Torbay and South Devon NHS
NHS Foundation Trust

NHS Continuing Healthcare Funding & Funded Nursing Care Policy

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Partners in Care

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Safeguarding Adults Policy			
Hospital Discharge Policy			
The Choice, Costs and Risk Policy			
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Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Approved	17 August 2011	This is the first organisational policy on this subject.	Care & Clinical Policies Group
2	Approved	15 October 2014	Reviewed and revised. Changes made in relation to author and inclusion of personal healthcare budgets.	Care & Clinical Policies Group
3	Ratified	20 January 2017	Policy review	Care and Clinical Policies Group
3		19 February 2019	Review date extended from 2 years to 3 years	

CONTENTS

1 INTRODUCTION

1.1 This Operational Policy sets out the responsibilities of Torbay and South Devon NHS Foundation Trust (TSDFT) for ensuring the correct implementation of the Department of Health (DH) document, National Framework for NHS Funded Continuing Healthcare and NHS-funded Nursing Care, November 2012 (revised). The overall responsibility of provision for NHS Continuing Healthcare lies with South Devon and Torbay Clinical Commissioning Group.

1.2 Torbay and South Devon NHS Foundation Trust is responsible for ensuring clear arrangements with other NHS organisations and Independent/Voluntary sector partners to make certain there is standardised practice in the effective operation of the National Framework and therefore the document should be used in conjunction with this.

1.3 This policy is not inclusive of all finite details in the National Framework and therefore the document should be used in conjunction with this.

2 POLICY STATEMENT

2.1 This policy provides the operational procedure for determining the eligibility of clients for NHS-funded Continuing Healthcare. It outlines the roles and responsibility of TSDFT staff for the implementation of the National Framework for NHS Continuing Healthcare (CHC) and Funded Nursing Care.

2.2 It specifies the responsibilities of TSDFT in those situations where eligibility for NHS-funded Continuing Healthcare (CHC) has not been agreed and, in such cases, the management of the appropriate appeals processes.

2.3 It explains the way in which TSDFT will commission and provide care in a manner that reflects the preferences of individuals whilst balancing the need to commission safe and effective care that makes the best use of resources.

3 ROLES & RESPONSIBILITES

3.1 It is the responsibility of all registered professionals involved in undertaking the Continuing Healthcare assessments to ensure individuals deemed eligible for consideration of NHS Continuing Healthcare funding, provide robust information in order that individuals are dealt with equitably and that the TSDFT is compliant with legislation.

3.2 It is the responsibility of all registered professionals dealing with the eligibility decision making process, to ensure that a full and detailed assessment of need is completed with contemporaneous supporting evidence.

4 SCOPE

4.1 NHS-funded Continuing Healthcare is provided free of charge, following the appropriate assessment, for people aged 18 or over that require assistance as a result of frailty, illness, accident or disability. It is a package of care and support that is provided to meet all assessed needs, including physical, mental health and personal care needs. The care is arranged and funded solely by the National Health Service (NHS), but can be provided by other agencies. The more recent provision of Personal Health Budgets will allow an individual that is eligible for CHC to purchase the care and support they need.

4.2 This care can be given in a variety of settings, including a residential care home, a nursing home or in a client's own home. In some cases, the choice of living environment may be restricted in order to meet complex or intensive medical health needs

4.3 For an application of NHS Continuing Healthcare to be agreed the care must be proven to be more than;

(a) incidental or ancillary to the provision of the accommodation that a Local Authority (LA) is under a duty to provided, pursuant to section 21 of the National Assistance Act 1948; and

(b) of a nature that an authority whose primary responsibility is to provide social services can be expected to provide.

4.4 If the care is deemed to be outside of this guidance this may signify a primary health need; that the overall needs are such that, the responsibility for those needs cannot be met by the LA and so must be the responsibility of the NHS.

5. ELIGIBILITY CRITERIA FOR NHS CONTINUING HEALTHCARE FUNDING

5.1 Following the Coughlan judgment (1999), and the Grogan judgment (2006), under the National Health Service Act 2006, the Secretary of State has developed the concept of a 'primary health need' to assist in deciding which treatment and other health services is appropriate for the NHS to provide.

5.2 There are many aspects to be considered when deciding if an individual has a primary health need. 'It is not about the reason why someone requires care or support, nor is it based on their diagnosis; it is about their overall actual day-to-day care needs taken in their totality, it is the level and type of needs themselves that have been considered when determining eligibility for NHS CHC'.

5.3 The DoH states that there are four characteristics to be taken into account when assessing eligibility for CHC; nature, unpredictability, complexity and intensity. These characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual's needs.

5.4 Assessment for eligibility for NHS CHC can take place in any setting, hospital, care home or domestic home. Anyone carrying out an assessment for eligibility should

always consider the individual's potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs.

5.5 Not every individual who uses the health services is eligible for NHS CHC funding and where there is uncertainty the NHS CHC Checklist should be initiated as a screening process.

6 APPLICATION PROCESS

Checklist

6.1 Eligibility for NHS CHC will be determined by, at first, using the Department of Health (DH) Checklist tool. This tool is designed to help practitioners determine the appropriateness of an individual to go forward for consideration for assessment for NHS CHC.

6.2 If after using the tool a referral for CHC assessment is made, this in itself is not an indication of the outcome of the eligibility decision. This fact should be communicated to the individual and, where appropriate their representative/advocate.

6.3 The purpose of the Checklist is to encourage proportionate assessments, so that resources are directed towards those people who are most likely to be eligible for NHS CHC. At this stage, **the threshold is set deliberately low** to ensure that all those who require full consideration of their needs do get this opportunity.

6.4 A Registered Nurse, Doctor, or other qualified healthcare professional, or Social Worker are trained to apply the Checklist to refer individuals for full consideration of eligibility for NHS CHC.

6.5 The Checklist indicators move from A - C; a full assessment for NHS CHC 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 Decision Support Tool), with any number of selections in other columns.

6.6 Informed consent from the individual or their representative should be obtained before commencing the Checklist.

6.7 It should be noted that individuals or their representative may withdraw their consent for the procedure at any time.

6.8 A third party cannot give or refuse consent for an assessment of eligibility for NHS CHC on behalf of a person who lacks capacity unless they have a valid and applicable Lasting Power of Attorney (LPA). This is a document that allows decisions to be made

in relation to a client's health and welfare. Alternatively, they may have been appointed a Welfare Deputy by the Court of Protection. **It is the responsibility of the practitioner to ascertain this before divulging confidential information regarding the individual.**

6.9 If the individual has not assigned an LPA and there is concern that the individual may not have capacity to make informed decisions, then a Best Interest process should be invoked. This is in accordance with the Mental Capacity Act 2005 and the associated code of practice.

6.10 The practitioner should be particularly aware of the five principles of the Mental Capacity Act 2005: -

- **A presumption of capacity:** every adult has the right to make his or her own decisions and must be presumed to have capacity to do so, unless it is proved otherwise.
- **Individuals being supported to make their own decisions:** must be given all practicable help before anyone treats them as not being able to make their own decision.
- **Unwise decisions:** just because an individual makes what might be regarded an unwise decision, they should not be treated as lacking capacity to make that decision.
- **Best interests:** an action taken or decision made under the act for or on behalf of a person who lacks capacity must be done in their best interest.
- **Least restrictive option:** anything done on or behalf of a person who lacks capacity should be the least restrictive of their basic rights of freedom.

6.12 If the individual lacks the mental capacity to consent to the procedure then a 'Best Interests' decision should be taken (and recorded) as to whether to proceed or not. Further information can be found in the Multi Agency Mental Capacity Act 2005 Policy.

6.13 In a hospital setting the Checklist should be applied as the first stage in the discharge process for individuals, in compliance with the Community Care (Delayed Discharges) Act 2003 which focuses on delayed discharge responsibilities.

6.14 The Checklist should be used by all practitioners in this environment as part of the assessment and care planning process.

6.15 If completion of the Checklist indicates that the individual is eligible to go forward for consideration for NHS-funded CHC, for Torbay clients a Health Needs Assessment (HNA) or Mental Health Needs Assessment (MHNA) or both will be completed to provide a report of the overall needs of the individual. For South Devon clients a Decision Support Tool will be completed by the relevant professionals. .

6.16 In relation to CHC a **HNA**/**MHNA** or both is only necessary if the Checklist criteria are met. Either assessment may also be completed by the healthcare professional if a recommendation for the future care needs of the individual is required for example

discharge planning of a change in residential accommodation due to a changing presentation.

7 Health Needs Assessment/Mental Health Needs Assessment

7.1 A Health Needs Assessment/Mental Health Needs Assessment (HNA or MHNA) is the process of gathering relevant, accurate and contemporaneous information about an individual's health and social care needs, and applying professional judgment to decide what the evidence signifies in relation to these needs.

7.2 An assessment that simply gathers information will not provide the rationale for any consequent decision it must be supported by evidence.

7.3 Assessment documentation should be obtained from any professional involved in the individual's care and should be clear, well recorded, factually accurate, contemporaneous, signed and dated. Evidence should be: -

- **Informed:** by information from those directly caring for the individual (whether paid or unpaid).
- **Holistic:** looking at the range of their needs from different professional and personal view points, and considering how different needs interact.
- **Taking into account:** differing professional views and reaching a commonly agreed conclusion.
- **Considerate:** of the impact of the individuals needs on others.
- **Focused:** - on improved outcomes for the individual.
- **Evidence – based:** providing objective evidence for any subjective judgments made.
- **Clear:** about needs requiring support in order to inform the commissioning of an appropriate package of care.
- **Clear:** about the degree and nature of any risks to the individual (or others), the individual's view on these, and how best to manage the risks.

7.4 An assessment is the systematic process used in engaging with specific clients to gather evidence from and about them, and utilising an evidence-based approach to effect service changes and improvements with their full involvement; it is to provide the substantiation to assist in identifying if an individual is eligible to receive full health funding.

7.5 The national framework provides a generic interpretation that will apply to a range of different circumstances, including situations in which the 'incidental/ancillary' test is not applicable. For example, the individual is to be cared for in their own home.

7.6 In order to help determine eligibility holistically the Government has used four characteristics of need, Nature, Complexity, Intensity and Unpredictability. Their

impact on the care required to manage them, may help determine whether the 'quality' or 'quantity' of care is more than the limits of the Local Authority.

7.7 **Nature:** this describes the particular characteristics of an individuals' needs; physical mental health or psychological, and the type of those needs.

- Is the individual's condition improving or deteriorating?
- What type of intervention is needed to meet the need?
- How many health needs are there?
- What are the overall impacts on the individual's health?
- What activities of daily living are restricted?
- What would happen if these needs were not met in a timely manner?

7.8 **Complexity:** this is concerned with how needs present and interact to increase the skill required to monitor symptoms, treat the condition(s) and or manage care.

- How much knowledge is required to address the need(s)?
- How difficult is it to manage the need(s)?
- How much skill is required to address the need(s)?
- How problematic is it to alleviate the need(s) and symptom(s)?
- Do they impact on each other to make the need(s) even more difficult to address?
- Is the individual or those who support him/her able to anticipate when the need(s) might arise?

7.9 **Unpredictability:** this describes the degree to which need(s) fluctuate and thereby create challenges in managing them. It also relates to the level of the risk to the person's health if adequate and timely care is not provided.

- Does the level of need often change?
- Does the level of support often have to change at short notice?
- What happens if the need isn't addressed when it arises?
- How significant are the consequences?
- Is the condition stable
- To what extent is professional knowledge/skill required to respond spontaneously and appropriately?
- What level of monitoring/review is required?

- Does the care relate to needs over several domains?

7.10 **Intensity**: this relates both to the extent ('quantity') and severity ('degree') of the needs and to the support required to meet them, including the need for sustained/ongoing care ('continuity').

- How severe is this need?
- How often is each intervention?
- For how long is each intervention required?
- How many carers/care workers are required at any one time to meet the needs?

7.11 On submission of the HNA/assessment the multidisciplinary team (MDT) will expect to have all relevant accompanying documents, e.g. Consultant/Specialist Nurse documentation, MUST, SALT, Waterlow Score, Falls Risk Assessment, Power of Attorney Certificate (copy unless on PARIS/CF6), Best Interests (where applicable)

7.12 The evidence in the HNA must be referenced; clarity must be available as to where evidence is sourced; **anecdotal information is not evidence.**

8. The Decision Support Tool

8.1 The Decision Support Tool (DST) is designed to ensure the correct implementation of the National Framework and inform consistent decision making. **The DST is not an assessment in itself.**

8.2 The DST is specifically designed to collate and present the evidence provided in the assessment in a way that assists consistent decision making for the NHS Continuing Healthcare eligibility.

8.3 The DST invites practitioners to document deterioration (this could include observed and likely deterioration) in an individual's condition to allow them to take this into account when determining using the tool.

8.4 The DST is a national tool and the format is not to be altered.

8.5 The DST should be used in conjunction with the guidance in the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

8.6 The consent of an individual who is the subject of the DST must be obtained before the assessment is carried out, as outlined above. The individual should be given the full opportunity to participate in the completion of the DST.

8.7 The individual should be given the opportunity to be supported or represented by a carer or advocate if they so wish.

8.8 The DST should be completed by an MDT following a comprehensive assessment of an individual's health & social care needs and their desired outcomes.

8.9 The MDT comprises of senior practitioners, whose own experience and professional judgment will enable the application of the primary health needs test in a way which is consistent with the limits on what can lawfully be provided by the Local Authority.

8.10 The MDT meets routinely to review the assessments for CHC funding.

8.11 The DST asks the MDT to set out the individual's needs in relation to 12 care domains (see DST). Each domain is broken down into a number of levels, each of which is carefully described. For each domain the MDT is asked to identify which level of description most closely matches the individual's needs.

8.12 The MDT, on the evidence provided along with their professional judgment, will make a recommendation as to whether the individual meets the eligibility criteria for CHC funding.

8.13 If an individual, after assessment, is found to be eligible for NHS CHC funding this should be agreed from the date of completion of the Checklist or from the date of the assessment, or a specific date of when a care package commenced. The start date will be decided at the discretion of the MDT.

9 Fast Track Applications

9.1 The Fast Track Pathway Tool is used to gain immediate access to NHS Continuing Healthcare funding where an individual needs an urgent package of care/support.

9.2 This tool bypasses the Checklist and DST and should only be used for individuals who have a primary health need through a rapidly deteriorating condition that may be entering a terminal phase, and have an increased level of dependency.

9.3 The framework makes it clear that the Fast Track pathway Tool can only be completed by an 'appropriate clinician', and the Responsibilities Directions define an 'appropriate clinician' as a person who is, '*(i) responsible for the diagnosis, treatment of care of the person in respect of whom the fast track tool is being completed, (ii) diagnosing, or providing treatment of care to, that person under the 2006 Act, and (iii) a registered nurse or is included in the register maintained under section 2 of the Medical Act 1983'.*

9.4 Those completing the Fast Track Pathway Tool could include consultants, registrars, GPs and registered nurses. This includes relevant clinicians working in end of life care services within independent and voluntary sector organizations if their organization is commissioned by the NHS to provide services.

9.5 Whoever the practitioner is, they should be knowledgeable about the individual's health needs, diagnosis, treatment or care and be able to provide comprehensive reasons as to why the individual meets the conditions required for the fast-tracking decision.

9.6 Others involved in supporting an individual with end of life needs, including those working within the wider independent or voluntary sector organisations should, with the individual's consent, contact the appropriate clinician responsible for that individual's

healthcare to request the Fast Track Pathway Tool to be completed. Alternatively, they should approach the relevant Trust/CCG and make the request.

9.7 TSDFT require that Fast Track applications are submitted for individuals with a rapidly deteriorating condition requiring an urgent decision to enable care needs to be met in a timely manner.

9.8 Neither a terminal condition nor palliative care needs alone are indications for Fast Track applications. If a person receiving palliative care for a terminal condition does not have a rapidly deteriorating condition, the DST will be used to consider eligibility.

9.9 Approval will be provided on receipt of the Fast Track Tool document by the Clinical Lead/ Lead Nurse or designated clinician within the Continuing Healthcare Team.. However, it must be supported with comprehensive and relevant information to allow an appropriate decision to be made.

9.10 The purpose of the Fast Track Tool is to ensure same day decisions about eligibility for NHS CHC to support the preferred priorities of the individual for their end of life care.

10 Step down/Interim Health Funding

10.1 The Framework states that it is preferable for eligibility for NHS CHC to be considered after discharge from hospital when the person's long-term needs are clearer, and for NHS-funded services to be provided in the interim.

10.2 This might include therapy and/or rehabilitation, if that could make a difference to the potential further recovery of the individual in the following weeks. It might also include intermediate care or an interim package of support in an individual's own home or in a care home. (see p.24 of the Framework)

10.3 Step down/Interim Health funding is a local funding stream for TSDFT that is not CHC funding but is available to enable timely discharge from hospital. The model of provision is dependent on whether the client is supported by the Torbay or South Devon Team.

Initiating Step down funding for Torbay clients requires;

The Hospital Discharge Liaison Nurse to refer clients to TSDFT Clinical Lead/Lead Nurse to consider eligibility

Initiating Interim Health Funding for a South Devon client requires the completion of a checklist which indicates that the client has health needs and further consideration for CHC

- Hospital Discharge team are required to liaise with the Clinical Lead/Lead Nurse for authorisation

10.4 The criterion is that: -

- The patient has had a prolonged period of ill health but is considered to be ready for hospital discharge; their physical/mental health is such that

rehabilitation is not appropriate, however, it is considered that the individual has not reached their optimum level of health and further improvement is likely. The care to aid this can be given either in the patient's own home or an appropriate placement following discharge or,

- It is not possible to make an accurate decision for CHC funding whilst the individual remains in an 'unstable' situation.

11 TIMEFRAMES

11.1 Decisions: the length of time from completed Checklist and receipt of assessment where all information is available:

- Fast-track applications-decisions made within 2 working days
- Eligibility for CHC against Decision Support Tool (DST) – 28 working days
- Length of time from Panel decision to correspondence sent to the individual/representative advising outcome within 10 working days

11.2 Scheduled health funding reviews:

- Appointments will be identified and booked 3 months following allocation of CHC/FNC funding and every 12 months thereafter.
- Time frame from completion of the review assessment to decision – 28 working days.
- Length of time from Panel decision to correspondence sent to the individual/representative advising outcome within 10 working days

12 MANAGEMENT OF COMPLAINTS, APPEALS, DISPUTES

12.1 **Appeals:** where an application has been declined, individuals/representatives are invited to appeal against this decision within 6 months of receipt of the DST. This is in line with guidance issued by NHS England. The appeal should be addressed to the Continuing Healthcare Team. When an appeal is received it will be formally acknowledged by letter explaining the process.

- Individuals/representatives are encouraged to submit their reasons for appeal which is documented on the Appeals form, thus providing their perspective on the individual's status which will add further information to aid the Appeal Panel in their decision making.
- All appeals are reviewed by the Lead Nurse within the area team. The Lead Nurse will look at all the available evidence with the expectation this can be resolved locally. A local resolution meeting will be offered to the client/representative.
- If the individual/representative is not in agreement with the decision of the Local Appeals Panel then an Independent Review Panel will be convened.

The members of this panel are independent of any previous MDT panel involved with the case but are still employed by the Trust. The client/representative will be invited to attend this meeting.

- Following the decision of the Local Review Panel if an individual/representative remains dissatisfied with this decision, they can make an application to NHS England for a further Independent Review. The panel members will be totally independent of TSDFT.

- NHS England will involve the individual/representative allowing them to attend the meeting and present their case to the review panel.

- If the individual/representative remains dissatisfied with the outcome there is a further route of appeal to the Parliamentary Health Service Ombudsman (PHSO) who will review the processes undertaken to ensure the individual has not been compromised. The PHSO only reviews the process not the decision. Further detail is provided within the Local Resolution Protocol.

12.2 **Complaints:** If an individual/representative is dissatisfied with the manner in which the procedure has been undertaken, their involvement in this or the manner in which decision has been made, they should be directed toward the Engagement and Feedback Team.

12.3 **Disputes:** The Trust is an integrated health and social care organisation. This means the social care aspect which is normally a part of the Local Authority, is an integral part of the health organisation. For this reason the MDT always includes a Social Worker at the panels to ensure all elements of an MDT are included.

- Should the need arise there is a Local Disputes Policy in place in order to manage disputes with both out of area Local Authorities (LA) and Clinical Commissioning Groups.

- On the occasions when an individual transfers from out of area and are in receipt of funding from a different organisation, if a dispute about funding arises, the Trust will ensure the dispute is resolved in a timely manner without it affecting the individual.

- All individuals will remain funded by the appropriate organisation until the dispute is resolved. The result of the decision will determine who is liable to pay, for example, if the relevant LA has continued to fund an arrangement and this is agreed to be NHS CHC funding the Trust will reimburse the LA for the outstanding balance.

13 DISCHARGE PLANNING

13.1 Arrangements for applying the Framework should form an integral part of the local hospital discharge policies, and be implemented in such a way that delays are minimised; timely assessments will prevent whole system delays within the acute hospital sector.

13.2 The Trust and other NHS bodies providing hospital services should ensure that there is clarity in local discharge protocols and pathways about how NHS CHC fits into these processes, and what their respective responsibilities are.

13.3 The Delayed Discharges (Continuing Care) Directions 2009 place certain responsibilities upon both CCG's and NHS Trusts in hospital discharge situations these should be referred to, to ensure correct discharge in this situation.

13.4 The Trust should ensure discharge policies with providers who are not NHS Trusts are clear on the respective responsibilities of the Trust and of the provider.

13.5 Safe discharge from hospital remains the responsibility of the discharging hospital, as set out in Schedule 2, part 2 of the Standard NHS Contract for Acute Services Terms and conditions for the provision of Health Services.

13.6 Hospital staff must be sure that appropriate provision will be available to meet the individual's needs after discharge, including

- Care provision
- A safe environment
- Moving and handling equipment
- Medication
- Continence supplies
- Advance notice to the GP and DN (if applicable)

13.7 Whilst awaiting a decision on eligibility, if the individual previously had Adult Services input, the hospital staff may need to liaise with social care staff to continue to supply the pre-existing care package, without prejudice.

13.8 Once an individual has been found eligible for NHS CHC funding, hospital staff should liaise with the Hospital Discharge Team regarding appropriate care provision and implementation prior to discharge.

13 9 Individuals/representatives do not have a free choice of care home. Every effort will be made to accommodate choice taking into account the assessed risk around any care package and overall use of resources. The Choice, Costs and Risk Policy provides further guidance on this.

14 PROCESS FOR COMMUNICATING REVIEWS

14.1 The Key Worker/Discharge Liaison Nurse will communicate the decision, either ratified or made through a full MDT panel procedure, to the individual and or their legal representative in a timely manner (within 48 hours of the decision wherever possible).

14.2 The reasons for deciding whether or not an individual is eligible and at what point in time will be fully documented and made available to the individual/representative.

14.3 The individual/representative can seek advice from the Trust's CHC department with regard to clarity about a decision or how to challenge a decision.

14.4 NHS CHC decision letter will be sent to the appropriate individual(s): -

- It will inform the individual/representative of the decision made by the MDT
- The DST will be enclosed for information enabling the appropriate individual to understand the evidence on which the decision was based

14.5 Should the appropriate individual(s) not agree with the MDT decision the process for appealing is documented above.

15 SECTION 117 AFTERCARE

15.1 A patient liable to detention under Section 3 of the Mental Health Act may be eligible for Section 117 aftercare. These arrangements are separate and different from NHS funded Continuing Healthcare, so the two should not be confused. Only if an individual has additional health needs that are not covered under the Section 117 might it be necessary to carry out consideration for NHS CHC funding. An example of this might be if there is a significant physical problem in addition to their mental health needs which may be the responsibility of health organisations. However their mental health and associated needs come under the Mental Health Act provision.

16 RETROSPECTIVE REVIEWS OF CARE

16.1 There may be circumstances where an individual not previously awarded NHS CHC funding believes that they were wrongly denied the funding.

16.2 In these circumstances the appropriate individual(s) can request a retrospective review of the individual's care needs and eligibility for NHS CHC funding.

16.3 The DoH has recently advertised the close down period of April 2004-April 2012. Therefore current retrospective claims can only be made for periods of care after this date unless there are extenuating circumstances that need to be taken into consideration.

16.4 Where a retrospective review of eligibility for NHS CHC funding is successful, appropriate arrangements will be made for financial recompense in accordance with the NHS Continuing Healthcare Refreshed Redress Guidance April 2015

16.5 Redress is about placing individuals in the position they would have been in had NHS Continuing Healthcare been awarded at the appropriate time and not about the NHS or the public profiting from public funds. CCG's are advised to apply the Retail Price Index for calculation of compound interest when considering redress cases. CCG's are advised to apply the average rate for the year which care costs are being reimbursed.

17 COMMISSIONING OF CARE PACKAGES, CASE REVIEWS, CONTRACTING ARRANGEMENTS OF CHOICE

17.1 The Trust is responsible for identifying commissioning and contracting for services to meet the needs of individuals who qualify for NHS CHC funding; this will be for the whole package of care including social care.

17.2 Care will only be commissioned from those care providers who have been deemed appropriate by the Trust using the information provided by the Care Quality Commission (CQC). Where a provider does not meet the required standards Continuing Healthcare packages of care will not be commissioned until the required standards have been met.

18 PATIENT CHOICE

18.1 The Trust will commission the provision of NHS CHC funding in a manner which reflects choice and preferences of individuals but balances the need for the Trust to commission care that is safe and effective and makes the best use of resources.

18.2 In circumstances where the CQC rating of a chosen care home is inadequate the Trust cannot commission care from the home at that time. However, the Trust will work with individuals/representatives to find a home that meets the Trust commissioning criteria.

18.3 In all cases the Choice, Costs & Risk policy will be utilised by Key Workers when they arrange packages of care.

19 CASE REVIEWS

19.1 If the NHS is providing any part of an individual's care, a case review will be undertaken to reassess that their care needs are being met and to the standard expected by the Trust.

19.2 Care reviews will be undertaken for individuals no later than three months following the initial decision and then as a minimum standard on an annual basis.

19.3 The purpose of the review is to ensure the care remains appropriate for the individual and that the individual remains eligible to receive NHS CHC funding.

19.4 The NHS has responsibility to provide and commission care based on the needs of the individual being primarily for healthcare. Therefore, this may not be for an indefinite period of time. In some circumstances an individual's needs might change and due to this, so might their eligibility for NHS CHC funding.*If this is the case their funding will be discontinued.

19.5 It is the Trust's responsibility to ensure that this change in funding is made clear to the individual/representative If indicated, the individual will be referred to the Local Authority who will undertake an assessment in relation to providing the package of care.

20 FUNDING

20.1 Where an assessment for NHS CHC is undertaken as part of the hospital assessment and care planning process for an effective discharge if, for any reason this has not been possible and the patient is ready for discharge from hospital and the Trust's CHC MDT Panel has not yet reviewed the application for the patient, the patient discharge cannot be delayed.

20.2 Where, following financial assessment, the individual would have their care needs funded by the Trust, Adult Social Care will arrange for discharge of the individual with a care package funded pending a decision for eligibility for NHS CHC funding, following the 'without prejudice' approach.

20.3 In order to progress discharge arrangements for individuals in these circumstances, where a decision has not yet been made on eligibility for NHS CHC funding, agreement for the Trust to fund the care arrangements in the interim must be officially agreed before progressing discharge; TSDFT CHC department is responsible for agreeing the funding arrangements for the care package in these circumstances.

20.4 'Topping up' payments, is legally permissible under legislation governing social services but it is **not** permissible under NHS legislation. See policy in relation Top-up payments to care homes.

20.5 It is important that the models of support that the provider use are appropriate to the individual's needs and they are confident in the provision of service.

20.6 In some circumstances individuals become eligible for NHS CHC when they are already resident in care home accommodation for which the fees are higher than the Trust would usually pay for someone with their needs. This may be where the individual was previously funding their own care or where they were previously funded by social services or a third party had topped up the fees.

20.7 In such situations, the Trust may consider whether there are reasons why they should meet the full cost of the care package, notwithstanding that it is at a higher rate, such as, that the frailty, mental health needs or other relevant needs of the individual mean that a move to other accommodation could involve significant risk to their health and wellbeing.

20.8 Where an individual is in an existing out of area placement funded by either the Local Authority or a third party and becomes eligible for NHS CHC, if the fee is of a higher cost than the Trust would usually meet, it is important before refusing, to take into account the market rates in the locality of the placement.

20.9 The Trust will ensure that when the above situations ensue they are dealt with sensitively and in close liaison with the individuals affected and where appropriate, their families, the existing service provider and social services if they have up to this point, been funding the care package.

20.10 Where separation of NHS and privately funded care arrangements is possible, the financial arrangement for the privately funded care is entirely a matter between the individual and the relevant provider and it should not form part of any service agreement between the TSDFT and the provider.

20.11 Where an individual wishes to dispute TSDFT's decision not to pay for higher-cost accommodation, they should do this via the NHS complaints process.

21 RESPONSIBLE COMMISSIONER

21.1 Who Pays? Determining responsibility for payments to providers (DOH 2014) sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, helping to determine who should pay for the individual's care

21.2 General principles: -

- Where the patient is registered on a General Practitioners (GP) practice list of NHS patients when they become eligible for NHS CHC funding, the responsible commissioner will be the CCG that holds the contract with the GP practice.
- If a patient is not registered with a GP practice, the responsible commissioner will be the CCG in whose geographical area the patient is 'usually resident'.
- If a patient is unable to give an address, in accordance with Responsible Commissioner directions the responsible commissioner will be determined as the CCG in which the individual is 'usually resident,' further information is provided in Annex B of this document.

21.3 There are a number of exceptions to this guidance and the Trust is required to refer to the criteria appropriate to the period being considered, that is the Responsible Commissioner Guidance in place for any particular period (DOH 2003 & 2006a).

21.4 The guidance indicates

- If the Trust has identified a person as eligible and the individual/representative exercise their right to request patient choice to move care home in another area, the originating CCG remain responsible to fund the placement. (If the placement chosen is not suitable, the Trust should liaise with the new host CCG re the placement.)
- The new host CCG will only pick up funding if the individual has moved (or relative has moved them) without any involvement or knowledge of the originating CCG. This is what the responsible commissioner guidance refers to as independently chosen. This only applies to care home placements.
- It is different if an individual is deemed eligible and the choice is to move to a family home in another area. In this situation the CCG responsible is the receiving CCG (GP registration applies) but the two CCG's/Trusts need to positively discuss the transfer to allow the receiving CCG to assess the care package.

21.5 It should be the exception that a CCG picks up funding for an NHS CHC funded client moving into their area or doesn't continue to fund a patient who moves elsewhere.

22 JOINTLY FUNDED PACKAGES OF CARE

22.1 The Framework states that if a person does not qualify for NHS CHC funding, the NHS may still have a responsibility to effectively contribute to that person's health requirements. This is sometimes known as a 'joint package of care'. The most obvious way in which this is provided is by means of Funded Nursing Care (FNC) which is given to patients residing in a nursing home.

22.2 There may be an occasion where a jointly funded package between health and social care is appropriate. Keyworkers are required to put in an application for joint funding to the High Cost Panel for consideration.

23 DIRECT PAYMENTS

23.1 If an individual is receiving a Direct Payment from the local authority and then becomes eligible for NHS Continuing Healthcare the existing care package will be reviewed to ascertain if it is still meeting the individual's needs. If the individual still wishes to have control over the care package then a Personal Health Budget will be offered.

24 PERSONAL HEALTH BUDGETS

24.1 A Personal Health Budget is an amount of money to support an individual's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. It currently applies for individuals that meet the criteria for NHS Continuing Healthcare. This process is detailed within the Implementation and Delivery of Personal Health Budgets (Draft). It is recognised that a further roll out for clients with long term conditions is likely in the near future.

The principles are as follows;

- Be able to choose the health and wellbeing outcomes they want to achieve, in agreement with a healthcare professional.
- Know how much money they have for their health and care support.
- Be enabled to create their own care plan with support if they want it.
- Be able to choose how their budget is held and managed, including the right to ask for a direct payment.
- Be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

24.2 It may not necessarily mean giving them the money itself. Personal Health Budgets could work in a number of ways, including:

- A notional budget held by the Trust.
- A budget managed on the individual's behalf by a third party, and
- A direct payment for healthcare; the money is paid to the person or their representative.

- Further details can be found Guidance on Direct Payments for Healthcare; Understanding the Regulations. (DH 2014).

25 SAFEGUARDING VULNERABLE ADULTS

25.1 **All professions** are responsible for the safety and welfare of our service users.

25.2 Anybody can see abuse taking place, be told about abuse or suspect abuse is occurring. All staff have a statutory obligation to report such concerns.

25.3 If on visiting an individual a safeguarding situation is identified it is important to proceed with the following;

- Report this to the Single Point of Contact (SPOC) (for Torbay clients)/Care Direct (for South Devon clients) immediately for discussion and action planning.
- Record their concerns plus any action taken in PARIS/CareFirst.
- Pass this concern to the Line Manager.

25.4 The individual at risk should be informed of the intention to report this information, where it is safe and appropriate to do so. When informing the individual:

- **DO NOT:** press the individual for further information

  Make promises you cannot keep
- **DO:** Reassure the individual

  Keep the individual informed as per policy

26 TRAINING

26.1 Training is provided to all staff about NHS CHC and the correct use of the NHS CHC Checklist Tool/Fasttrack Tool/Decision Support Tool alongside training in the importance of writing a robust Health Needs Assessment, complete with references and supporting evidence to ensure the correct implementation of the principles outlined in the Framework.

27 AUDIT & MONITORING

27.1 There is an internal IT system used, CHIPPS, for which all individuals details processed within the team are inputted. There is a formal reporting system in place which requires the CHC team to submit data to South Devon and Torbay Clinical Commissioning Group via the Placed People Governance Group. Financial benchmarking data is provided quarterly to NHS England. Internal and External audit will be undertaken as requested by the regulatory bodies. The information collated is overseen by the Continuing Healthcare manager.

27.2 The ongoing decision making by the multidisciplinary team will be monitored by the Clinical Lead and Lead Nurses within each area. Overall responsibility will be with the CHC Manager.

.REFERENCES

Department of Health, November 2012 (revised), The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

Torbay and Southern Devon Health and Care NHS Trust Policy on Choice, Cost and Risks regarding NHS Continuing Healthcare and Social Care Provision (Jan 2013)

Torbay Care Trust Policy Document, Safeguarding Adults Operational Guide

Who Pays? Determining responsibility for payments to providers August 2013 DH

Guidance on Direct Payments for Healthcare; Understanding the regulations (DH March 2014)

Outline Local Resolution Process for Appeals from Individuals Regarding Eligibility for Continuing Healthcare

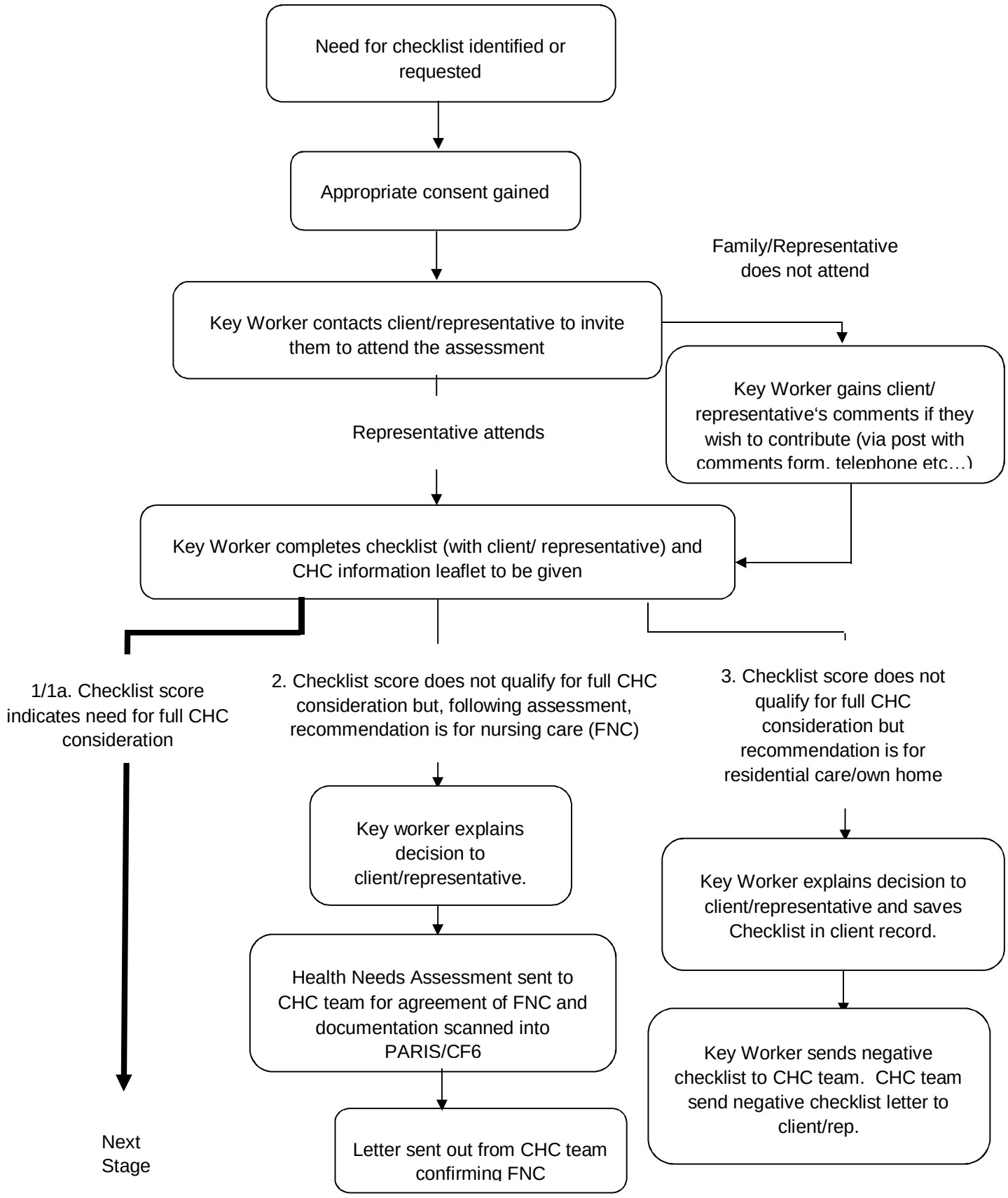
Updated May 2012 to reflect the new timescales introduced by the Department of Health applicable from 1 April 2012

Torbay and South Devon NHS Foundation Trust Policy on Top-up Payments to Care Homes.

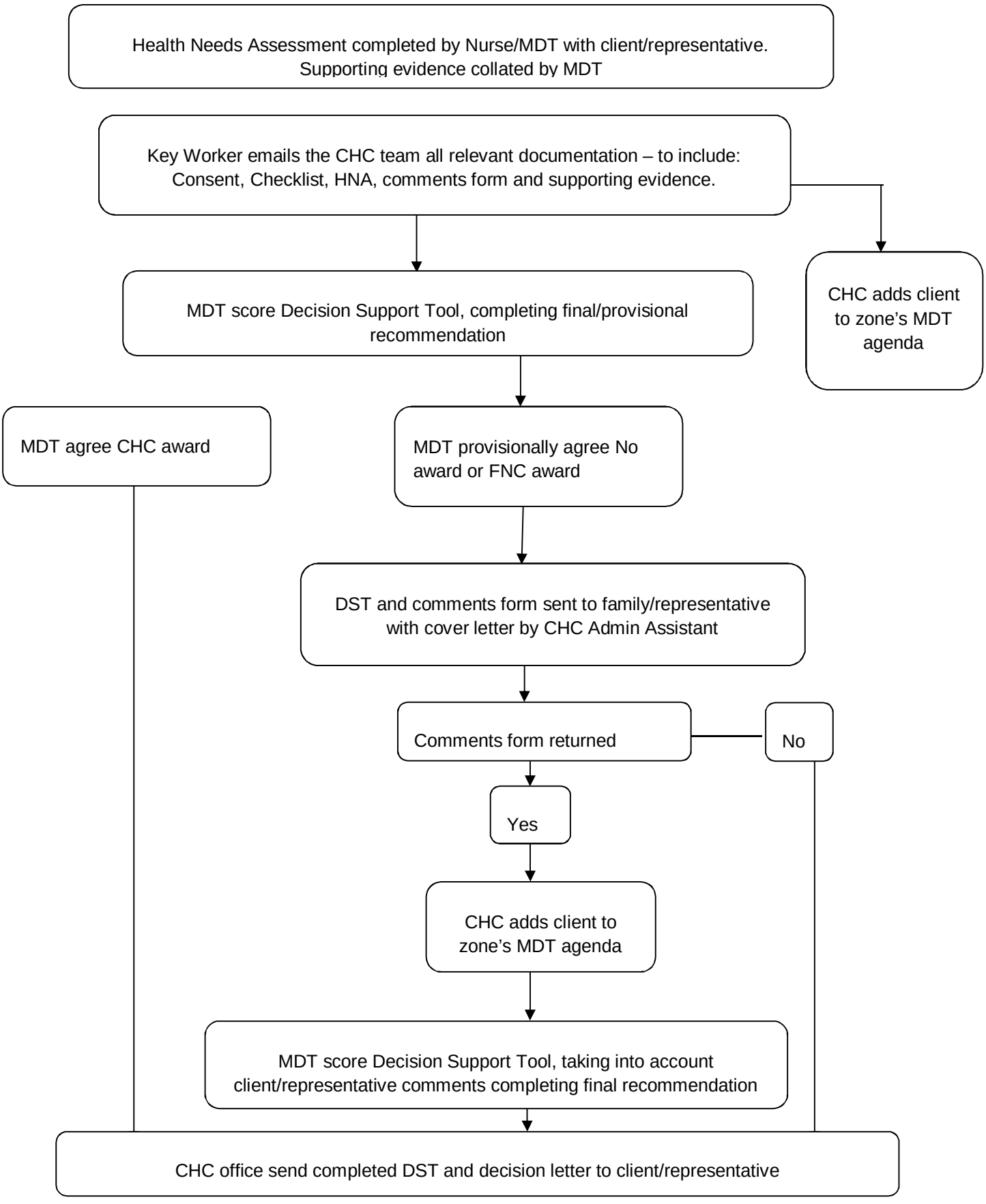
Implementation and Delivery of Personal Health Budgets (Draft)

NHS Continuing Healthcare Refreshed Redress Guidance April 2015

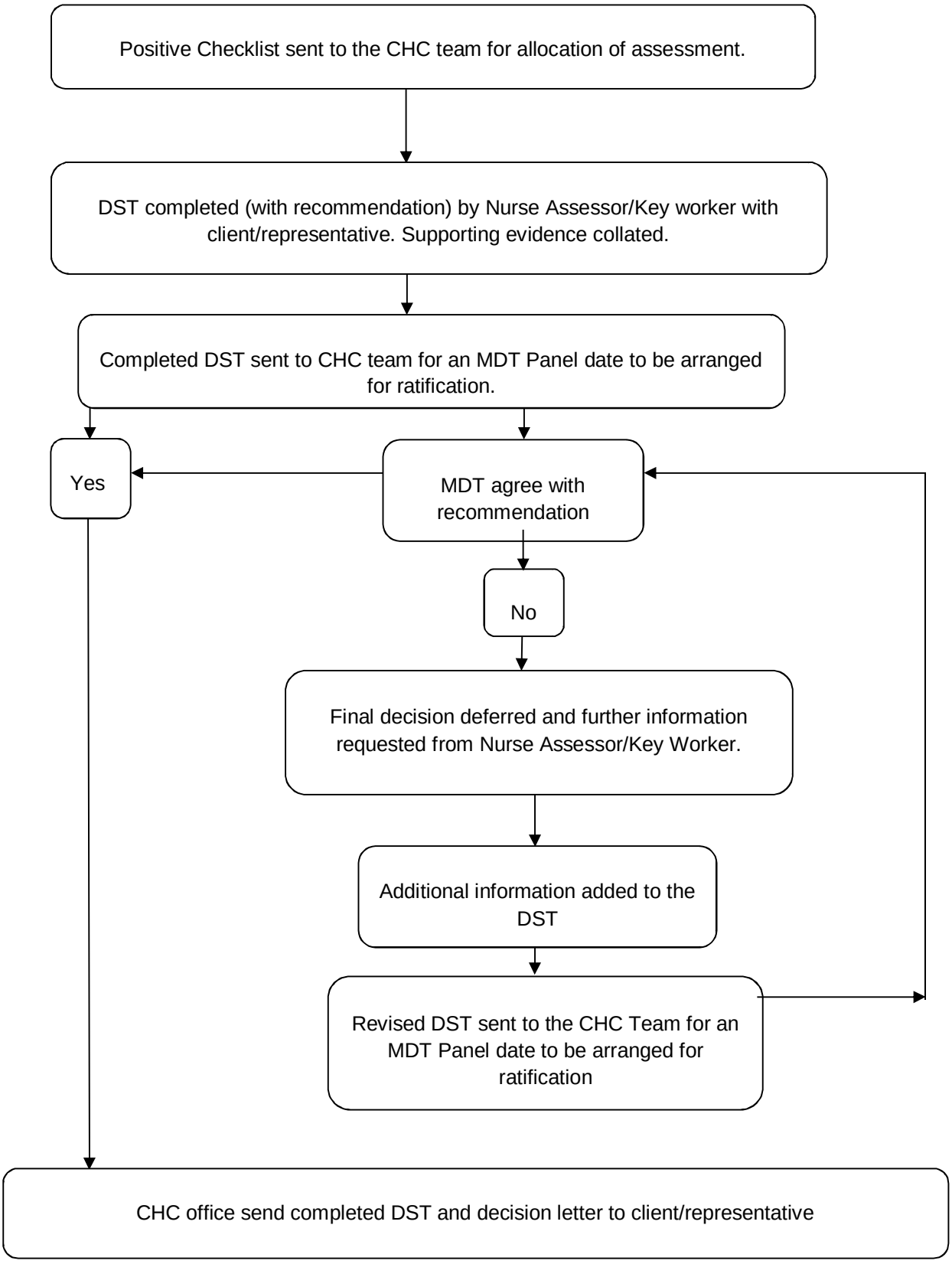
Process for Zone and Community Hospital Assessments



1. Checklist score indicates need for full CHC consideration - Torbay



1a. Checklist score indicates need for full CHC consideration - South



Appendix 2. Health Needs Assessment- Torbay.doc

Appendix 3. Mental Health Nursing Needs Assessment July 2013.doc

Appendix 4. NHS-CHC-Checklist.docx

Appendix 5. Generic NHS Torbay and South Devon Consent Form ver 1 0.docx

Continuing Healthcare - Choice Costs and Risks

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☐
	General Public	☒	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☒
	NHS Organisations	☐	Police	☐
	Councils	x	Carers	☒
	Staff	x	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process?	☒
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Details *(please state):*	CHC is a national framework and consultation would have been undertaken by DH		

Torbay and South Devon NHS
NHS Foundation Trust

NHS South Devon and Torbay Clinical Commissioning Group

Torbay and South Devon NHS
NHS Foundation Trust

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	***1863 NHS Continuing Healthcare Funding & Funded Nursing Care***	**Version and Date**	*October 2016 Version 3*
Policy Author	Clinical Lead Continuing Healthcare		

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

Age	Yes ☐ No☒	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒
Please provide details for each protected group where you have indicated 'Yes'.	

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☒ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☒ No☐
Does the policy/procedure encourage individualised and person-centred care?	Yes ☒ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒
If 'Yes', how will you mitigate this risk to ensure fair and equal access?	

EXTERNAL FACTORS

Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☒ No☐
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)	
This policy is an updated version, there have been minimal changes to the National Framework	
Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?	

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Clinical Lead Continuing Healthcare	**Signature**	
Validated by (line manager)	Manager	**Signature**	

Torbay and South Devon NHS
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