Adult Social Care Policies and Procedures

NHS CONTINUING HEALTHCARE

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Lancashire County Council

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POLICY VERSION CONTROL

POLICY NAME	Continuing Healthcare		
Document Description	This policy sets out how Lancashire County Council will work, in accordance with the Care Act and the National Framework for Continuing Healthcare, with the NHS to ensure that individuals are assessed if they are eligible for funding from the NHS. Please note that this is an interim policy that aligns with the NHS National Framework and is in response to the county council's legislative responsibilities under both the Framework and the Care Act. It does not reflect the current situation across Lancashire where the current structures and systems do not always facilitate effective and efficient decision making in relation to agreeing the funding of individual's packages of care.		
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1. POLICY STATEMENT

Please note that this is an interim Policy that aligns with the NHS National Framework and is in response to the county council's legislative responsibilities under both the Framework and the Care Act. It *does not* reflect the current situation across Lancashire where the current structures and systems do not always facilitate effective and efficient decision making in relation to agreeing the funding of individual's packages of care. This can result in financial risk to the council's budget position in circumstances where the county council steps in to provide funding on a 'no prejudice'/short term basis but cannot then quickly and easily get to a position where funds are recovered from the NHS.

Work is underway to develop local policies across the county council and the NHS (the system) to agree where responsibilities begin and cease. Once these policies have been agreed, this policy will be updated.

The county council puts the people it serves at the heart of everything it does and the council wants to make sure that our social care staff consider CHC as part of the Assessment of Needs policy and, where an individual is being assessed for CHC, that their needs are accommodated as far as the county council can. In some cases, this may mean that the county council may not be able to provide care and support whilst a CHC decision is being made by the NHS (normally 28 days).

Although through this legislation the county council has to follow a process, while we are committed to understanding the needs of all individuals there are some limitations to what the county council can deliver at present if it wishes to avoid incurring additional costs that should be met by the NHS.

1.1 NHS Continuing Healthcare National Framework

This revised National Framework takes account of legislative changes brought about by the Care Act 2014, which preserves the existing boundary and limits of Local Authority responsibility in relation to the provision of nursing and/or healthcare

The revised 2018 National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care. This guidance replaces the previous version of the National Framework, published in November 2012, and was implemented on 1 October 2018. Practice guidance is included to support staff delivering NHS Continuing Healthcare.

This revised 2018 National Framework followed an extensive period of external engagement with stakeholders, across the NHS, Local Authorities, and patient representative groups.

The 2018 National Framework has been collaboratively written by the Department, NHS-England and Local Authorities and clarifies a number of policy areas, including:

a) Setting out that the majority of NHS Continuing Healthcare assessments should take place outside of acute hospital settings. This will support accurate assessments of need and reduce unnecessary stays in hospital.

b) Providing additional advice for staff on when individuals do and do not need to be screened for NHS Continuing Healthcare in order to reduce unnecessary assessment processes and respond to a call for greater clarity on this.

In addition to the 2018 revision of the National Framework, there is also an update to the Practice Guidance and the annexes which accompany the Framework. The user notes for the Checklist, Decision Support Tool and Fast Track Pathway Tool have been updated (see Appendix 1-4), alongside some minor clarifications to the domain wordings and descriptors. The updated National Tools are to be used from 1st October 2018 alongside the updated National Framework.

Importantly, none of the 2018 amendments and clarifications to the National Framework, Practice Guidance, annexes or National Tools are intended to change the eligibility criteria for NHS Continuing Healthcare.

As part of LCC's responsibility to ensure consistent application of the National Framework, a review of Checklist completion, the pattern of recommendations made by LCC staff may be undertaken, in order to improve practice.

1.2 The Care Act 2014 and Continuing Healthcare

As part of the Assessment of Needs process, the county council will consider whether the person's needs could be eligible for Continuing Healthcare. Continuing Healthcare is a package of care provided over a set period of time, and then reviewed, to a person aged 18 or over, to meet significant and complex physical or mental health needs that have arisen as a result of disability, accident or illness.

It is funded solely by the NHS and is free for those who are assessed as eligible. Care arranged as part of NHS continuing healthcare can be provided in a variety of different settings including; care homes, hospices or an individual's home.

An individual is eligible for NHS Continuing Healthcare if they have a 'primary health need'. This is a concept developed by the Secretary of State to assist in determining when the NHS is responsible for providing for all of the individual's assessed health and associated social care needs.

In order to determine whether an individual has a primary health need, a detailed assessment and decision-making process must be followed, as set out in the National Framework. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for commissioning a care package that meets the individual's health and associated social care needs.

If a person does not qualify for NHS Continuing Healthcare, the NHS may still have a responsibility to contribute to that individual's health needs – either by directly

commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both a local authority and a Clinical Commissioning Group (CCG), this is known as a 'joint package of care'.

NHS England, CCGs and local authorities must comply with their responsibilities, as set out in the Standing Rules[1] and Care Act legislation, as appropriate, in relation to NHS Continuing Healthcare.

Local authorities should consider the National Framework and review whether their current practice and processes fit with their responsibilities outlined within this National Framework. Lancashire County Council and the NHS are currently working together to review existing processes.

1.3 Roles and responsibilities of the local authority

Where it appears that a person may be eligible for NHS Continuing Healthcare, the local authority must refer the individual to the relevant CCG.

There are specific requirements for local authorities to cooperate and work in partnership with CCGs in a number of key areas.

Local authorities must, as far as is reasonably practicable, provide advice and assistance when consulted by the CCG in relation to an assessment of eligibility for NHS Continuing Healthcare. This duty applies regardless of whether an assessment of needs for care and support under section 9 of the Care Act 2014 is required.

Where the local authority has carried out such an assessment of needs it must (as far as it is relevant) use information from this assessment to assist the CCG in carrying out its responsibilities.

A local authority must, when requested to do so by the CCG, co-operate with the CCG in arranging for a person or persons to participate in a multidisciplinary team. Local authorities should:

- respond within a reasonable timeframe when consulted by a CCG prior to an eligibility decision being made
- respond within a reasonable timeframe to requests for information when the CCG has received a referral for NHS Continuing Healthcare.

It is also good practice for local authorities to work jointly with CCGs in the planning and commissioning of care or support for individuals found eligible for NHS Continuing Healthcare wherever appropriate, sharing expertise and local knowledge (whilst recognising that CCGs retain formal commissioning and care planning responsibility for those eligible for NHS Continuing Healthcare).

[1] *The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*

Regulations state that local authorities must nominate individuals to be appointed as local authority members of independent review panels where requested to do so by NHS England. This duty includes both nominating such individuals as soon as is reasonably practicable and ensuring that they are, so far as is reasonably practicable, available to participate in independent review panels.

The Care Act imposes certain restrictions on the provision of health services by the county council and these apply to meeting needs in provider failure cases. The county council may not meet needs in provider failure cases by, for example, providing NHS Continuing Healthcare (NHS CHC).

Where the failed provider's clientele consists of persons in receipt of NHS CHC, unless their needs appear to have changed, the county council could reasonably conclude that it was not necessary to do anything to meet those needs. This is because the duty to provide NHS CHC falls on the NHS and the county council cannot provide it.

Therefore to fulfil its duty under Section 6 of the Care Act, the county council will, working with its statutory, voluntary and private sector partners, comply with the national threshold relating to care and support that is relevant, coherent, timely and sufficient.

The county council will make all reasonable adjustments to ensure that all disabled people have equal access to participate in the eligibility decision in line with the Equality Act 2010.

The geography and population of Lancashire is diverse and our policies and practice will aim to deliver services and supports that are representative of the communities in which we work.

The county council will follow relevant legislation, policies and guidance to ensure our practice is of high quality and legally compliant. Where our customers or those we come into contact with wish to challenge or raise concerns in regard to our decisions, regarding eligibility the county council's complaints procedures will be made available and accessible.

2. KEY DEFINITIONS AND PRINCIPLES

2.1 NHS Continuing Healthcare

Is a package of ongoing care arranged and funded solely by the NHS, where the individual, aged 18 years and over, has been found to have a primary health need. It can be provided in any setting. In a person's own home, it means that the NHS funds all the care that is required to meet the service users assessed health and social care needs. In care homes the NHS also makes a contract with the care home and pays the full fees for the person's accommodation as well as all their care both personal and nursing.

2.2 Primary Health Need

An individual has a primary health need if, having taken account of all their needs (following completion of the Decision Support Tool), it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs. Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality

2.3 Health need and social care need

Some needs are clearly health needs and some needs are clearly social care needs; and some needs may be either or both. The difference between health needs and social care needs emerging from the legal principles outlined above are set out below.

Whilst there is not a legal definition of a health need (in the context of NHS Continuing Healthcare), in general terms it can be said that such a need is one related to the treatment, control, management or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).

Similarly, there is not a legal definition of the term 'social care need' in the context of NHS Continuing Healthcare. However, the Care Act 2014 introduced National Eligibility Criteria for care and support to determine when an individual or their carer has eligible needs which the local authority must address, subject to means where appropriate. The criteria sets out that an individual has eligible needs under the Care Act 2014 where these needs arise from (or relate to) a physical or mental impairment or illness which results in them being unable to achieve two or more of the following outcomes which is, or is likely to have, a significant impact on their wellbeing:

- managing and maintaining nutrition;
- maintaining personal hygiene;
- managing toilet needs;
- being appropriately clothed;
- being able to make use of the home safely;
- maintaining a habitable home environment;
- developing and maintaining family or other personal relationships;
- accessing and engaging in work, training, education or volunteering;
- making use of necessary facilities or services in the local community, including public transport and recreational facilities or services; and
- carrying out any caring responsibilities the adult has for a child.

In the context of NHS Continuing Healthcare, therefore, a 'social care need' can be taken to relate to the Care Act 2014 eligibility criteria outlined above.

2.4 Identifying people for whom CHC is a possibility

Where it appears that a person may be eligible for NHS Continuing Healthcare, the county council must refer the individual to the relevant CCG. In the case of a person

who is detained in Her Majesty's Prison (HMP) then NHS England is responsible for managing the process.

When carrying out a needs assessment, under section 9 of the Care Act 2014, where it appears that a person may be eligible for NHS Continuing Healthcare the county council must refer the individual to the relevant CCG (regulation 7 of the Care and Support (Assessment) Regulations 2014). The CCG then has a duty to take reasonable steps to ensure an assessment of eligibility is carried out where it appears there may be a need for such care (regulation 21(2) of the Standing Rules).

Also, if in the course of undertaking a needs assessment (under the Care Act 2014) the county council identifies needs which might be met by other agencies, (e.g. Housing or the NHS) it should make the necessary referrals to these other agencies.

If an NHS body is assessing a person's needs (whether or not potential eligibility for NHS Continuing Healthcare has been identified) and the assessment indicates a potential need for care and support that may fall within the county council's responsibilities, it should notify the county council of this in order for the county council to then fulfil its responsibilities.

There are specific requirements for the county council to cooperate and work in partnership with CCGs in a number of the following key areas.

A. Assessment

The county council is under a duty to assess any person who it appears may be in need of care and support. Where the county council is satisfied, on the basis of their assessment, that the adult has needs for care and support, it must then determine whether any of these needs meet the Care Act 2014 national eligibility criteria If not, the county council may still have the power to meet them. If the county council is required to meet needs or decides to meet them, they must consider how it will do so.

Section 22 of the Care Act 2014 places a limit on social care:

'A local authority may not meet needs under sections 18 to 20 by providing or arranging for the provision of a service or facility that is required to be provided under the National Health Service Act 2006 unless:

a) *doing so would be merely incidental or ancillary to doing something else to meet needs under those sections, and*
b) *the service or facility in question would be of a nature that the local authority could be expected to provide'.*

The limit on social care pre-existed the Care Act 2014 and was considered and clarified in 1999 by the Court of Appeal in the Coughlan judgment. This judgment considered the responsibilities of health authorities and local authorities for social service provision, in particular the limits on the provision of nursing care (in a broad sense, i.e. not just registered nursing care) by local authorities. The principles from this judgment therefore inform section 22 of the Care Act 2014.

Section 22(3) of the Care Act 2014 provides a further limit of the care and support that can be provided by a county council. This section prohibits the county council from providing, or arranging for the provision of, nursing care by a registered nurse.

Also, if in the course of undertaking a needs assessment the county council identifies needs which might be met by other agencies (e.g. Housing or the NHS) it should make the necessary referrals to these other agencies.

We can also expect that if the NHS identifies a potential need for care and support that may fall within the county council's responsibilities, it should notify the county council of this in order for the county council to then fulfil its responsibilities.

B. Work with the NHS

The county council must, as far as is reasonably practicable, provide advice and assistance when consulted by the CCG in relation to an assessment of eligibility for NHS Continuing Healthcare. This duty applies regardless of whether an assessment of needs for care and support under section 9 of the Care Act 2014 is required (refer to paragraphs 124-130 of the National Framework).

Where the county council has carried out such an assessment of needs it must (as far as it is relevant) use information from this assessment to assist the CCG in carrying out its responsibilities (refer to paragraph 21 of the National Framework).

C. Co-operate with the NHS

The county council must, when requested to do so by the CCG, co-operate with the CCG in arranging for a person or persons to participate in a Multi-Disciplinary Team (MDT). The county council should:

- respond within a reasonable timeframe when consulted by a CCG prior to an eligibility decision being made (refer to paragraph 21 of the National Framework)
- respond within a reasonable timeframe to requests for information when the CCG has received a referral for NHS Continuing Healthcare.

If an NHS body is assessing a person's needs (whether or not potential eligibility for NHS Continuing Healthcare has been identified) and the assessment indicates a potential need for care and support that may fall within The county council's responsibilities, it should notify the county council of this in order for the county council to then fulfil its responsibilities.

D. Share Expertise

It is also good practice for the county council to work jointly with CCGs in the planning and commissioning of care or support for individuals found eligible for NHS Continuing Healthcare wherever appropriate, sharing expertise and local knowledge (whilst recognising that CCGs retain formal commissioning and care planning responsibility for those eligible for NHS Continuing Healthcare).

E. Independent Review Panels

Regulations state that the county council must nominate individuals to be appointed as county council members of independent review panels where requested to do so by NHS England. This duty includes both nominating such individuals as soon as is reasonably practicable and ensuring that they are, so far as is reasonably practicable, available to participate in independent review panels.

F. Core Values

Access to assessment, decision-making and provision should be fair and consistent. There should be no discrimination because of race, disability, sex, age, sexual orientation, religion or belief, gender reassignment, pregnancy or maternity status, marriage or civil partnership status or type of health need (for example, whether the need is physical, mental or psychological). CCGs and partner organisations are responsible for ensuring that discrimination does not occur and should use effective auditing to monitor this.

Assessments of eligibility for NHS Continuing Healthcare should be organised so that the individual being assessed and their representative understand the process and receive advice and information that will maximise their ability to participate in the process in an informed way. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike

Individuals being assessed for NHS Continuing Healthcare are frequently facing significant changes in their life and therefore a positive experience of the assessment process is crucial. The process of assessment of eligibility and decision-making should be person-centred. This means placing the individual at the heart of the assessment and care-planning process.

Staff undertaking this assessment are trained and competent to do so ensuring that the individual and/or their representative is fully and directly involved in the assessment process;

a) taking full account of the individual's own views and wishes, ensuring that their perspective is incorporated in the assessment process;
b) addressing communication and language needs;
c) obtaining consent to assessment and sharing of records (where the individual has mental capacity to give this);
d) dealing openly with issues of risk; and
e) keeping the individual (and/or their representative) fully informed.

3. PROCEDURES

3.1 Before an assessment of eligibility for NHS Continuing Healthcare

3.1.1 Consent

While health and social care professionals can rely on a lawful basis other than consent to lawfully process personal data, consent is required to satisfy the common law duty of confidentiality. Where the individual concerned has capacity, their informed consent should be obtained before the start of the process to determine eligibility for NHS Continuing Healthcare. This consent will need to encompass permission to undertake the NHS Continuing Healthcare assessment process and also to the 'sharing and processing of data' (i.e. sharing relevant personal information between professionals in order to undertake the eligibility assessment for NHS Continuing Healthcare and, where appropriate, for audit and monitoring of decisions). For consent to be valid for these purposes it must be:

- **Explicit.** Consent must be expressly confirmed and recorded in writing, in a very clear and specific statement of consent, which is prominent and kept separate from other information.
- **Specific.** It should be made clear to the individual what they are being asked to consent to (e.g. just to having a Checklist completed or to the full assessment of eligibility process as well, if their Checklist is positive) and whether their information will be obtained and shared for a specific aspect of the eligibility consideration process or for the full process. Also it needs to be explained that, subject to their consent, their personal information will be shared between different organisations involved in their care in order to complete the assessment of eligibility for NHS Continuing Healthcare.
- **Informed**. The individual should be informed about what the NHS Continuing Healthcare eligibility assessment process involves, what information will be obtained, and who it will be shared with before the start of the process to determine eligibility for NHS Continuing Healthcare. See Appendix 1 – NHS CHC Public Information Leaflet and Appendix 2 – NHS CHC Easy Read.
- **Freely given.** This means consent must be given voluntarily by an appropriately informed person who has both the capacity and authority to consent to the intervention in question. It also means giving people genuine ongoing choice and control over how their personal information is used and shared. In the context of NHS Continuing Healthcare this means that the individual must have the capacity to consent freely and voluntarily to the NHS Continuing Healthcare eligibility assessment process as set out in this Framework. The individual should have a choice about whether or not to consent, and consent must not be conditional on the individual agreeing to something that is not related to the NHS Continuing Healthcare eligibility assessment process.
- **Can be withdrawn**. The individual must be made aware that they can withdraw their consent at any time, and made aware of the process for doing so, and that this includes withdrawing consent to share information. It should be explained that, depending on the information in question, the decision to withdraw or withhold consent to share information might affect whether it is possible to complete the NHS Continuing Healthcare eligibility assessment.

If an individual with capacity does not consent to being assessed for NHS Continuing Healthcare or to sharing information which is essential for carrying out this assessment, the potential consequences of this should be carefully explained. This might affect the ability of the NHS and the county council to provide appropriate services to them.

The fact that an individual declines to be assessed for NHS Continuing Healthcare does not, in itself, mean that the county council has an additional responsibility to meet their needs, over and above the responsibility it would have had if they had been assessed for NHS Continuing Healthcare. Where there are concerns that an individual may have significant ongoing needs, and that the level of appropriate support could be affected by their decision to decline the assessment, or to withhold consent to sharing essential information, the appropriate way forward should be considered jointly by the CCG and the county council, taking account of each organisation's legal powers and duties. It may be appropriate for the organisations involved to seek legal advice.

When agreed, the Consent Form will be published as an appendix.

3.1.2 Capacity

If there is a concern that the individual may not have capacity to give consent to the assessment process or the sharing of information, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice[2]. CCGs should be particularly aware of the five principles of the Act:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

It is important to be aware that just because an individual may have difficulty in expressing their views or understanding some information, this does not in itself mean that they lack capacity to make the decision in question. Appropriate support and adjustments, for example, using alternative methods of communication, should be made available to the person in compliance with the Mental Capacity Act 2005[3], and with disability discrimination legislation[4].

[2] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
[3] http://www.legislation.gov.uk/ukpga/2005/9/contents
[4] https://www.legislation.gov.uk/ukpga/2010/15/contents

CCGs and the county council should ensure that all staff involved in NHS Continuing Healthcare assessments are appropriately trained in Mental Capacity Act 2005 principles and responsibilities. Where the assessor is not familiar with Mental Capacity Act principles and the person appears to lack capacity the assessor should consult their employing organisation and ensure that appropriate actions are identified.

Please also refer to the Independent Mental Capacity and Mental Health Advocacy PPG.

Best Interests Decisions

If the person lacks the mental capacity to either give or refuse consent to the assessment process or the sharing of information, a decision must be made in the person's 'best interests' as to whether to proceed with the assessment and sharing of information. The best interest decision should be recorded. The person leading the assessment is responsible for making this decision and should bear in mind the expectation that everyone who is potentially eligible for NHS Continuing Healthcare should have the opportunity to be considered for eligibility. A third party cannot give or refuse consent for an assessment of eligibility for NHS Continuing Healthcare, or for sharing information, on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (Health and Welfare)[5] or they have been appointed as a Deputy (Health and Welfare) by the Court of Protection.

If someone states that they have such authority the assessor should request sight of a certified copy of the original Deputyship Order or registered Lasting Power of Attorney and check the wording of the order to confirm that the person does have the relevant authority stated.

Where a 'best interests' decision needs to be made, the 'decision-maker' must take into account[6] the views of any relevant third party who has a genuine interest in the individual's welfare (if it is reasonable and practicable to consult them). This will normally include family and friends. The decision-maker should be mindful of the need to respect confidentiality and should not share personal information with third parties unless it is considered in the best interests of the individual for the purposes of the NHS Continuing Healthcare assessment of eligibility. Where the individual has made an 'advanced statement' to the effect that they do not want personal information shared with specific individuals, this should be taken into account in assessing the individual's best interests.

Although the decision-maker must take account of the views of relevant third parties, those consulted (including family members) do not have the authority to consent to or refuse consent to the actions proposed as a result of the best interest process. The responsibility for the decision rests with the decision maker, not with those consulted. Where there is a difference of opinion between the decision-maker and those consulted, every effort should be made to resolve this informally. However, this process should not unduly delay timely decisions being made in the person's best interests.

[5] https://www.gov.uk/lasting-power-attorney-duties/health-welfare
[6] http://www.legislation.gov.uk/ukpga/2005/9/contents

An individual's capacity to make decisions may fluctuate, and there may be circumstances where an individual presents with a temporary loss of decision making capacity. In these circumstances a decision needs to be made as to whether it would be in the person's best interests to delay seeking consent until capacity is regained. If this is the case, the best interest decision to be made may also include whether to provide an interim care or support package.

A Continuing Healthcare Consent form has been developed, but not yet agreed, for use by the Midland and Lancashire Commissioning Support Unit (CSU). However, if the individual who is being assessed is outside of the area managed by this CSU, then a different consent form may be required to be completed by LCC staff – check with local NHS.

3.2 Assessment of eligibility for NHS Continuing Healthcare

3.2.1 Screening using the Checklist tool

The Checklist (see Appendix 3) is the NHS Continuing Healthcare screening tool which can be used in a variety of settings to help practitioners identify individuals who may need a full assessment of eligibility for NHS Continuing Healthcare.

The purpose of the Checklist is to encourage proportionate assessments of eligibility so that resources are directed towards those people who are most likely to be eligible for NHS Continuing Healthcare, and to ensure that a rationale is provided for all decisions regarding eligibility.

The Checklist has 11 care domains broken down into three levels: A, B or C (where A represents a high level of care need, and C is a low level of care need). The outcome of the Checklist depends on the number of As, Bs, and Cs identified.

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 have this opportunity. There may, very occasionally, be exceptional circumstances where a full assessment of eligibility for NHS Continuing Healthcare is appropriate even though the individual does not apparently meet the indicated threshold.

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

3.2.2 When should a Checklist be completed?

Where it has been identified that an individual has a need for care which is above the level that the county council may lawfully provide - there may be a need for NHS Continuing Healthcare, a Checklist should normally be completed.

Screening 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 will help practitioners to correctly identify individuals who require a full assessment of eligibility for NHS Continuing Healthcare.

Local Health and Social Care joint processes are being developed to make it easier for county council staff to identify individuals for whom it may be appropriate to complete a Checklist, including for individuals in community settings.

Wherever an individual requires a Nursing home placement or has significant support needs, a Checklist would be expected to be completed (unless the decision is made to go straight to the completion of a Decision Support Tool).

There will be many situations where it is not necessary to complete a Checklist. But it is necessary for staff to record that this consideration has been given and the rationale for not proceeding is documented clearly in LAS. These situations include where:

- It is clear to practitioners 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 a Checklist should be undertaken.
- The individual has short-term Healthcare needs or is recovering from a temporary condition and has not yet reached their optimum potential (if there is doubt between practitioners about the short-term nature of the needs it may be necessary to complete a Checklist).
- It has been agreed by the CCG that the individual should be referred directly for full assessment of eligibility for NHS Continuing Healthcare.
- 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.
- An individual is receiving services under Section 117 of the Mental Health Act that are meeting all of their assessed needs.
- 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.

3.2.3 Who can complete the Checklist tool?

The Checklist can only be completed by county council staff who have been trained in its use. This training is available as e-learning from the NHS and is complimented by further training from LCC.

Records of training will be kept by the council's Learning and Development Team and it is likely that the NHS will ask for proof of completion.

For Agency/Temporary staff we will require proof that this training has taken place previously or they will be expected to carry out training at the county council.

It is for each CCG and the county council to identify and agree who can complete the Tool but it is expected that it should, as far as possible, include staff involved in assessing or reviewing individuals' needs as part of their day-to-day work.

3.2.4 The role of the individual in the screening process

The individual should be given reasonable notice of the intention to undertake the Checklist, and should normally be given the opportunity to be present at the completion of the Checklist, together with any representative they may have.

Before the Checklist is completed, it is necessary to ensure that the individual and (where appropriate) their representative understand that the Checklist does not indicate that the individual will be eligible for NHS Continuing Healthcare – only that they are entitled to be assessed for eligibility.

An individual cannot self-refer for NHS Continuing Healthcare by completing a Checklist themselves. The individual can request a Checklist to be undertaken from their CCG.

Providers should refer to the CCG if a Checklist needs to be completed for a service user they support.

3.2.5 How the Checklist should be completed

The Checklist requires practitioners to record a brief description of the need and source of evidence used to support the statements selected in each domain. This could, for example, be by indicating that specific evidence for a given domain was contained within the in-patient nursing notes on a stated date. This will enable evidence to be readily obtained for the purposes of the MDT if the person requires a full assessment of eligibility for NHS Continuing Healthcare.

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

Practitioners should refer to the Checklist User Notes for more detail on how it should be completed.

3.3 After an assessment of eligibility for NHS Continuing Healthcare

3.3.1 What happens after the Checklist?

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 checklist should be sent without delay to the Commissioning Support Unit (CSU who will communicate the outcome in writing to the individual or their representative. This should include the reasons why the Checklist outcome was reached. Normally this will be achieved by providing the individual with a copy of the Checklist.

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

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 of all 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.

A clear and written response should be given including the individual's (and, where appropriate, their representative's) rights under the **NHS complaints procedure** if they remain dissatisfied with the position.

3.3.2 What happens following a positive checklist?

A positive Checklist means that the individual requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean the individual is eligible for NHS Continuing Healthcare.

The NHS has 28 days to complete the process. It is important to note that the 28 days starts from the date received, not the date completed by county council staff so delays sending completed documents should be kept to the minimum.

An individual should not be left without appropriate support while they await the outcome of the assessment and decision-making process. A person only becomes eligible for NHS Continuing Healthcare once a decision on eligibility has been made by the CCG. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment.

If, at the time of referral for an NHS Continuing Healthcare assessment, the individual is already receiving an ongoing care package (however funded) then those arrangements should continue until the CCG makes its decision on eligibility for NHS Continuing Healthcare, subject to any urgent adjustments needed to meet the changed needs of the individual. In considering such adjustments, the county council and CCGs should have regard to the limitations of their statutory powers.

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

Once an individual has been referred for a full assessment of eligibility for NHS Continuing Healthcare then, irrespective of the individual's setting, the CCG has responsibility for coordinating the process until the decision on funding has been made. The CCG should identify an individual (or individuals) to carry out this coordination role, which is pivotal to the effective management of the assessment and decision-making process. By mutual agreement, the coordinator may either be a CCG member of staff or be from an external organisation.

3.3.3 When and where to screen and assess eligibility for NHS Continuing Healthcare

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. The full assessment of eligibility should normally take place when the individual is in a community setting. 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.

3.3.4 How NHS Continuing Healthcare interacts with Hospital Discharge

In the majority of cases, it is preferable for eligibility for NHS Continuing Healthcare to be considered after discharge from hospital when the person's ongoing needs should be clearer. The aim in most cases will be for the individual to return to the place from which they were admitted to hospital, preferably their own home. It should always be borne in mind that an assessment of eligibility for NHS Continuing Healthcare that takes place in an acute hospital, might not accurately reflect an individual's longer-term needs. This could be because, with appropriate support, the individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment.

Local protocols have been developed between the county council, other NHS bodies, and other relevant partners, but staff should find out what protocols exist for those individuals who are placed outside the Lancashire boundaries.

Where an individual is ready to be safely discharged from acute hospital it is very important that this should happen without delay. Therefore the assessment process for NHS Continuing Healthcare should not be allowed to delay hospital discharge.

In order to ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few weeks or months. It might also include intermediate care or an interim package of support, preferably in an individual's own home. In such situations, assessment of eligibility for NHS Continuing Healthcare, if still required, should be undertaken when an accurate assessment of ongoing needs can be made. The interim services should continue until it has been decided whether or not the individual has a need for NHS Continuing Healthcare. There must be no gap in the provision of appropriate support to meet the individual's needs.

Where the NHS body is considering issuing an Assessment Notice to the county council under the provisions of the Care & Support (Discharge of Hospital Patients) Regulations 2014[7], the responsible NHS body is required to consider whether or not to provide the individual with NHS Continuing Healthcare before issuing such a notice. This does not necessarily mean a Checklist needs to be completed if it is clear to the professionals involved that there is no need for NHS Continuing Healthcare.

CCGs and their partner organisations should ensure appropriate processes and pathways exist for individuals who may have a need for NHS Continuing Healthcare, for example:

a) rather than completing a Checklist in hospital a decision is made to provide interim NHS-funded services to support the individual after discharge. In such a case, before the interim NHS-funded services come to an end, screening, if required, for NHS Continuing Healthcare should take place through use of the Checklist and, where appropriate, the full MDT process using the Decision Support Tool (i.e. an assessment of eligibility); or
b) a 'negative' Checklist is completed in an acute hospital (i.e. the person does not have a need for NHS Continuing Healthcare) in which case, where appropriate, an Assessment Notice may be issued to the county council; or
c) a 'positive' Checklist is completed in an acute hospital and interim NHS funded services are put in place to support the individual after discharge until it is either determined that they no longer require a full assessment (because a further Checklist has been completed which is now negative) or a full assessment of eligibility for NHS Continuing Healthcare is completed; or
d) a 'positive' Checklist is completed in acute hospital and (exceptionally and for clear reasons) a full assessment of eligibility for NHS Continuing Healthcare takes place before discharge. In a small number of circumstances it may be decided to go directly to a full assessment within the acute hospital, without the need for a Checklist. If the full assessment does not result in eligibility for NHS Continuing Healthcare then, where appropriate, an Assessment Notice may be issued to the county council; or,
e) where the individual has an existing package or placement which all relevant parties agree can still safely and appropriately meet their needs without any changes, then they should be discharged back to this placement and/or package under existing funding arrangements. In such circumstances any screening for NHS Continuing Healthcare, if required, should take place within

[7] http://www.legislation.gov.uk/uksi/2014/2823/contents/made

six weeks of the individual returning to the place from which they were admitted to hospital. If this screening results in a full assessment of eligibility and the individual is found eligible for NHS Continuing Healthcare through this particular assessment, then reimbursement will apply back to the date of discharge.

3.3.5 Disregarding a Checklist

CCGs are able, as documented in the Framework, to assess that if an individual's needs have reduced in a short time frame between a positive Checklist and a full assessment of eligibility taking place, it is legitimate to undertake a second Checklist, rather than necessarily proceeding to full assessment of eligibility for NHS Continuing Healthcare.

The county council and the individual should be kept fully informed of the changed position and documented on LAS.

3.5.6 Intermediate Care and NHS Continuing Healthcare

Intermediate care is a programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live independently. Intermediate care is aimed at individuals who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute or longer-term in-patient care or long-term residential care. It should form part of a pathway of support. For example, intermediate care may be appropriately used where an individual has received other residential rehabilitation support following a hospital admission and, although having improved, continues to need support for a period prior to returning to their own home. It should also be used where an individual is at risk of entering a care home and requires their needs to be assessed in a non-acute setting with rehabilitation support provided where needed. This is irrespective of current or potential future funding streams.

3.5.7 Assessment for NHS Continuing Healthcare using the Decision Support Tool

Once an individual has been referred for a full assessment of eligibility for NHS Continuing Healthcare (following use of the Checklist or, if a Checklist is not used in an individual case, following direct referral for full consideration), then, a Multi-Disciplinary Team must assess whether the individual has a primary health need using the Decision Support Tool.

3.5.8 The Multidisciplinary Tool

The core purpose of the MDT is to make a recommendation on eligibility for NHS Continuing Healthcare drawing on the multidisciplinary assessment of needs and following the processes set out in the National Framework.

In accordance with regulations an MDT in this context means a team consisting of at least:

- two professionals who are from different healthcare professions, or

- one professional who is from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014.

Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs and, where possible, have recently been involved in the assessment, treatment or care of the individual. As far as is reasonably practicable, the CCG must consult with the county council before making any decision about an individual's eligibility for NHS Continuing Healthcare and in doing so cooperate with the county council in arranging for such persons to participate in an MDT for that purpose. CCGs may use a number of approaches (e.g. face-to-face, video/tele conferencing etc.) to arrange these MDT assessments in order to ensure active participation of all members as far as is possible.

If the county council is consulted, there is a requirement for it to provide advice and assistance to the CCG, as far as is reasonably practicable. The county council must, when requested to do so by a CCG, co-operate with the CCG in arranging for persons to participate in an MDT. The involvement of county council colleagues as well as health professionals in the assessment process should streamline the process of care planning and will make decision-making more effective and consistent. As with any assessments that they carry out, the county council should not allow an individual's financial circumstances to affect its participation in a joint assessment.

In the event of the county council being unable to provide a practitioner to participate in an MDT, CCGs have had instructions from NHS England to go ahead with the MDT.

The MDT works together to collate and review the relevant information on the individual's health and social care needs. The MDT uses this information to help clarify individual needs through the completion of the Decision Support Tool, and then works collectively to make a professional judgement about eligibility for NHS Continuing Healthcare, which will be reflected in its recommendation. This process is known as a multidisciplinary assessment of eligibility for NHS Continuing Healthcare.

3.3.9 Identifying an individual's need

Establishing whether an individual has a primary health need requires a clear, reasoned decision, based on evidence of needs from a comprehensive range of up to date assessments relating to the individual. A good-quality multidisciplinary assessment of needs that looks at all of the individual's needs 'in the round' – including the ways in which they interact with one another – is crucial both to addressing these needs and to determining eligibility for NHS Continuing Healthcare. The individual and (where appropriate) their representative should be enabled to play a central role in the assessment process.

It is important that the individual's own view of their needs, including any supporting evidence, is given appropriate weight alongside professional views. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion

naturally progresses, rather than working through an assessment document in a linear fashion.

It is important that those contributing to this process have the relevant skills and knowledge. It is best practice that where the individual concerned has, for example a learning disability, or a brain injury, someone with specialist knowledge of this client group is involved in the assessment process.

The multidisciplinary assessment of an individual's needs informs the process for determining whether or not they are eligible for NHS Continuing Healthcare. However, regardless of whether the individual is determined to be eligible for NHS Continuing Healthcare, CCGs and the county council should always consider whether the multidisciplinary assessment of needs has identified issues that require action to be taken. For example, if a multidisciplinary assessment of needs indicates that the individual has significant communication difficulties, referral to a speech and language service should be considered.

If a needs assessment under the Care Act 2014 has already been carried out by the county council and is still relevant to an individual's current needs then, in accordance with the relevant regulations, the county council must use this assessment to provide advice and assistance to the CCG. For clarity, the county council's duty to provide advice and assistance does not, in itself, trigger a duty to assess under section 9 of the Care Act 2014. The county council should provide any other relevant information relating to the individual's up-to-date needs, where appropriate.

However, once an individual has been brought to the attention of the county council, in addition to giving advice and assistance it should, having regard to the facts of the case, also consider whether a needs assessment under the Care Act 2014 is required. The absence of a needs assessment under the Care Act 2014 should not delay an assessment of eligibility for NHS Continuing Healthcare.

The Decision Support Tool should be used for all adults who require assessment for NHS Continuing Healthcare, irrespective of their client group/diagnosis. The Tool focuses on the individual's needs, not on their diagnosis. Regulations require that the Decision Support Tool is used to inform the decision as to whether an individual has a primary health need, and if the CCG concludes that they do they must be found eligible for NHS Continuing Healthcare

3.3.10 Using the Decision Support Tool (See Appendix 4)

The Decision Support Tool (DST) has been developed to aid consistent decision making. The DST supports practitioners in identifying the individual's needs. This, combined with the practitioners' skills, knowledge and professional judgement, should enable them to apply the primary health need test in practice.

The DST is not an assessment of needs in itself. Rather, it is a way of bringing together and applying evidence in a single practical format, to facilitate consistent, evidence-based assessment regarding recommendations for NHS Continuing Healthcare eligibility. The evidence and rationale for the recommendation should be accurately and fully recorded.

The DST should not be completed without a multidisciplinary assessment of needs (meaning a comprehensive collection and evaluation of an individual's needs, refer to paragraphs 124-130 of the National Framework). If any assessments relating to the individual's health and wellbeing (such as a needs assessment under the Care Act 2014) have recently been completed by practitioners, they may be used to complete the DST. However, care should be taken to ensure that such assessments provide an accurate reflection of current need.

The purpose of the DST is to help identify eligibility for NHS Continuing Healthcare. It is designed to collate and present the information from the assessments of need in a way that assists consistent decision making regarding NHS Continuing Healthcare eligibility. The DST is a national Tool and should not be altered.

The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. The Tool provides practitioners with a method of bringing together and recording the various needs in 12 'care domains', or generic areas of need. Each domain is broken down into a number of levels. The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided.

The care domains are:

1. Breathing
2. Nutrition
3. Continence
4. Skin Integrity
5. Mobility
6. Communication
7. Psychological & Emotional needs
8. Cognition
9. Behaviour
10. Drug therapies and medication
11. Altered states of consciousness
12. Other significant care needs.

Completion of the Tool should result in a comprehensive picture of the individual's needs that captures their nature, and their complexity, intensity and/or unpredictability – and thus the quality and/or quantity (including continuity) of care required to meet the individual's needs. Figure 1 indicates how the domains in the Decision Support Tool can illustrate (both individually and through their interaction) the complexity, intensity and/or unpredictability of needs. The overall picture, and the descriptors within the domains themselves, also relate to the nature of needs.

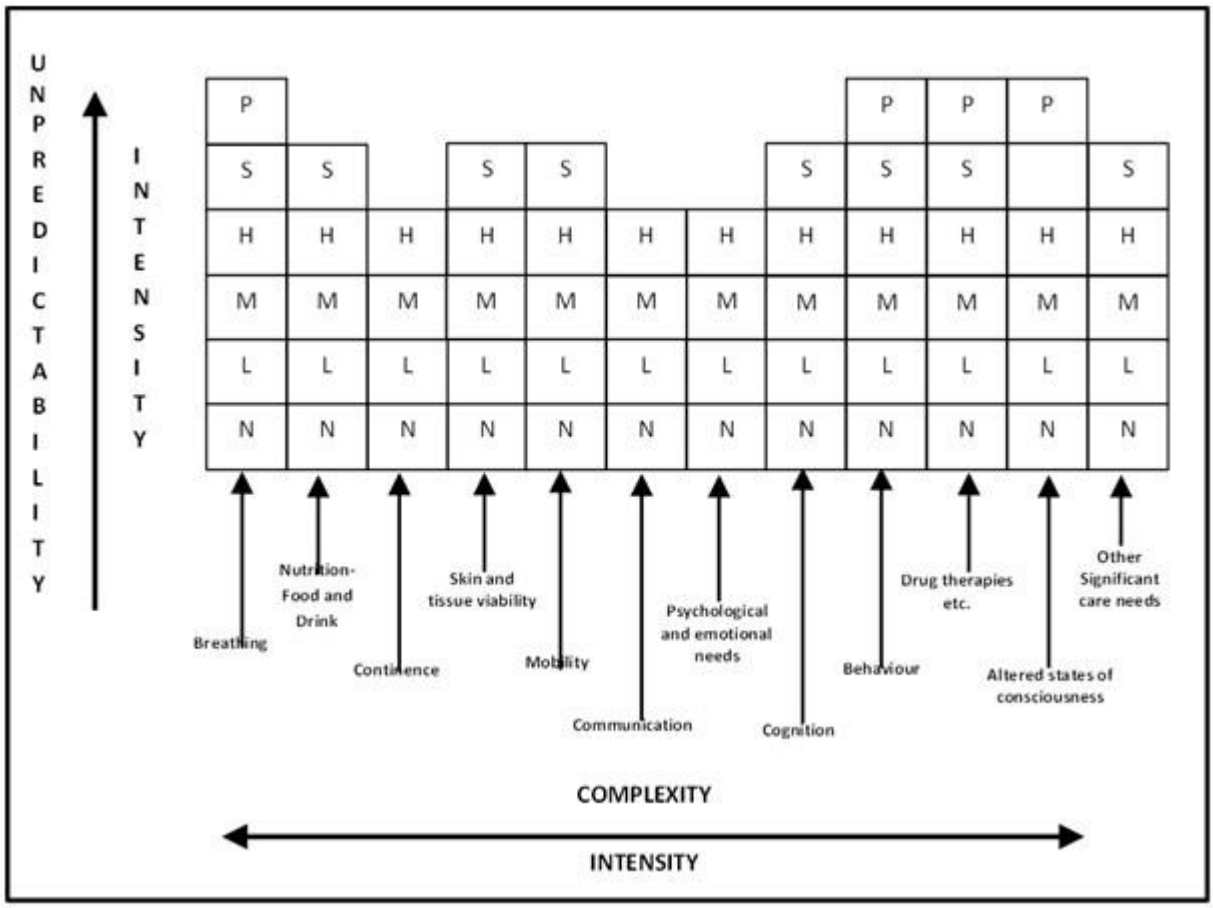


Figure 1: How the different care domains are divided into different levels

3.3.11 How the different care domains are divided into levels of need

In certain cases, an individual may have particular needs that are not easily categorised by the care domains described here. In such circumstances, it is the responsibility of the MDT to determine the extent and type of the need and to take that need into account (and record it in the 12th care domain) when recommending whether a person has a primary health need.

Where deterioration can be reasonably anticipated to take place in the near future, this should also be taken into account, in order to avoid the need for unnecessary or repeat assessments.

The Tool supports the process to determine eligibility but indicative guidelines as to threshold are set out in the Tool (for example, if one area of need is at Priority level, then this demonstrates a primary health need), but these are not to be viewed prescriptively. Professional judgement should be exercised in all cases to ensure that the individual's overall level of need is correctly determined. The Tool is to aid decision-making in terms of whether the nature, complexity, intensity or unpredictability of a person's needs are such that the individual has a primary health need.

3.3.12 Well-managed needs

The decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on NHS Continuing Healthcare eligibility.

An example of the application of the well-managed needs principle might occur in the context of the behaviour domain where an individual's support plan includes support/interventions to manage challenging behaviour, which is successful in that there are no recorded incidents which indicate a risk to themselves, others or property. In this situation, the individual may have needs that are well-managed and if so, these should be recorded and taken into account in the eligibility decision.

In applying the principle of well-managed need, consideration should be given to the fact that specialist care providers may not routinely produce detailed recording of the extent to which a need is managed. It may be necessary to ask the provider to complete a detailed diary over a suitable period of time to demonstrate the nature and frequency of the needs and interventions, and their effectiveness.

Care should be taken when applying this principle. Sometimes, needs may appear to be exacerbated because the individual is currently in an inappropriate environment rather than because they require a particular type or level of support – if they move to a different environment and their needs reduce, this does not necessarily mean that the need is now 'well-managed', the need may actually be reduced or no longer exist.

It is not intended that this principle should be applied in such a way that well controlled conditions should be recorded as if medication or other routine care or support was not present (Practice Guidance note 23 in the National Framework can be referred to for how the well managed needs principle should be applied). The multi-disciplinary team should give due regard to well-controlled conditions when considering the four characteristics of need and making an eligibility recommendation on primary health need.

3.3.13 Making the recommendation of eligibility to the CCG

The MDT is required to make a recommendation to the CCG as to whether or not the individual has a primary health need and are therefore eligible for NHS Continuing Healthcare funding. In coming to this recommendation the MDT should work collectively using professional judgement.

The written recommendation needs to be clear and concise whilst providing sufficient detail to enable the CCG and the individual to understand the underlying rationale for the recommendation.

The recommendation regarding eligibility for NHS Continuing Healthcare should contain:

- a summary of the individual's needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs.
- statements about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these characteristics provided in paragraphs 54-66 of the National Framework.
- an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability.
- in the light of the above, give a recommendation as to whether or not the individual has a primary health need (with reference to paragraphs 54-66 of this National Framework). It should be remembered that, whilst the recommendation should make reference to all four characteristics of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

Where an MDT recommends an individual is not eligible for NHS Continuing Healthcare, a clear rationale that considers the four key characteristics must still be provided. Care planning for those individuals with ongoing needs, including the consideration of need for NHS-funded Nursing Care, will still be necessary.

If an MDT is unable to reach agreement on the recommendation this should be clearly recorded and the rationale for the disagreement documented in the Social Care assessment.

Where an individual and/or their representative expresses concern about any aspect of the MDT or DST process, the CCG coordinator should discuss this matter with them and seek to resolve their concerns. Where the concerns remain unresolved, these should be noted within the DST so that they can be brought to the attention of the CCG making the final decision. It remains the role of the NHS to negotiate with family members.

3.3.14 Decision-making on eligibility by the CCG

CCGs are responsible, not the county council, for decision making regarding NHS Continuing Healthcare eligibility, based on the recommendation made by the multidisciplinary team in accordance with the process set out in this National Framework. Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed.

Until formal notification of the CCG's decision is received by the county council, the process is not complete and remains active. Care plans (Care Plan Line Items) should not be altered until this notification is received.

Any communications received from the NHS should be recorded on LAS making sure that full names, position in the organisation and contact details are included.

CCGs should ensure consistency and quality of decision making. The CCG may ask a multidisciplinary team to carry out further work on a Decision Support Tool (DST) if it is not completed fully or if there is a significant lack of consistency between the evidence recorded in the DST and the recommendation made. However, the CCG

should not refer a case back, or decide not to accept a recommendation, simply because the multidisciplinary team has made a recommendation that differs from the one that those who are involved in making the final decision would have made, based on the same evidence.

CCGs should not make decisions in the absence of recommendations on eligibility from the multidisciplinary team, except where exceptional circumstances require an urgent decision to be made.

Exceptional circumstances where these recommendations may not be accepted by a CCG may include where:

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

In such cases the matter should be sent back to the MDT with a full explanation of the relevant matters to be addressed. Where there is an urgent need for care/support to be provided, the CCG (and the county council where relevant) should make appropriate interim arrangements.

CCGs may choose to verify the multidisciplinary team's recommendation in a number of different ways. It is expected that whether the verification is done by an individual or by a panel, this process should not be used as a gate-keeping function or for financial control. A decision not to accept the multidisciplinary team's recommendation should never be made by one person acting unilaterally. The final eligibility decision should be independent of budgetary constraints, and finance officers should not be part of a decision-making process.

As part of the county council's responsibility to ensure consistent application of the National Framework, a review of the pattern of recommendations made by multidisciplinary teams, may be undertaken in order to improve practice. However, this should be carried out separately from taking the decision on eligibility in individual cases. Care must be taken to ensure that any review of the pattern of recommendations supports compliance with the 'primary health need' test set out in this National Framework.

3.3.15 Communicating the eligibility decision to the individual

Once the eligibility decision is made by the CCG, the individual who has been assessed should be informed in writing as soon as possible (although this could be preceded by verbal confirmation where appropriate). The county council should also be informed of the ratification of the decision to enable a smooth transfer of funding and to prevent double funding of care packages.

This written confirmation should include:

- the decision on primary health need, and therefore whether or not the individual is eligible for NHS Continuing Healthcare;
- the reasons for the decision;
- a copy of the completed DST;
- details of who to contact if they wish to seek further clarification; and
- how to request a review of the eligibility decision.

Where an individual is not eligible for NHS Continuing Healthcare, the outcome letter may also include, where applicable and appropriate, information regarding NHS funded Nursing Care or a joint package of care.

3.3.16 Timeframe for decision making

It is expected that CCGs will normally respond to MDT recommendations within 48 hours (two working days), and that the overall assessment and eligibility decision making process should, in most cases, not exceed 28 calendar days from the date that the CCG receives the positive Checklist (or, where a Checklist is not used, other notice of potential eligibility) to the eligibility decision being made.

In the minority of cases where an assessment of eligibility is being carried out in an acute hospital setting, the process should take far fewer than 28 calendar days if an individual is otherwise ready for discharge.

When there are valid and unavoidable reasons for the process taking longer, timescales should be clearly communicated to the person and (where appropriate) their representative(s). An example of this might occur where additional work is required to ensure that the DST and supporting evidence submitted to the CCG accurately reflect the full extent of an individual's needs.

It should also be noted that the 28 calendar day timescale does not apply to children and young people in transition to adult services but will start on individual's 18th birthday.

3.3.17 Care packages

Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health and associated care and support needs. The CCG has responsibility for ensuring this is the case, and determining what the appropriate package should be. In doing so, the CCG should have due regard to the individual's wishes and preferred outcomes. Although the CCG is not bound by the views of the county council on what services the individual requires, any county council assessment under the Care Act 2014, will be important in identifying the individual's needs and in some cases the options for meeting them. Whichever mechanism is used for meeting an individual's assessed needs, the approach taken should be in line with the principles of personalisation.

CCGs should operate a person-centred approach to all aspects of NHS Continuing Healthcare, using models that maximise personalisation and individual control and that reflect the individual's preferences, as far as possible, including when delivering

NHS Continuing Healthcare through a Personal Health Budget, where this is appropriate

Unnecessary changes of provider or of care package should not take place purely because the responsible commissioner has changed from a CCG to a county council (or vice versa).

3.3.18 Case management

Once an individual has been found eligible for NHS Continuing Healthcare, the CCG is responsible for their case management, including monitoring the care they receive and arranging regular reviews. CCGs should ensure arrangements are in place for an ongoing case management role for all those eligible for NHS Continuing Healthcare, as well as for the NHS elements of joint packages. This could be through joint arrangements with the county council, subject to local agreement (currently in development). Best practice would be for CCGs to assign a named case manager or named of point of contact for anyone in receipt of NHS Continuing Healthcare.

3.3.19 Safeguarding

Where an individual who is in receipt of NHS Continuing Healthcare becomes the subject of a safeguarding concern, this must be addressed by the responsible CCG using the local safeguarding procedures. CCGs are reminded of their duties under the Care Act 2014 to co-operate with the county council and the county council is reminded of our responsibilities to make enquiries and also our responsibility to ensure, where appropriate, that an individual subject to a safeguarding enquiry has access to independent advocacy.

3.4 Fast Track Pathway for NHS Continuing Healthcare

This is not a social care function but county council staff should be aware that those individuals who are fast tracked may have an existing care package which needs to be ceased.

Individuals with a rapidly deteriorating condition that may be entering a terminal phase may require ‘fast tracking’ for immediate provision of NHS Continuing Healthcare.

3.4.1 Fast Track Pathway Tool

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 a Decision Support Tool (DST). Therefore, the completed Fast Track Pathway Tool, with clear reasons why the individual fulfils the criteria and which clearly evidences that an individual is both rapidly deteriorating and may be entering terminal phase, is in itself sufficient to establish eligibility.

In Fast Track cases, it is the ‘appropriate clinician’ who determines that the individual has a primary health need. The CCG must therefore decide 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.

An ‘appropriate clinician’ is defined as a person who is:

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

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 criteria.

3.4.2 Joint packages of health and social care

If a person is not eligible for NHS Continuing Healthcare, they may potentially receive a joint package of health and social care. This is where an individual’s care or support package is funded by both the NHS and the county council. This may apply where specific needs have been identified through the DST that are beyond the powers of the county council to meet on its own. This could be because the specific needs are not of a nature that the county council could be expected to meet, or because they are not incidental or ancillary to something which the county council would be doing to meet needs under sections 18-20 of the Care Act 2014. It should be noted that joint packages can be provided in any setting.

CCGs should work in partnership with their county council colleagues to agree their respective responsibilities in such cases. These should be identified by considering the needs of the individual. Where there are overlapping powers and responsibilities, a flexible, partnership-based approach should be adopted, including which party will take the lead commissioning role.

Apart from NHS-funded Nursing Care, additional health services may also be delivered by existing NHS services or funded by the NHS, if these are identified and agreed as part of an assessment and care plan. The range of services that the NHS is expected to arrange and fund includes, but is not limited to:

- primary healthcare;
- assessment involving doctors and registered nurses;
- rehabilitation/reablement and recovery (where this forms part of an overall package of NHS care, as distinct from intermediate care);
- respite healthcare;
- community health services;
- specialist support for healthcare needs; and
- palliative care and end of life healthcare.

Subject to the national eligibility criteria for adult care and support and to means testing where appropriate, the county council is responsible for providing such care and support as can lawfully be provided. More information on this can be found in the section on Legislation in the National Framework.

In a joint package of care the CCG and the county council can each contribute to the package by any one, or more, of the following:

a) delivering direct services to the individual
b) commissioning care/services to support the care package
c) transferring funding between their respective organisations
d) contributing to an integrated personal budget

Although the funding for a joint package comes from more than one source it is possible that one provider, or the same worker(s), could provide all the support.

Examples can include:

- an individual in their own home with a package of support comprising both health and social care elements;
- an individual in a care home (with nursing) who has nursing or other health needs, that are beyond the scope of the NHS-funded Nursing Care contribution; or
- an individual in a care home (without nursing) who has some specific health needs requiring skilled intervention or support, that cannot be met by community nursing services and are beyond the power of the county council to meet.

Jointly coordinated CCG and county council reviews should be considered for any joint package of care in order to maximise effective care and support for the individual.

3.4.3 NHS-funded Nursing Care

NHS-funded Nursing Care is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse for those assessed as eligible for NHS-funded Nursing Care. Section 22 of the Care Act 2014 prohibits the county council from providing, or arranging for the provision of, nursing care by a registered nurse, save in the very limited circumstances set out in Section 22 (4).

Any admission to a Nursing home must be arranged following a Registered Nurse Assessment (RNA) having been completed with a copy to LAS. The Registered Nurse will recommend that the person is eligible to receive FNC payment.

This will be paid directly to Nursing Home and is not transferrable to community placement or residential care without a Registered Nurse being on site 24/7.

If an individual is not eligible for NHS Continuing Healthcare, the need for care from a registered nurse may need to be determined. An individual is eligible for NHS-funded Nursing Care if:

- the individual has such a need; and
- it is determined that the individual's overall needs would be most appropriately met in a care home with nursing.

The registered nurse's[8] input is defined in the following terms:

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

'Nursing care by a registered nurse' covers:

- time spent on nursing care, in the sense of care which can only be provided by a registered nurse, including both direct and indirect nursing time;
- paid breaks;
- time receiving supervision;
- stand-by time; and
- time spent on providing, planning, supervising or delegating the provision of other types of care which in all the circumstances ought to be provided by a registered nurse because they are ancillary to or closely connected with or part and parcel of the nursing care which the nurse has to provide.

Eligibility for NHS Continuing Healthcare must be considered, and a decision made and recorded (either at the Checklist or DST stage), prior to any decision on eligibility for NHS-funded Nursing Care. For clarity, people who do not require a full assessment of eligibility for NHS Continuing Healthcare can still be eligible for NHS-funded Nursing Care. If an individual has a negative Checklist this simply means that they are not eligible for, and do not require, assessment of eligibility for NHS Continuing Healthcare at this point in time. However, they may require registered nursing care in a care home with nursing. The decision regarding this must be based on a nursing needs assessment, which specifies their day-to- day care and support needs and how they meet the criteria outlined above. More on NHS-funded Nursing Care reviews can be found below.

Once the need for such care is agreed, the CCG is responsible for paying a flat- rate contribution to the care home with nursing towards registered nursing care costs.

Since 2007, NHS-funded Nursing Care has been based on a single-band rate, set out in the Standing Rules and amended each financial year by the Department of Health and Social Care.

Individuals who are in receipt of NHS-funded Nursing Care are entitled to continue to receive this until on review, it is determined that they no longer have any need for registered nursing care; or they are no longer resident in a care home that provides registered nursing care; or they become eligible for NHS Continuing Healthcare; or they die.

[8] Supreme Court judgment, R (on the application of Forge Care Homes Ltd and others) v Cardiff and Vale University Health Board and others (Secretary of State for Health intervening) [2017] UKSC 56

3.4.4 Equipment

Where individuals in receipt of NHS Continuing Healthcare require equipment to meet their care needs, there are several routes by which this may be provided:

If the individual is, or will be, supported in a care home setting, the care home may need to provide certain equipment in order to meet regulatory standards or as part of its contract with the CCG. Further details of the regulatory standards can be found on the Care Quality Commission's website[9].

Individuals who are eligible for NHS Continuing Healthcare should have the same access to standard joint equipment services as other people. Therefore, when planning, commissioning and funding joint equipment services CCGs should ensure that the needs of current and future recipients of NHS Continuing Healthcare are taken into account.

Some individuals in receipt of NHS Continuing Healthcare will require bespoke equipment (or other non-bespoke equipment that is not available through routes (a) and (b) above) to meet specific assessed needs. CCGs should make appropriate arrangements to assess and meet these and any subsequent equipment needs that might arise, including responsibility for any essential servicing and repair that might be required for particular items of equipment.

CCGs should ensure that there is clarity about which of the above arrangements is applicable in each individual situation, including responsibility for any essential servicing and repair that might be required for particular items of equipment CCGs are reminded of their ability to utilise Personal Health Budgets as a means of meeting equipment needs (including servicing and repair).

Where an individual is assessed in a hospital setting as being eligible for NHS Continuing Healthcare, CCGs must have systems in place to minimise delays to discharge due to equipment provision.

3.4.5 Advocacy

Although not related to the eligibility decision making process, the county council has a duty under the Care Act to promote the wellbeing of individuals at all times. Where relevant, this incudes making arrangements for independent advocacy in relation to safeguarding enquiries relevant to the individual.

3.4.6 Mental Health Legislation (Section 117)

CCGs and the county council should be familiar with the relevant sections of the Mental Health Act 1983.

Under Section 117 of the Mental Health Act 1983 ('Section 117'), CCGs and local authorities have a joint duty to provide after-care services to individuals who have

[9] https://www.cqc.org.uk/

been detained under certain provisions of the Mental Health Act 1983. The duty applies when those individuals cease to be detained and are discharged from hospital (including on Section 17 leave, or under a Community Treatment Order under Section 17a) until such time as the CCG and local authority are satisfied that the person is no longer in need of such services. Section 117 is a freestanding duty to provide after-care services to the individual for needs arising from, or related to, their mental disorder. CCGs and local authorities should have in place local policies detailing their respective responsibilities, including funding arrangements.

The Care Act 2014 introduced a definition of Section 117 after-care services as follows:

'services which have both of the following purposes;

a) *meeting a need arising from or related to the person's mental disorder; and*
b) *reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder).'*

It is important to make a distinction between needs that must be met under Section 117 arrangements, and needs to be met under a different arrangement.

Responsibility for the provision of Section 117 services lies jointly with the county council and the NHS. Where an individual is eligible for services under Section 117 these must be provided under Section 117 and not under NHS Continuing Healthcare. It is important for CCGs to be clear in each case whether the individual's needs (or in some cases which elements of the individual's needs) are being funded under Section 117, NHS Continuing Healthcare or any other powers.

There are no powers to charge for services provided under Section 117, regardless of whether they are provided by the NHS or the county council. Accordingly, the question of whether services should be free NHS services (rather than potentially charged-for social services) does not arise. It is not, therefore, necessary to assess eligibility for NHS Continuing Healthcare if <u>all</u> the services in question are in fact to be provided as after-care services under Section 117.

However, a person in receipt of after-care services under Section 117 may also have ongoing needs that do not arise from, or are not related to, their mental disorder and that may, therefore, not fall within the scope of Section 117. Also a person may be receiving services under Section 117 and then develop separate physical health needs (e.g. through a stroke) which may then trigger the need to consider NHS Continuing Healthcare, but only in relation to these separate needs, bearing in mind that NHS Continuing Healthcare must not be used to meet Section 117 needs. Where an individual in receipt of Section 117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase, consideration should be given to the use of the Fast Track Pathway Tool.

Local policies (currently being developed) should be in place dealing with the approach to Section 117 which should include apportionment of financial responsibility having regard to the nature of the services being provided.

The county council and CCGs may use a variety of different models and tools as a basis for working out how Section 117 funding costs should be apportioned. However, where this results in a CCG fully funding a Section 117 package this does not constitute NHS Continuing Healthcare.

It is preferable for the CCG to have separate budgets for funding Section 117 and NHS Continuing Healthcare. Where they are funded from the same budget they still continue to be distinct and separate entitlements.

The legislation relating to assessment for NHS-funded Nursing Care contained in the Standing Rules, applies to Section 117 individuals as it does to other individuals.

3.4.7 Carers

The important role played by carers is recognised by both central and local government, irrespective of how the cared-for individual has their care funded. CCGs and the county council have a joint responsibility to identify, and work in partnership with, carers and young carers so that they can be better supported to continue with their caring role, if they are willing and able to do so.

Healthcare professionals and social care practitioners should be proactive in identifying carers and be sensitive to the level of support they need and desire. This empathetic approach should be reflected in any Checklist and/or full assessment of eligibility for NHS Continuing Healthcare with carers and family members involved where appropriate.

Consideration should also be given to making a referral for a separate carer's assessment by the county council. Under the Care Act 2014, all NHS bodies have a reciprocal duty to cooperate with the county council in exercise of their respective functions relating to carers of particular relevance is the county council's duty to conduct a carer's assessment 'on the appearance of need for support'. This means that where on the basis of the steps above the CCG believes that there may be a need for support, a referral should be made. This may be particularly relevant where the carer has needs in relation to education, leisure or work (unrelated to their caring role) as these fall outside the scope of NHS Continuing Healthcare but can be addressed through Care Act 2014 provisions.

3.4.8 Transitions

Guidance is currently being developed to inform practitioners of when and how to refer young people in transition to adulthood for assessment for Continuing Healthcare. It will explain what actions should be taken by practitioners to ensure such assessments are carried out in line with national guidance and local policies.

3.4.9 Inter-agency disputes

Disputes between the county council and CCGs

The county council is currently working with NHS colleagues to finalise a Dispute Policy. Further detailed guidance is available at Appendix 5 – National Framework for CHC and FNC

A fundamental principle is for CCGs and the county council to minimise the need to invoke formal inter-agency dispute resolution procedures by, for example:

All parties following the guidance set out in this National Framework;

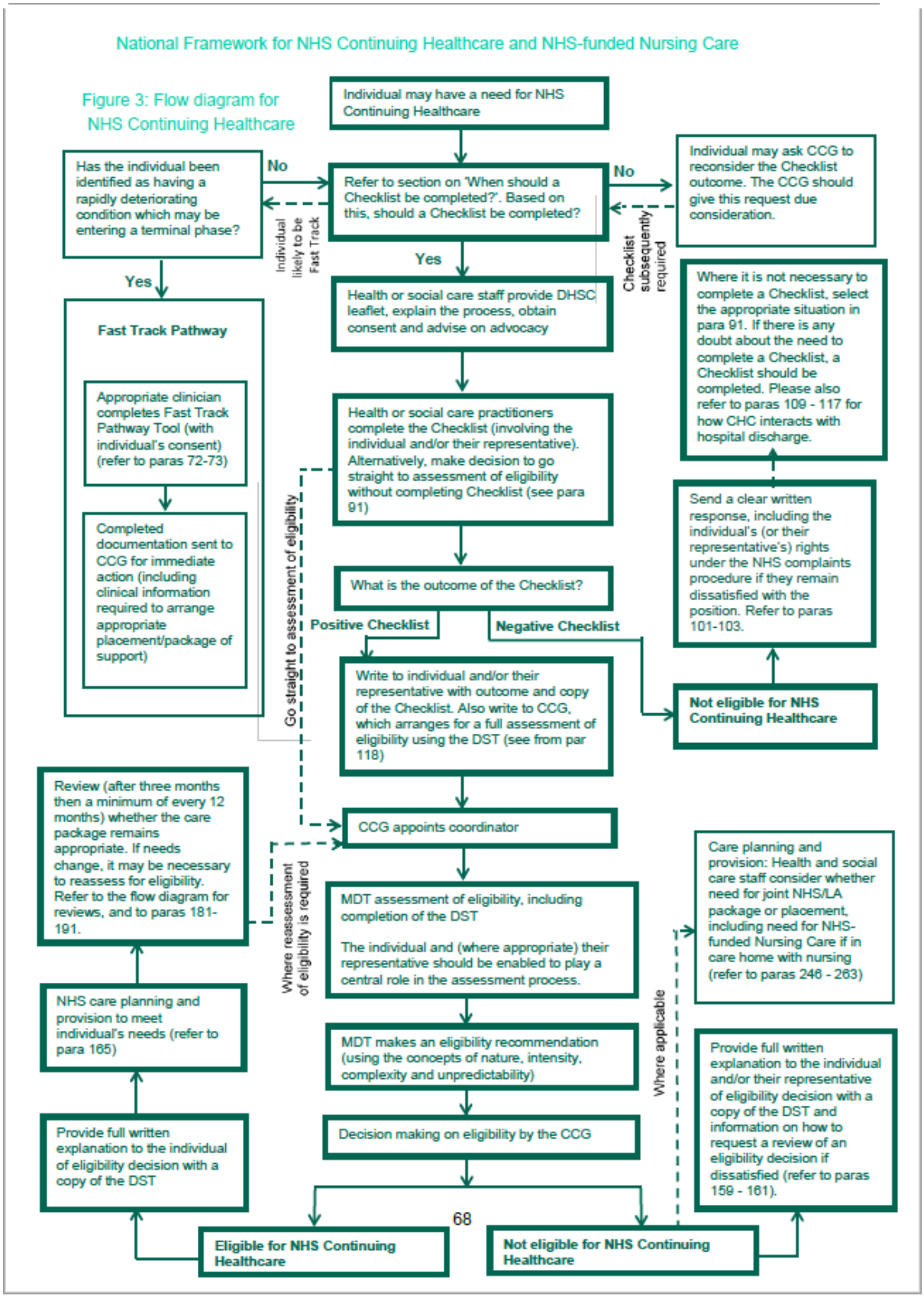
a) agreeing and following local protocols and/or processes which make clear how the CCG discharges its duty to consult with the county council and how the county council discharges its duty to co-operate with the CCG
b) developing a culture of genuine partnership working in all aspects of NHS Continuing Healthcare;
c) ensuring that eligibility decisions are based on thorough, accurate and evidence-based assessments of the individuals' needs;
d) always keeping the individual at the heart of the process and ensuring a person-centred approach to decision-making;
e) always attempting to resolve inter-agency disagreements at an early and preferably informal stage;
f) dealing with genuine disagreements between practitioners in a professional manner without drawing the individual concerned into the debate in order to gain support for one professional's position or the other;
g) ensuring practitioners in health and social care receive high-quality joint training (i.e. health and social care) which gives consistent messages about the correct application of the National Framework.

Individuals must never be left without appropriate support while disputes between statutory bodies about funding responsibilities are resolved.

CCGs and LCC are in the process of agreeing a local disputes resolution process to resolve cases where there is a dispute between them about:

- a decision as to eligibility for NHS Continuing Healthcare, or
- where an individual is not eligible for NHS Continuing Healthcare, the contribution of a CCG or local authority to a joint package of care for that person, or
- the operation of refunds guidance (see Appendix 5).

4. FLOW CHARTS/DIAGRAMS OR EXAMPLES



5. RELATED DOCUMENTS

POLICY, PROCEDURE AND GUIDANCE (PPG) DOCUMENTS	Adult services policies, procedures and guidance (PPG) intranet site Assessment of Needs PPG Advocacy Advocacy IMCA & IMHA
LEGISLATION AND REGULATIONS	• Department of Health and Social Care National Framework for NHS Continuing Healthcare and NHS Nursing Care October 2018 revised • Department of Health NHS Continuing Healthcare and NHS Nursing Care Public Information Leaflet • NHS Continuing Healthcare and NHS Nursing Care Public Information Leaflet – EASY READ VERSION • Department of Health and Social Care NHS Continuing Healthcare Checklist October 2018 (revised) • Department of Health and Social Care NHS Continuing Healthcare Decision Support Tool October 2018 (revised) • Department of Health and Social Care NHS Continuing Healthcare Fast Track Pathway Tool for NHS Continuing Healthcare published December 2018

6. EQUALITY IMPACT ASSESSMENT

The Equality Act 2010 requires the county council to have "due regard" to the needs of groups with protected characteristics when carrying out all its functions, as a service provider and an employer. The protected characteristics are: age, disability, gender identity/gender reassignment, sex/gender, race/ethnicity/nationality, religion or belief, pregnancy or maternity, sexual orientation and marriage or civil partnership status.

The main aims of the Public Sector Equality Duty are:

- To eliminate discrimination, harassment or victimisation of a person because of protected characteristics;
- To advance equality of opportunity between groups who share protected characteristics and those who do not share them. This includes encouraging participation in public life of those with protected characteristics and taking steps to ensure that disabled people in particular can participate in activities/processes;
- Fostering good relations between groups who share protected characteristics and those who do not share them/community cohesion.

It is anticipated that the guidance on NHS Continuing Healthcare in this document will support the county council in meeting the above aims when applied in a person-centred, objective and fair way which includes, where appropriate, ensuring that

relevant factors relating to a person's protected characteristics are included as part of the process.

7. APPENDICIES

1.1. Appendix 1 – NHS CHC Public Information Leaflet
1.2. Appendix 2 – NHS CHC Easy Read
1.3. Appendix 3 – CHC Checklist
1.4. Appendix 4 – CHC Decision Support Tool
1.5. Appendix 5 – National Framework for CHC and FNC