
	C	**B**	**A**
Nutrition	Able to take adequate food and drink by mouth to meet all nutritional requirements. **OR** Needs supervision, prompting with meals, or may need feeding and/or a special diet (for example to manage food intolerances/allergies). **OR** Able to take food and drink by mouth but requires additional/supplementary feeding.	Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. **OR** Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. **OR** Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR** Nutritional status 'at risk' and may be associated with unintended, significant weight loss. **OR** Significant weight loss or gain due to an identified eating disorder. **OR** Problems relating to a feeding device (e.g. PEG) that require skilled assessment and review.

Brief description of need and source of evidence to support the chosen level		**Write A, B or C below:**

Name of individual		**Date of completion**	
	C	**B**	**A**

Continence	Continent of urine and faeces. **OR** Continence care is routine on a day-to-day basis. **OR** Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. **AND** Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.	Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation or other bowel problems.	Continence care is problematic and requires timely and skilled intervention, beyond routine care. (for example frequent bladder wash outs/irrigation, manual evacuations, frequent re-catheterisation).
Brief description of need and source of evidence to support the chosen level			**Write A, B or C below:** ☐

Name of individual	**Date of completion**

	C	B	A	
Skin integrity	No risk of pressure damage or skin condition. **OR** Risk of skin breakdown which requires preventative intervention once a day or less than daily, without which skin integrity would break down. **OR** Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound. **OR** A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. **OR** An identified skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment	Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is responding to treatment. **OR** Specialist dressing regime in place which is responding to treatment.	
Brief description of need and source of evidence to support the chosen level				**Write A, B or C below: C** ☐

Name of individual		Date of completion	
	C	**B**	**A**
Mobility	Independently mobile. **OR** Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Not able to consistently weight bear. **OR** Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. **OR** In one position (bed or chair) for majority of the time but is able to cooperate and assist carers or care workers. **OR** At moderate risk of falls (as evidenced in a falls history or risk assessment)	Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning. **OR** Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. **OR** At a high risk of falls (as evidenced in a falls history and risk assessment). **OR** Involuntary spasms or contractures placing the individual or others at risk.
Brief description of need and source of evidence to support the chosen level			**Write A, B or C below:**

Name of individual		**Date of completion**	
	C	**B**	**A**
Communication	Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language. **OR** Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The individual has to have most of their needs anticipated because of their inability to communicate them.
Brief description of need and source of evidence to support the chosen level			**Write A, B or C below: C**

Name of individual		Date of completion	
	C	**B**	**A**
Psychological/ Emotional	Psychological and emotional needs are not having an impact on their health and well-being. **OR** Mood disturbance or anxiety symptoms or periods of distress, which are having an impact on their health and/or well-being but respond to prompts, distraction and/or reassurance. **OR** Requires prompts to motivate self towards activity and to engage them in care planning, support and/or daily activities.	Mood disturbance, hallucinations or anxiety symptoms or periods of distress which do not readily respond to prompts, distraction and/or reassurance and have an increasing impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in support, care planning and/or daily activities.	Mood disturbance, hallucinations or anxiety symptoms or periods of distress that have a severe impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.

Brief description of need and source of evidence to support the chosen level		**Write A, B or C below:**

Name of individual		**Date of completion**	
	C	**B**	**A**
Cognition	No evidence of impairment, confusion or disorientation. **OR** Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support,	Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their	Cognitive impairment that could for example include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues, they are unable to do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult, even with supervision, prompting or assistance, to make decisions about key aspects of their lives, which

	prompting or assistance. However, the individual has insight into their impairment.	lives, which consequently puts them at some risk of harm, neglect or health deterioration.	consequently puts them at high risk of harm, neglect or health deterioration.

Brief description of need and source of evidence to support the chosen level		**Write A, B or C below:** ☐

Name of individual		**Date of completion**	
	C	**B**	**A**

Behaviour*	No evidence of 'challenging' behaviour. **OR** Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or create a barrier to intervention. The individual is compliant with all aspects of their care.	'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The individual is nearly always compliant with care.	'Challenging' behaviour of type and/or frequency that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.
Brief description of need and source of evidence to support the chosen level			**Write A, B or C below:** ☐

Name of individual		**Date of completion**	
	C	**B**	**A**

Drug therapies and medication: symptom control*	Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects. **OR** Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living; pain and other symptoms do not have an impact on the provision of care.	Requires the administration of medication (by a registered nurse, carer or care worker) due to: – non-compliance, or – type of medication (for example insulin); or – route of medication (for example PEG). **OR** Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage. **OR** Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.
Brief description of need and source of evidence to support the chosen level			**Write A, B or C below:** ☐

Name of individual	**Date of completion**

	C	B	A	
Altered states of consciousness*	No evidence of altered states of consciousness (ASC). **OR** History of ASC but effectively managed and there is a low risk of harm.	Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. **OR** Occasional ASCs that require skilled intervention to reduce the risk of harm.	
Brief description of need and source of evidence to support the chosen level				**Write A, B or C below:**
Total from all pages				

Please highlight the outcome indicated by the Checklist:

1. Referral for full assessment for NHS Continuing Healthcare is necessary.

or

2. No referral for full assessment for NHS Continuing Healthcare is necessary.

Rationale for decision

Negative Checklist

Please send this completed Checklist to the CCG without delay.

Name(s) and signature(s) of assessor(s)	**Date**

Contact details of assessors (name, role, organisation, telephone number, email address)

01384 321777

About you – equality monitoring

Please provide us with some information about yourself. This will help us to understand whether people are receiving fair and equal access to NHS continuing healthcare. All the information you provide will be kept completely confidential by the Clinical Commissioning Group. No identifiable information about you will be passed on to any other bodies, members of the public or press.

1 What is your sex?
Tick one box only.

Male	
Female	x
In another way	
Prefer not to answer	

2 Which age group applies to you?
Tick one box only.

18-24	
25-34	
35-44	
45-54	
55-64	
65-74	
75-84	
85+	x
Prefer not to answer	

3 Do you have a disability as defined by the Disability Discrimination Act (DDA)?
Tick one box only.

The Disability Discrimination Act (DDA) defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

Yes	
No	x
Prefer not to answer	

4 What is your ethnic group?
Tick one box only.

A White

English/Welsh/Scottish/Northern Irish/British	x
Irish	
Gypsy or Irish Traveller	

Any other White background, write below

B Mixed

White and Black Caribbean	
White and Black African	
White and Asian	

Any other Mixed background, write below

C Asian, or Asian British

Indian	
Pakistani	
Bangladeshi	
Chinese	

Any other Asian background, write below

D Black, or Black British

Caribbean	
African	

Any other Black background, write below

E Other ethnic group

Arab	

Any other ethnic group, write below

Prefer not to answer

5 What is your religion or belief?
Tick one box only.

Christian includes Church of England/Wales/ Scotland, Catholic, Protestant and all other Christian denominations.

- None ☐
- Christian ☐
- Buddhist ☐
- Hindu ☐
- Jewish ☐
- Muslim ☐
- Sikh ☐
- Prefer not to answer ☐

Any other religion, write below

6 Which of the following best describes your sexual orientation?

Tick one box only.

- Heterosexual or Straight ☐
- Gay or Lesbian ☐
- Bisexual ☐
- Prefer not to answer ☐

Other, write below

Department of Health & Social Care

Fast Track Pathway Tool for NHS Continuing Healthcare

October 2018 (*Revised)*
Published March 2018

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Title: Fast Track Pathway Tool for NHS Continuing Healthcare
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1. This revised tool accompanies the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care 2018 (the National Framework) and the NHS Continuing Healthcare Checklist (the Checklist) and the Decision Support Tool for NHS Continuing Healthcare (DST). This is the version that Clinical Commissioning Groups (CCGs) and NHS England[1] should use from 1st October 2018. Please use the tool in conjunction with the National Framework, with particular reference to paragraphs 216-245.
2. Standing Rules Regulations2 have been issued under the National Health Service Act 20063 and directions are issued under the Local Authority Social Services Act 1970 in relation to the National Framework.

What is the Fast Track Pathway Tool?

3. Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require 'fast tracking' for immediate provision of NHS Continuing Healthcare.
4. The intention of the Fast Track Pathway is that it should identify individuals who need to access NHS Continuing Healthcare quickly, with minimum delay, and with no requirement to complete the Checklist or the Decision Support Tool (DST). Therefore, the completed Fast Track Pathway Tool, which clearly evidences that an individual is both rapidly deteriorating and may be entering terminal phase, is in itself sufficient to establish eligibility.

Who can complete the Fast Track Pathway Tool?

5. In Fast Track cases, the Standing Rules state that it is an 'appropriate clinician' who determines that the individual has a primary health need. The CCG must therefore determine that the individual is eligible for NHS Continuing Healthcare and should respond promptly and positively to ensure that the appropriate funding and care arrangements are in place without delay.
6. An 'appropriate clinician' is defined as a person who is:

    a) 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

    b) a registered nurse or a registered medical practitioner.
7. The 'appropriate clinician' should be knowledgeable about the individual's health needs, diagnosis, treatment or care and be able to provide an assessment of why the individual meets the Fast Track Pathway Tool criteria.

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[1] For the purposes of this document references to CCGs after this point also include NHS England where it is responsible for commissioning services for an individual for whom a Fast Track Pathway Tool has been completed.

[2] The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the Standing Rules")

[3] National Health Service Act 2006 (c.41), ("the 2006 Act").

8. An ‘appropriate clinician’ can include clinicians employed in voluntary and independent sector organisations that have a specialist role in end of life needs (for example, hospices), provided they are offering services pursuant to the 2006 Act.

9. Others, who are not approved clinicians as defined above, but are involved in supporting those with end of life needs, (including those in wider voluntary and independent sector organisations) may identify the fact that the individual has needs for which use of the Fast Track Pathway Tool might be appropriate. They should contact the appropriate clinician who is responsible for the diagnosis, care or treatment of the individual and ask for consideration to be given to completion of the Fast Track Pathway Tool.

When should the Fast Track Pathway Tool be used?

10. The Fast Track Pathway Tool must only be used when the individual has a rapidly deteriorating condition and may be entering a terminal phase.

11. The Fast Track Pathway Tool replaces the need for the Checklist and the Decision Support Tool (DST) to be completed. However, a Fast Track Pathway Tool can also be completed after the Checklist if it becomes apparent at that point that the Fast Track criteria are met.

12. The Fast Track Pathway Tool can be used in any setting. This includes where such support is required for individuals who are already in their own home or are in a care home and wish to remain there. It could also be used in other settings, such as hospices.

13. If an individual meets the criteria for the use of the Fast Track Pathway Tool then the Tool should be completed even if an individual is already receiving a care package (other than one already fully funded by the NHS) which could still meet their needs. This is important because the individual may at present be funding their own care or the local authority may be funding (and/or charging) when the NHS should now be funding the care in full.

14. The completed Fast Track Pathway Tool should be supported by a prognosis, where available. However, strict time limits that base eligibility on a specified expected length of life remaining should not be imposed:

    a) ‘rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining; and

    b) ‘may be entering a terminal phase’ is not intended to be restrictive to only those situations where death is imminent.

It is the responsibility of the appropriate clinician to make a decision based on whether the individual’s needs meet the Fast Track criteria.

15. An individual may at the time of consideration be demonstrating few symptoms yet the nature of the condition is such that it is clear that rapid deterioration is to be expected in the near future. In these cases it may be appropriate to use the Fast Track Pathway Tool in anticipation of those needs arising and agreeing the responsibilities and actions to be taken once they arise, or to plan an early review date to reconsider the situation. It is the

responsibility of the appropriate clinician to base their decision on the facts of the individual's case and healthcare needs at the time.

How should the Fast Track Pathway Tool be used?

16. Appropriate clinicians should complete the attached fast-track documentation and set out how their knowledge, and evidence about the patient's needs, leads them to conclude that the patient has a rapidly deteriorating condition and that the condition may be entering a terminal phase.

17. It is helpful if an indication of how the individual presents in the current setting is included with the Fast Track Pathway Tool, along with the likely progression of the individual's condition, including anticipated deterioration and how and when this may occur. However, CCGs should not require this information to be provided as a prerequisite for establishing entitlement to NHS Continuing Healthcare.

18. Whilst the completed Fast Track Pathway Tool itself is sufficient to demonstrate eligibility, a care plan will be required which describes the immediate needs to be met and the patient's preferences. This care plan should be provided with the Fast Track documentation, or as soon as practicable thereafter, in order for a CCG to commission appropriate care.

19. The setting where an individual wishes to be supported as they approach the end of their life may be different to their current arrangements (e.g. even though they are currently in a care home setting they may wish to be supported in their family environment).The important issue is that (wherever possible) the individual concerned receives the support they need in their preferred place as soon as reasonably practicable, without having to go through the full process for consideration of NHS Continuing Healthcare eligibility.

How should the individual/representative be involved?

20. The overall Fast Track process should be carefully and sensitively explained to the individual and (where appropriate) their representative.

21. It is also important for the CCG to know what the individual or their representative have been advised about their condition and prognosis and how they have been involved in agreeing the end of life care pathway.

22. Clinicians completing the Fast Track Pathway Tool should make the individual aware that their needs may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review.

Careful decision-making is essential in order to avoid the undue distress that might result from changes in NHS Continuing Healthcare eligibility within a very short period of time

Fast Track Pathway Tool for NHS Continuing Healthcare

To enable immediate provision of a package of NHS Continuing Healthcare

Date of completion of the Fast Track Pathway Tool _____

Name | **D.O.B.**

NHS number:

Permanent address and telephone number	**Current location (i.e. name of hospital ward etc.)**

Gender _____

Please ensure that the equality monitoring form at the end of the Fast Track Pathway Tool is completed

Contact details of referring clinician (name, role, organisation, telephone number, email address)

(please turn over)

Fast Track Pathway Tool for NHS Continuing Healthcare

To enable immediate provision of a package of NHS Continuing Healthcare

The individual fulfils the following criterion:

He or she has a rapidly deteriorating condition and the condition may be entering a terminal phase. For the purposes of Fast Track eligibility this constitutes a primary health need. No other test is required.

Brief outline of reasons for the fast-tracking recommendation:

Please set out below the details of how your knowledge and evidence of the patient's needs mean that you consider that they fulfil the above criterion. This may include evidence from assessments, diagnosis, prognosis where these are available, together with details of both immediate and anticipated future needs and any deterioration that is present or expected.

(continue overleaf)

Please continue on separate sheet where needed. This should include the patient's name and NHS number, and also be signed and dated by the referring clinician.

I, an appropriate clinician, confirm that I have explained to the individual/their representative (tick as appropriate):

the reasons why a Fast Track application for NHS Continuing Healthcare has been made to the CCG. ☐

that the purpose of this is to enable the individual's needs to be urgently met as they have a rapidly deteriorating condition which may be entering a terminal phase. ☐

that their needs may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review ☐

Please ensure this form is sent directly to the CCG without delay

Name and signature of referring clinician	**Date**

Name and signature confirming approval by CCG	**Date**

About you – equality monitoring

Please provide us with some information about yourself. This will help us to understand whether people are receiving fair and equal access to NHS continuing healthcare. All the information you provide will be kept completely confidential by the Clinical Commissioning Group. No identifiable information about you will be passed on to any other bodies, members of the public or press.

1 What is your sex?
Tick one box only.

- Male ☐
- Female ☐
- In another way ☐
- Prefer not to answer ☐

2 Which age group applies to you?
Tick one box only.

- 18-24 ☐
- 25-34 ☐
- 35-44 ☐
- 45-54 ☐
- 55-64 ☐
- 65-74 ☐
- 75-84 ☐
- 85+ ☐
- Prefer not to answer ☐

3 Do you have a disability as defined by the Disability Discrimination Act (DDA)?
Tick one box only.

The Disability Discrimination Act (DDA) defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

- Yes ☐
- No ☐
- Prefer not to answer ☐

4 What is your ethnic group?
Tick one box only.

A White

- English/Welsh/Scottish/Northern Irish/British ☐
- Irish ☐
- Gypsy or Irish Traveller ☐
- Any other White background, write below

B Mixed

- White and Black Caribbean ☐
- White and Black African ☐
- White and Asian ☐
- Any other Mixed background, write below

C Asian, or Asian British

- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Chinese ☐
- Any other Asian background, write below

D Black, or Black British

- Caribbean ☐
- African ☐
- Any other Black background, write below

E Other ethnic group

- Arab ☐
- Any other ethnic group, write below

Prefer not to answer ☐

5 What is your religion or belief?
Tick one box only.

Christian includes Church of England/Wales/ Scotland, Catholic, Protestant and all other Christian denominations.

- None ☐
- Christian ☐
- Buddhist ☐
- Hindu ☐
- Jewish ☐
- Muslim ☐
- Sikh ☐
- Prefer not to answer ☐

Any other religion, write below

6 Which of the following best describes your sexual orientation?

Tick one box only.

- Heterosexual or Straight ☐
- Gay or Lesbian ☐
- Bisexual ☐
- Prefer not to answer ☐

Other, write below

Continuing Care Transition Notification Form

Young person's details					
Name:					
Date of birth:		**Age:**		**NHS Number:**	
Address:					
Gender (delete as appropriate)	**MALE/FEMALE**		**Ethnicity:**		
First language (if not English)			**Translator needed:**		
			Other communication support needed:		
Mother's/Carers name:			**Father's/Carers name:**		
Contact no:			**Contact no:**		
NB. details of one parent only are acceptable, but it must be the parent with responsibility.					
If parental responsibility is not held by parents					
Parental responsibility held by:			**Contact no:**		
			E-mail:		
Basis of parental responsibility: (e.g. legal guardian, LA section 20 etc.)			**Address:**		

GP: **Contact:**	**Social Worker:** **Contact :**
Community Nurse: **Contact:**	**School Nurse:** **Contact:**

Consent					
	Child / Young Person			**Parent / Carer**	
Have they consented to being brought to the attention of the Adult Continuing Healthcare Team and for the sharing and obtaining of information in relation to the transition process? (delete as appropriate).	Yes	No	N/A	Yes	No

Medical History (and responsible Consultants)
Provide a brief summary below of the young person's primary health needs, with details of any diagnoses and provision.

Social Care
Provide a brief summary below of the young person's social care needs with details of any arrangements in place. (including direct payments/short breaks)

Education	
Name of school or college attending	
Year group	
Contact details (where known)	
What additional support or reasonable adjustments are required in that setting?	
Does the child or young person have special educational needs?	
Do they have an EHCP?	

Notification Date:			
Sent by:		**Signature:**	
Designation:			

Thinking Differently

NHS
Dudley
Clinical Commissioning Group

NHS CONTINUING HEALTH CARE

OPERATIONAL POLICY FOR LOCAL APPEALS

UNIQUE REFERENCE NUMBER:
DOCUMENT STATUS:
DATE ISSUED:
DATE TO BE REVIEWED:

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
D1.0	08/03/2019	Initial Draft Proposed
D2.0		
D3.0		

REVIEWERS

This document has been reviewed by:

NAME	DATE	TITLE/RESPONSIBILITY	VERSION
Miss A Price	08/03/2019	Business Manager	D1.0

APPROVALS

This document has been approved by:

VERSION	NAME	DATE

N.B: the version of this policy posted on the intranet must be a PDF copy of the approved version.

DOCUMENT STATUS
This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS
These documents will provide additional information.

NAME OF DOCUMENT	VERSION
The National Framework of NHS Continuing Health and Free Nursing Care (2018)	Department of Health Website https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care
NHS Continuing Healthcare Practice Guidance	
Dudley CCG NHS Continuing Healthcare Policy	
Choice and Resource Allocation Policy	

1.0 Introduction

1.0.1 Purpose of this document

1.0.2 All Clinical Commissioning Groups (CCGs) are required to establish arrangements to consider appeals against decisions on eligibility for NHS Continuing Healthcare. The right to request an appeal rests with the patient or their representative. This document sets out the operational policy to be adopted by the CCG when individuals exercise their right to appeal and the arrangements for setting up Local Review Panels.

1.1 Background

1.1.1 The Department of Health first established a National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care in October 2007. The framework set out a common process to be adopted by the NHS and Local Authorities when considering whether a patient had a primary health need and therefore was considered for fully funded NHS CHC. The Framework was subsequently revised in October 2009 and again in November 2012. The Framework has been further reviewed and a revised National Framework for NHS CHC and supporting tools was introduced with effect from October 2018.

1.1.2 The establishment of a national process has not been matched by a national agreement on how CCGs should operate their local appeals procedures. It is understood that NHS England has arranged for the former regional SHA policies to be revised but this is not yet available.

1.2 The role of CCGs as determined by national guidance

1.2.1 This operational policy takes account of the role of CCGs when an appeal against a decision on eligibility is sought by a patient and/or their representative. That role is set out in the following national guidance:

- National Health Services Act 2006
- Local Authority Social Services Act 1970
- The Care Act 2014
- The NHS Continuing Health Care (Responsibilities) Directions 2007
- The National Framework for NHS Continuing Health Care and NHS Funded Nursing Care – Oct 2018 (Revised)
- The NHS Continuing Health Care (Responsibilities) Directions 2009

1.2.2 This operational policy will be reviewed when further directions on guidance are issued. It may also be necessary to modify the policy particularly where this helps to further clarify processes and practices in the light of experience.

1.3 The relationship between the Complaints Policy and the Appeals Policy

1.3.1 Dudley CCG's Policy to support people to raise a concern, tell us their story or make a complaint enables people to make complaints about Dudley CCG in respect of its activities as a commissioner of NHS care.

1.3.2 Complaints about provider services involved in continuing care processes can be directed to the service itself, although the NHS Dudley CCG Complaints Team can help to facilitate access to the complaints procedure on the complainant's behalf if they prefer.

1.3.3 The Appeals Policy for NHS Continuing Health Care (CHC) enables people who are not happy with the outcome of the determination of eligibility for CHC to appeal against the decision, with a subsequent right to ask for an independent review by NHS England (West Midlands) There is a further right to refer the matter to the Parliamentary and Health Service Ombudsman (PHSO).

1.3.4 The appeals process requires the appeal panel to ensure that due process has been followed and as such it is expected that any concerns about process would be examined as the case progresses through the appeal panel and on to NHS England and PHSO if progression is requested by the appellant. The complaints process cannot be used as an alternative means to challenge either the outcome of the decision on CHC eligibility or the process followed. Rather, once an appeal has been made, such concerns should be highlighted via onward progression of the appeals process.

1.3.5 The complaints process can however be used where the issue complained about has no material involvement or relationship to the appeals process (which would affect or influence the decision making on eligibility) but is incidental to it (e.g. the manner and attitude of staff). It is the role of the Local Appeal Panel to determine whether the assessment process has been followed and correctly applied to the eligibility criteria set out in the national framework.

1.3.6 Where the individual complains to the PHSO about the outcome of the Independent Review Panel on the grounds of process, the PHSO might request or require the CCG to consider the matter via the CCG's complaints process before deciding whether to investigate the complaint further. Although, the PHSO cannot make a decision on eligibility the PHSO can investigate complaints where the assessment process and the local appeal process has not been followed or where full and proper explanation of the rationale for the decision has not been provided to the patient if their representatives.

1.3.7 To be clear, disagreements about the assessment process and rationale for decision making is the remit of this appeals process and cannot be pursued separately in parallel or alternatively via the complaints process.

2. THE LOCAL APPEALS PROCESS

2.0.1 *Requests for a review of eligibility*

2.1.1 The CCG may need to make a distinction between requests for review of care needs (eligibility) and requests to appeal against a decision that an individual is ineligible. Where this distinction is unclear there should be a discussion with the individual or their representative to agree the course of action to be followed. This must be confirmed in writing so that there is no ambiguity about whether the request is for a review of care needs or a formal appeal. An example of this would be when the individual's care needs have not been reviewed for some time (or not previously assessed) and a current assessment using a DST would be helpful to establish a baseline. This also avoids funding delays for those who are deemed to be eligible based on an up-to-date assessment rather than delay until a more protracted review can take place for retrospective periods of care.

2.1.2 Requests for a review of care needs should not be registered as an appeal until the outcome of the fresh review is communicated in writing and this is then followed by a written request to appeal against a decision on eligibility.

2.2. ***Involvement in the assessment process***

2.2.1 Every effort should be made to engage individuals or their representatives in discussions about eligibility for NHS continuing healthcare and assessments should ideally be discussed with them by the CHC assessor or one or more representatives of the Multi-Disciplinary Team (MDT). This process will ensure that all significant care factors are taken into account and will help to develop a better understanding of the criteria for eligibility. This may not always be possible to achieve and the absence of involvement or participation does not invalidate the assessment. However, an important prelude to the setting up of a Local Review Panel is to discuss and explain the assessment with the patient or their representative if, for any reason, they were not present or have had no dialogue or discussion about the content of the Decision Support Tool.

2.2.2 Individuals or their representatives have a right to be informed about the outcome of an assessment for eligibility for NHS continuing healthcare. This includes the outcome of applying the Checklist (the initial screening tool) and the outcome following the use of the Decision Support Tool (full assessment tool).

2.23 Individuals should be given clear information stating whether they meet the criteria and explaining the reasons for the decision reached. Disputes frequently occur because people are not made aware of the criteria and are not able to understand why they do not qualify.

2.3 ***Authority to make an appeal***

2.3.1 On some occasions, CCGs may receive requests for an appeal from a close relative, friend or other representative who does not have Power of Attorney or deputy status. Where the individual has capacity, the CCG should ask the individual whether this request is in accordance with their instructions, and where they do not have capacity, a best interest's process should be used to consider whether to proceed with the request to make an appeal.

2.3.2 Where requests are received from a close relative, friend or other representative for an individual who is deceased, the CCG should only proceed with the appeal once it is satisfied that the person making the request have the authority to act on the deceased's behalf (e.g. Grant of Probate, Letter of Administration).

2.4 **Minimum requirements before an appeal can proceed**

2.4.1 Before proceeding with a Local Review Panel the commissioner for CHC will ensure that the following key elements of the process have been complied with:-

i. There must have been a full assessment using the national Decision Support Tool (DST)

ii. The DST must have been completed by a trained CHC Assessor with involvement of other MDT members (as defined in the operational policy for the assessment process)

iii. The decision on eligibility has been confirmed in writing by the Commissioner for Continuing Healthcare to the individual or their representative

iv. A copy of the DST has been provided to the individual or their representative

v. If it was not possible for family members to be involved and participate in the assessment, for whatever the reason, arrangements should be made for the CHC

Assessor (or other person designated by the senior commissioner) to discuss the DST with them

2.4.2 Failures in the key elements of process are not grounds for appeal alone. Where such failures are identified in the preparation for the appeal, the Commissioning Manager may instruct the assessment to be re-done in order to ensure that the key components have been followed. The important principle to understand is that no one will be eligible for CHC simply on the grounds of 'failure of process'.

2.5 Time limits for appeals

2.5.1 Time limits for appeals against assessment outcomes will follow the guidelines issued by the Department of Health in March 2012. This is 6 months from the date of written notification by the CCG informing the individual that they are not eligible or no-longer eligible for CHC. The time limit of 6 months commenced from 1 April 2012 and this is made known to individuals in the letter confirming the decision.

2.5.2 Based on advice from NHS England, the CCG will not consider appeals against assessed periods of eligibility prior to 1 April 2012 unless an appeal was lodged within 12 months of the notification of non-eligibility received at the time.

2.6 Request for reviews of previously un-assessed periods of care

2.6.1 On 15 March 2012, the Department of Health announced the introduction of deadlines for individuals to request as assessment of eligibility for NHS Continuing Healthcare funding for cases during the period 1 April 2004 to 31 March 2012.

2.6.2 Individuals or their representatives were asked to notify NHS Dudley in respect of previously un-assessed periods of time where there is evidence that they should have been assessed for eligibility for NHS Continuing Healthcare funding.

2.6.3 The time periods and the deadlines for notifying NHS Dudley have now passed. For completeness, these deadlines are set out below:

Period	**Deadline**
1 April 2004 – 30 September 2007	30 September 2012
1 October 2007 – 31 March 2011	30 September 2012
1 April 2011 – 31 March 2012	31 March 2013

2.6.4 The Department of Health introduced separate guidelines setting out the process for considering requests for reviews for previously un-assessed periods of care for April 2012 onwards. Below is the process followed by Dudley CCG.

2.6.5 In cases where there is evidence that a full assessment should have taken place, Checklists which indicate that a full assessment is necessary will be sent to the claimant along with a Needs Portrait. A deadline of 6 weeks will be given to respond to the Checklist and Needs Portrait and this will be notified to the claimant in writing. Appeals against negative DSTs produced as part of this process must be made within the normal timescale of 6 months from the date of written notification of non-eligibility.

3 Stages for Dispute Resolution

The stages of the process are summarised as follows:-

Stage 1: Informal procedure

Discussion with individual or their representatives with one or more members of the MDT or separate discussion with the CHC Assessment Co-ordinator and /or Lead Nurse, if appropriate. If the individual is not satisfied, then an appeal can be made by the individual or their representative in writing to CCG.

Stage 2: Local Appeal Panel Hearing

Individual or their representative has the right to make a case for eligibility to a Local Review Panel.

If the case falls well outside the eligibility criteria the chair and clinical advisor will review the case and a letter and report will be produced and sent to the applicant and the CCG. In cases where the chair determines that a full panel is required, a Local Review Panel will be convened.

Written communication with explanation to individual or their representative within a maximum of 8 weeks unless there are exceptional circumstances which must be communicated to the appellant.

Stage 3: Appeal to NHS England (West Midlands)

If the individual or their representative does not accept the decision of the Local Review Panel they can ask NHS England (West Midlands) to convene an Independent Review Panel (IRP) to consider the case.

Stage 4: Appeal to the Parliamentary and Health Service Ombudsman

If the individual is dissatisfied with the outcome of the Independent Review Panel they have the right to appeal to the Parliamentary and Health Service Ombudsman. The PHSO cannot make a decision on eligibility but can examine the process by which the decision has been reviewed by the CCG and NHS England at Stages 2 and 3 above. Once the IRP has determined the outcome of the appeal the CCG should not enter into further detailed correspondence with the appellant until the process has been considered by the Ombudsman or unless requested to do so by the Ombudsman's office.

3.1.1 This document sets out in more detail the procedures to be followed at local (CCG) level for Stages1 and 2 of the overall appeals process and this information is also provided in the information leaflet given when a request for appeal received.

STAGE 1 - INFORMAL PROCEDURE

3.1.2 *Prior to proceeding to the formal appeal stage*

3.1.3 If the individual or carer does not agree with the outcome of the CHC assessment they can ask for the case to be reviewed. However this sometimes happens because the eligibility criteria is not understood or because the reason for the decision has not been properly explained to them.

3.1.4 This informal stage is an essential pre-requisite to the formal appeals process at Stage 2 and Stage 3. Ideally, carers should already have had the opportunity to participate in the completion of the Decision Support Tool. They will therefore have been able to contribute to the assessment and also gain a better understanding of how the level of care needs was determined for each of the care domains.

3.1.5 If, for any reason, the carer was not able to participate in the assessment, the opportunity to comment on the accuracy of the assessment can still be provided to them at this informal stage. During the assessment stage, the CHC assessor is empowered to make adjustments to the DST and the recommended outcome if evidence is provided which had not previously been taken into account.

3.1.6 This stage will also include an explanation of rationale for the decision including how the assessed care needs have been applied to the eligibility criteria set out in the National Framework for NHS Continuing Health Care.

3.1.7 This informal stage is designed to ensure that there is a structured approach to dealing with all the concerns expressed either about the process, the accuracy of the assessment or the application of the care needs to the criteria. In view of the complexity of CHC, such concerns are rarely satisfied by protracted correspondence beforehand on each and every point without full explanation and understanding.

3.2 STAGE 2 - LOCAL APPEAL PANEL HEARINGS

3.2.1 ***The right to make an appeal***

3.2.2 If the informal procedure fails to achieve resolution, the individual has the right to make a formal appeal. Appeals must be in writing and signed by the individual or a representative who is authorised to act on their behalf.

3.2.3 It is not appropriate for legal representatives to represent individuals or carers at Local Review Panels. This is not a legal process but one which looks at care needs with professional / clinical judgements being used to apply these to the eligibility criteria. Solicitors can attend Local Appeal Panels to represent the views of individuals but must not act in a legal capacity or make legal challenges about the national framework.

3.2.4 ***The role of the Local Review Panel***

3.2.5 The role of the Local Review Panel is to ensure that:

I. the assessment process has been followed (see section on ‘minimum requirements before an appeal can proceed’)
II. the assessment is an accurate reflection of the individual’s care needs
III. that these have been properly applied to the eligibility criteria set out in the National Framework for NHS CHC (i.e. that the individual has a primary health need)

3.2.6 ***The Local Review Panel cannot:-***

3.2.7 Consider challenges to, or make rulings against, the National Framework for NHS Continuing Health Care and NHS Funded Nursing Care (applicable to claim periods after 1 October 2007) or to consider challenges to the Birmingham and Black Country SHA criteria in use prior to this date.

3.3 *Timescales for Local Review Panel Hearings*

3.3.1 A review by a Local Review Panel should not proceed where the individual concerned has not undergone a full assessment using the Decision Support Tool or has not had the opportunity of an informal discussion. Stage 1 should be completed before a Local Review Panel is convened.

3.3.2 Local Review Panel hearings should be convened without undue delay. However, it has become impossible to give a fixed timescale because there are so many variable factors. These include:

(i) The receipt of the completed pro-forma which incorporates consent to obtain hospital, social work, care home and GP records etc.

(ii) The receipt of evidence of 'authority to act' in the case of deceased patients

(iii) The volume of records to be considered across the timespan of the period from which the clinical assessor must then compile a 'needs portrait'

(iv) The volume of other appeals under consideration at the time

v) Finding suitable dates for family and panel members for the LRP to be held

3.3.3 When the records have been received the Appeals Administrator will communicate with the individual or their representative to inform them and to give an estimate of the likely timescale for the appeal to be heard. Similar communications should take place in circumstances where there are delays or difficulties in obtaining copies of records.

3.4 ***Membership of the Local Review Panel***

3.4.1 The Local Review Panel will normally consist of:

- A panel chair (an individual who is not an employee of the CCG)
- A representative nominated by the Local Authority
- A senior manager or non-Executive Director from the CCG (not involved in CHC)

3.4.2 In attendance will be a clinical advisor to the panel (who will be a nurse who is experienced in CHC assessments and can advise the panel on the application of the assessment to the eligibility criteria).

3.5.1 ***Role of the Clinical Advisor***

3.5.2 Most panels will have a clinical advisor present. Their role is to:

- Advise the Local Review Panel on the original clinical judgements and how they relate to the National Framework. They should not provide a second opinion on the clinical diagnosis, management or prognosis of the individual.

- Examine the information provided in the case file

- Panels may also wish to seek the advice of a Clinical Advisor to help understand the wider nature of conditions and how different needs may interact.
-
- Ensure that no significant clinical issues have been overlooked by the panel during their deliberations.

- Provide any other observation on the holistic clinical care needs associated with the condition.

- Advise the panel on whether any information provided by the person making the appeal could have a bearing on the outcome on eligibility.

- Advise the panel on whether any important information or evidence is missing which could influence the outcome of the decision (this could include seeking advice from other clinical specialists if appropriate).

3.6 ***Local Review Panel Decision***

3.6.1 The Local Review Panel will carefully consider all of the arguments put forward by the family and weight this against the recommendation made by the MDT. The panel must consider each care domain and reach a view on which kind of care is appropriate.

3.6.2 Taking into account the individual's care needs as a whole, the panel must base its decision on whether it considers that the individual has a primary health need using the four key indicators defined in the national framework (i.e. Nature, Complexity, Intensity and Unpredictability)

3.6.3 The panel chair should encourage the panel to make a unanimous decision wherever possible. They must take into account the view of the clinical advisor. If this cannot be achieved then a majority decision must be made.

3.6.4 The panel will not take into account the financial impact of the decision. Such decisions will be based solely on the objective consideration of care needs and the application of the Primary Health Needs test (i.e. the 4 key indicators set out in the National Framework).

3.7 **Communicating the outcome of the Local Review Panel Hearing**

3.7.1 The outcome of the Local Review Panel's decision should be communicated in writing to the appellant within a maximum of 6 weeks of the decision being made unless there are exceptional circumstances which prevent this. In such circumstances the appellant will be informed in writing the reason for this giving an anticipated timescale of when the report can be expected.

3.7.2 If the outcome is that the individual is not eligible, a full written explanation must be provided giving clear reasons why they do not meet the eligibility criteria. The letter should also inform the individual or carer of the right to ask NHS England to convene an Independent Review Panel.

3.7.3 The decision made by the Local Review Panel will stand even if there is a further appeal to NHS England and be implemented from the date of the letter signed by the Head of Commissioning for NHS Continuing Healthcare.

4 Moving a patient during an appeal

4.1.1 The CCG has no obligation to fund on-going care pending the outcome of an appeal although this decision could be revised by the local appeals process or by successful appeal to an Independent Review Panel.

4.1.2 Where an individual who has previously been eligible for CHC funding is considered to be no longer eligible, funding will continue for a period of 28 days from the date of the letter to the individual giving notice that they are no longer eligible.

5 Requests to reconsider negative Checklists

5.1.1 If an individual has been screened out from full consideration following use of the checklist, they may ask the CCG to reconsider its decision and (i.e. arrange for the Decision Support Tool to be completed and a decision made on eligibility). Such requests must be made in writing to the Complaints Department within 6 months of the checklist being completed.

Complaint Department
Dudley CCG
2nd Floor, Brierley Hill Health and Social Care Centre
Venture Way
Brierley Hill
DY5 1RU

5.1.2 The CCG should give this request due consideration taking account all the information available, including additional information from the individual or carer. A clear and written response should be given. If the individual or their representative remain dissatisfied with the outcome they would have to pursue this with the Parliamentary Health Service Ombudsman.

6 *Unjustified Appeals*

6.1.1 The CCG has the discretion not to convene a Local Review Panel in exceptional circumstances. It is expected that the exercise of such discretion would be confined to cases where an individual, their family or carer wishes to challenge an assessment decision, but the patient clearly falls well outside the eligibility criteria because the DST indicates such low or no level of health care need to make an appeal unjustifiable. To identify cases of this nature, the following steps should be followed:

- There must be clear written evidence that the assessment was undertaken in accordance with the National Framework and supporting tools.
- The individual must fall clearly outside of the criteria for Continuing Health Care or, as appropriate, NHS Funded Nursing Care
- The Lead Nurse for NHS Funded Care must have reviewed the paperwork and provided the CCG with his/her professional advice in writing; and
- The matter should be discussed with the NHS Continuing Care Lead at NHS England (West Midlands) in order to seek agreement that the need to convene an appeals panel under the circumstances is unreasonable.

6.1.2 Before making such a decision, a Director or other designated CCG Manager should be notified and agree with this decision. In such cases, a full written explanation should be provided to the individual or their representative together with a reminder of their rights under the NHS Complaints Procedure.

7 *Legal involvement and legal costs*

7.1.1 There is no role for legal professionals in the Local Appeals Process. Individuals or their representatives who attend Local Review Panels should restrict their comments to statements about the individual's condition and care needs and descriptions of the process followed by the CCG. The Local Review Panel will not consider any legal challenges to either the eligibility criteria or the responsibilities of the NHS. If individuals choose to instruct lawyers

to challenge the decision on eligibility they should be advised that any legal costs incurred will not be reimbursed by the NHS.

8 STAGE 3 – APPEAL TO NHS ENGLAND

8.1.1 *The right to ask for an independent review*

8.1.2 The NHS Continuing Health Care (Responsibilities) Directions 2009 require NHS England to establish independent review procedures. The procedures are in place so that individuals or their nominated representatives can challenge a CCG's decision about their eligibility for NHS Continuing Health Care.

8.1.3 The CCG will advise individuals of their right to appeal to NHS England if they are unhappy with the Outcome of the Local Review Panel.

8.1.4 The Operational Policy for Independent Review Panels (IRPs) produced by Strategic Health Authorities (November 2009) provides detailed guidance to CCGs about the case files / documentation required by IRPs and the role of the CCG representatives in presenting the CCG's case. This guidance is being revised by NHS England but remains in place until such time as it has been finalised

8.1.5 Unless there are exceptional circumstances, the CCG will comply with the outcome of the IRP on the recommendation of NHS England. Any challenge by the CCG to NHS England's recommendation must only be made following discussion with the Chief Executive.

9 STAGE 4 – APPEAL TO THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

9.1.1 *The right of further appeal about the process*

9.1.2 Individuals or their representatives have the right of further appeal to the Parliamentary and Health Service Ombudsman (PHSO) if they remain unhappy with the outcome of the Independent Review Panel. The PHSO cannot determine eligibility for NHS Continuing Health Care. The role of the PHSO is to consider whether due process has been followed and to ensure that full and clear explanation has been given to the appellant about the reasons why they were not eligible.

9.1.3 Dependent upon the nature of the concern raised with them, the PHSO may advise the individual to pursue the matter via the CCG's complaints procedure before deciding whether to investigate the matter further.

10 ADMINISTRATIVE PROCESS FOR APPEALS

10.1.1 *Initial appeal request*

10.1.2 Once the Director of Commissioning for Dudley CCG has determined that the written request represents an appeal against a decision on eligibility, the appeals administrator will:

- Give the case a unique reference number and enter it on to a database
- Create a file and attach a tracking sheet
- Acknowledge the request for review and ask the individual to complete a review questionnaire and consent form if they have not already done so.

- Enclose a copy of the CCG's information pack, entitled 'Information about CHC Eligibility and the Appeals Process (Appendix 1)

- Inform the Lead Nurse for CHC of the request

10.2 ***Obtaining the clinical / case records***

10.2.1 The appeals administrator will obtain the following records after all appropriate consent forms have been received and advice from the Lead Nurse about which records are essential:-

- hospital records
- general practitioner records
- social care records
- records from community nurses or therapists involved with the individual's
- care home records

10.2.2 The appeals administrator will inform the commissioning manager if any of these records cannot be obtained in a timely manner so that a decision can be made about how to proceed. If records are said to be missing or have been destroyed, a written statement to this effect must be obtained from the care home or agency concerned.

10.2.3 Once the records have been received, these will be passed to the clinical practitioner responsible for completing the "needs portrayal" which summarises the key facts about the individual's care needs. The needs portrayal will include a summary of the medical/clinical history and a chronology of significant events. It will highlight when previous assessments have been undertaken.

10.3 ***Arranging the Local Appeal Panel***

10.3.1 The appeals administrator will make sure that the Local Review Panel membership accords with that determined by the CCG.

10.3.2 4 weeks prior to the panel hearing, the individual who requested the appeal will be sent an invitation letter and appeal pack. This will confirm the date and venue of the panel, names of panel members and all information collated about the individual in relation into CHC assessment under review.

10.3.3 Any person may have a family member or other person (who should operate independently of Local Authorities and NHS bodies) to advocate on their behalf.

10.3.4 Upon completion of the above steps, the appeals administrator will send the core set of documents to the panel members and clinical advisor to allow time for reading and preparation for the panel.

10.4 **Papers to be circulated in advance of the panel hearing**

10.4.1 The appeals administrator will prepare a pack of case papers to be sent to the appeal panel members and advisors in advance of the panel hearing. The same set of papers will also be sent to the individual or their representative at the same time. The documents circulated will be accommodated by a numbered list of each document stating what it is and its date.

10.4.2 A minimum data set will include:-

- A copy of the Decision Support Tool (DST) against which the appeal has been lodged
- A copy of all other DSTs covering the whole of the appeal period
- A copy of the letter of appeal
- A copy of any statements produced by the appellant which outlines their reasons for appeal (including the pro-forma completed by the appellant)
- A needs portrait which summarises the individuals care needs from the various care records

10.5 **Independent expert reports**

10.5.1 The Local Review Panel may consider any reports produced on the individual's behalf by independent experts and the author may attend the panel to outline their findings provided their attendance is notified to the appeals administrator beforehand.

10.5.2 The CCG is not prepared to delay or defer the date of the Local Review Panel in order to give more time for independent experts to produce reports.

11 Local Appeal Panel – proceedings on the day

11.1.1 The Chair of the panel will explain the panel process, the remit of the panel and will seek to allay any concerns or anxieties appellants may have about what to expect.

11.1.2 The Chair will introduce the panel members and clinical advisor to all present and set out how the meeting will be structured.

11.1.3 The Chair will ask the CCG (Nurse Assessor and Lead Nurse) to present the case to the Panel. Which will provide the panel with a summary of the case from point of referral to the completion of the first stage of the appeals process.

11.1.3 The individual/family representatives will then be invited to make their representations and discuss the decision support tool and the needs portrayal in open forum. The Chair will make sure that everyone has had an opportunity to contribute to the discussions and clarify any outstanding issues prior to asking the family to leave.

11.1.4 In closing the open forum element of the meeting, the Chair will make sure that the family understand when they can expect a copy of the report from the CCG.

11.1.5 The panel and clinical advisor will then deliberate in private and comment on any differences of view between the family representatives and the MDT view and the needs portrayal. The Appeal Administrator will remain for this part of the panel.

11.2 ***Records of appeal panel proceedings***

11.2.1 The Appeal Administrator will take notes of the discussion and these will be developed into a report which summarises the important factors which inform the decision making. The drafting of the report will be the responsibility of all panel members, led by the Chair. A verbatim transcript or separate minutes will be produced alongside the report. The Local Review Panel meetings will be recorded for note taking purposes only and are not kept by the CCG once the minutes have been completed and verified as correct by the Chair.

11.2.2 The Chair of the panel will send a signed copy of the panel report to the commissioning manager who will in turn send the report to the individual/family representative. The report will set out the CCG's decision as a result of the Local Review Panel and will also advise on the fact that the individual, or their representative, can ask NHS England to convene an Independent Review Panel (IRP).

11.2.3 The Local Review Panel process will be considered complete at the point at which the decision letter is sent to the family. The Individual or their representative has 6 months from the date of the Local Review Panel report to request NHS England to review the decision. All papers relating to the appeal will be retained until the 6 month deadline has passed.

11.2.4 Documentation relating to individual cases will be retained for a period of time in keeping with the Department of Health's guidance on retention of records.

11.2.5 It is the responsibility of the Lead Commissioner for Continuing Healthcare to make sure that the decision made by the Local Review Panel is implemented. Any restitution/reimbursement of funds will be made in accordance with separate guidelines produced by the Department of Health.