Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2324/179

Subject: Continuing Healthcare Policy

*I can confirm that the ICB **does hold the information requested**; please see responses below:*

QUESTION	RESPONSE
Please provide a copy of your continuing health care policy	The Operational Continuing Healthcare policy is enclosed. The ICB has a commissioning policy for individual funded care: https://bnssg.icb.nhs.uk/library/commissioning-policy-for-individual-funded-care/ The ICB has a PHB policy which relates to Continuing Healthcare: https://bnssg.icb.nhs.uk/wp-content/uploads/2022/06/BNSSG_Personal_Health_Budgets_Policy.pdf

The information provided in this response is accurate as of 1 September 2023 and has been approved for release by Rosi Shepherd, Chief Nursing Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Adults Continuing Healthcare Operational Policy

Shaping better health

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	72
Responsible Executive Director:	Rosi Shepherd, Director of Nursing and Quality
Author and Job Title:	Renata Jerome, Head of Funded Care Operations
Date Approved:	7th June 2022
Approved by:	Governing Body
Date of next review:	7th June 2023

Policy Review Checklist

	Yes / No / N/A	**Supporting information**
Has an Equality Impact Assessment Screening been completed?	Yes	Attached
Has the review taken account of latest Guidance/Legislation?	Yes	Including the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (Department of Health) July 2022 (Revised) NHS England Operating Module for NHS Continuing Healthcare (2015) Full list of relevant policies is included in section 3.

	Yes / No / N/A	Supporting information
Has legal advice been sought?	No	
Has HR been consulted?	Yes	Corporate Policy Review Group – 21/04/22
Have training issues been addressed?	Yes	NHSE e-learning – CHC in house training
Are there other HR related issues that need to be considered?	No	
Has the policy been reviewed by Staff Partnership Forum?	N/A	
Are there financial issues and have they been addressed?	N/A	Resourced from existing budget allocation.
What engagement has there been with patients/members of the public in preparing this policy?	N/A	
Are there linked policies and procedures?	Yes	Please see section 3.
Has the lead Executive Director approved the policy?	Yes	
Which Committees have assured the policy?		Quality Committee May 2022
Has an implementation plan been provided?	Yes	
How will the policy be shared		Via the CCG website.
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	
Has a DPIA been considered in regards to this policy?	Yes	DPIA is not required in this instance.

	Yes / No / N/A	**Supporting information**
Have Data Protection implications have been considered?	Yes	CHC information assets and data flows are reviewed annually with the CCG's Information Governance lead.

Table of Contents

Adults Continuing Healthcare Operational Policy

1 Introduction

The Adults Continuing Healthcare Operational Policy ("**CHC Operational Policy**") sets out the process that Bristol North Somerset and South Gloucestershire ("**BNSSG**") Clinical Commissioning Group ("**CCG**") will follow in the delivery of NHS Continuing Healthcare ("**CHC**") and NHS-funded Nursing Care ("**FNC**"). The policy is aligned to the principles laid down within The National Framework for Continuing Healthcare and Funded Nursing Care 2022 (Revised) ("**the Framework**"). This policy will be framework compliant and will not restate the content of the Framework.

1.1 BNSSG CCG Values

This policy contributes to the CCG values by ensuring that the organisation meets its statutory responsibilities around NHS CHC funded care. This policy will support the CCG to act with integrity, strive for excellence, and ensure we do the right thing in delivering CHC services for the BNSSG population.

2 Purpose and scope

This CHC Operational Policy is the overarching statement of approach for the delivery of the CHC service. This policy applies only to individuals registered with a BNSSG GP at time of referral, who have been referred for assessment by the CHC service, or who have already been made eligible under the Framework. This is inclusive of:

- Adults referred for assessment and awaiting outcome decision.
- Adults receiving CHC funding in any environment.
- Adults receiving Funded Nursing Care (FNC) contributions in a registered nursing home.
- Adults not CHC/FNC eligible but agreed to be covered by NHS/Local Authority (LA) joint funding arrangements after identification of an unmet health need. (See joint funding policy for further description).

3 Duties – legal framework for this policy

The National Framework sets out the principles and processes relevant to CHC and FNC.

The Framework also provides national tools to be used in both FNC, CHC assessments and for Fast Track cases. It concentrates mainly on the process for establishing eligibility for NHS Continuing Healthcare and the principles of care planning and dispute resolution relevant to that process.

This policy should be read in conjunction with:

- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (Revised) 2022
- The National Health Service Act 2006
- The Health and Social Care Act 2012
- The Care Act 2014
- The NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended) ("**Standing Rules**").
- Mental Capacity Act 2005
- The Human Rights Act 1998
- The Equality Act 2010
- BNSSG CCG's Mental Capacity Act and Deprivation of Liberty Safeguards Policy
- BNSSG CCG Commissioning Policy for Individual Funded Care
- BNSSG CCG Personal Health Budgets Policy
- Who Pays? Determining responsibility for payments to providers (NHS England 2020, revised).

With the passage of the Health and Care Bill currently before Parliament the CCG will become an Integrated Care Board (ICB) and references to the CCG shall be read as meaning the BNSSG ICB. It is anticipated this will be effective as of 1 July 2022.

4 Responsibilities and Accountabilities

4.1 BNSSG CCG

BNSSG CCG is responsible and accountable for system leadership for CHC and FNC delivery, including assessment and commissioning arrangements, both on a strategic and an individual basis.

BNSSG CCG has a responsibility to ensure that all commissioned services are safe, equitable, and any identified risks are appropriately and reasonably managed.

4.2 Executive Management Team

The Executive Management Team is responsible for ensuring that sufficient resources are provided to support the requirements of the policy.

4.3 Nursing and Quality Directorate Senior Management Team

It is the role of the Nursing and Quality Directorate Senior Management Team to define CCG policy in respect of CHC and FNC, considering legislative and NHS requirements.

4.4 The Funded Care Team

The Funded Care Team is based within the Nursing and Quality Directorate in the CCG and is responsible for the assessment, care planning, procurement of care, case management, review and support for individuals in receipt of CHC.

4.5 Head of CHC Operations

The Head of service oversees the day-to-day delivery of CHC. Their role is to ensure the service is delivered in line with the National Service Framework for CHC to ensure excellence, fairness and equity.

4.6 Clinical leads

Clinical Leads manage and co-ordinate the CHC teams ensuring the service is compliant with the national service framework in line with NHSE expectations. This role works across BNSSG and includes referral and assessment processes, decision making and case management for all patients.

4.7 CHC Nurse Assessors

CHC Nurse Assessors work within the Funded Care Team and have a primary responsibility for assessing eligibility for CHC and FNC, providing care coordination and case management for individuals found eligible.

4.8 Multidisciplinary Team

In the context of assessing eligibility for CHC funded care, a Multidisciplinary Team ("**MDT**") is a team of at least two professionals, usually from the health and the social care disciplines. The MDT is responsible for making a recommendation to the CCG around whether an assessed individual is eligible for CHC/FNC or not. In BNSSG an MDT will in most case comprise a Nurse Assessor and a Social Worker from the relevant Local Authority.

4.9 Local Authorities

The Standing Rules require CCGs to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for CHC. The National Framework states three main responsibilities for Local Authorities:

- Where it appears that a person may be eligible for CHC, the Local Authority must refer the individual to the relevant CCG.

- 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 CHC.
- 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.

In conducting CHC assessments the CCG will liaise with each Local Authority based upon the assessed individual's ordinary residence status.

4.10 Fast Track Team

The CCG has a dedicated Fast Track End of Life team ("**Fast Track Team**") who have the primary responsibility for screening individuals referred to the service via the Fast Track Pathway Tool for eligibility and access to Fast Track funding. This team is responsible for the case management and onward referrals for all patients eligible for this funding stream.

4.11 Local Resolution and Retrospective Reviews Team

There is a dedicated team of clinicians and administrators who manage the appeals process where the individual or their family/carer/representative disagrees with outcome of assessment. This team will also process applications for retrospective reviews of previous periods of unassessed care and disputes, where a Local Authority disputes the outcome of an assessment.

4.12 Funding Panels

Depending on the complexity of a proposed care package it may be necessary to seek authorisation via an additional funding and decision panel e.g. Complex Case Panel. This panel will consider the level of care needs identified, patient choice, risk, care provision, sustainability and resources available to effectively meet the need of the individual before authorising care provision in line with the Commissioning Policy for Individual Funded Care ("**Commissioning Policy**").

4.13 Brokerage Team

BNSSG CCG utilises two brokerage teams, one based within the CCG serving the Bristol and South Gloucestershire population, and one based within North Somerset Council serving the North Somerset population.

Brokers working within these teams liaise closely with nurse assessors, individuals eligible for CHC and their family/carer/representative(s), and care providers to identify care packages and placements that meet assessed needs.

5 Definitions/explanations of terms used

In addition to the terms described below further definitions are included in the section above.

5.1 Clinical Commissioning Group

Clinical Commissioning Groups ("**CCGs**") are clinically-led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. From 1 July 2022 the NHS Funded Care functions of the CCG will transfer into the BNSSG Integrated Care Board ("**ICB**").

5.2 NHS Continuing Healthcare

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the National Health Service ("**NHS**") specifically for those individuals who are found to have a 'primary health need'. Further information on the Primary Health need test can be found in the National Framework.

5.3 Checklist Tool

The CHC Checklist Tool ("**Checklist**") is a screening tool which can be used in a variety of settings to help health and social care professionals who have received CHC training to identify those who may need a full assessment of eligibility for CHC. It is essential that the appropriate consent is sought prior to commencing this process and that the individual and their representative is involved in this process.

5.4 Decision Support Tool

The Decision Support Tool ("**DST**") is a national tool which has been developed by the Department of Health and Social Care to aid consistent decision making within CHC services. The DST supports practitioners in identifying an 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.

5.5 Care Needs Plan

A Care Needs Plan ("**CNP**") details an individual's identified health needs and how those needs should be met by a care provider. The CNP will be informed by current assessments including those under the Care Act 2014 as well as the individual preferences, where possible.

5.6 Fast Track Pathway Tool

Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require 'Fast Tracking' for immediate provision of CHC. A completed Fast Track Pathway Tool, with clear rationale as to why the individual fulfils the criteria, and which clearly evidences that an individual is both rapidly deteriorating and may be entering terminal phase, is sufficient to establish eligibility with no requirement to complete a DST.

5.7 NHS-Funded Nursing Care

For individuals in care homes with nursing, registered nurses are usually employed by the care home itself. To fund the provision of such nursing care by a registered nurse, the NHS makes a payment direct to the care home. This is called 'NHS-Funded Nursing Care' and is a contribution towards the cost of providing registered nursing care for those individuals who are eligible residing within the home.

5.8 Section 117 Aftercare

If an individual has been sectioned under the Mental Health Act (detained for treatment in a psychiatric hospital), mental health aftercare may be required after discharge from hospital and should be provided free of charge.

This aftercare is given to try to prevent a deterioration in the persons mental health condition and to avoid needing to be re-admitted to hospital

5.9 Discharge to Assess (D2A)

This is a funding stream used to support people to leave hospital when it is safe to allow their care continuing their care and assessment out of the hospital environment and is separate to NHS CHC funding.

6 Consent and Advocacy

The Mental Capacity Act (2005) created a statutory service, the Independent Advocacy service, to support vulnerable people who lack capacity and need support in making important decisions. BNSSG CCG and the individual's Local Authority have a duty under the Act to instruct and consult with an Advocate if the person lacks capacity in relation to the decision and has no family, friends or representative available (or appropriate) for consultation on their behalf.

If an individual has capacity and does not consent to assessment of eligibility for CHC, the potential effect this will have on the ability of the NHS and the Local Authority (LA) to provide care will be explained to them. If an individual does not consent this does not mean the LA acquires additional responsibility to meet their needs, over and above the limit of the LA responsibility.

Where the individual is assessed as lacking the mental capacity either to refuse or consent, a 'best interests' decision will be taken and recorded in line with the MCA 2005. A third party cannot give or refuse consent for an assessment of eligibility for CHC on behalf of a person who lacks capacity to consent to the process unless they have a valid and applicable Lasting Power of Attorney (for health and welfare) or have been appointed as a Deputy by the Court of Protection (for personal welfare).

If an individual does not meet the criteria for the Advocacy service but has no formal representation, they may be represented by a family member or other person to act

on their behalf. When there is no representative available the CCG will ensure that individuals are made aware of local advocacy services, charity organisations that may support and the Local Authority is alerted.

7 CHC Screening

Where there may be a need to consider eligibility for CHC a Checklist should normally be completed by a health or social care professional involved in the patient's care. Such screening should take place at the right time and location for the individual, and when the individual's ongoing needs are known.

There will be many situations when it is not necessary to complete a Checklist, for example, when it is clear to health and social care practitioners that there is no need for NHS CHC referral at this point in time. Such decisions should be recorded, along with the rationale for the decision.

The purpose of the Checklist is to encourage proportionate assessments so that resources are directed towards those who are likely to be eligible for NHS CHC.

A Checklist must include sufficient information to evidence levels of need, and this should be provided at referral to support the outcome. As a minimum the Checklist should record:

- A brief description of the need.
- The source of evidence used to support the statement selected in each domain.

Receipt of completed checklists will be acknowledged by the CCG within one working day. Receipt of the positive Checklist is the start of the 28-day timescale for eligibility decisions. Checklists that are incomplete will be returned to the referrer for clarification within one working day of receipt. Performance against timescales is monitored.

A negative Checklist means the individual does not require a full assessment of CHC eligibility. The individual or referrer may ask the CCG to reconsider the Checklist outcome. The CHC team will give these requests due consideration, taking account all of the evidence presented. There is however no obligation to undertake for the CHC team to undertake a further Checklist; this will be assessed on an individual basis.

7.1 Hospital Discharges

As part of the BNSSG Discharge to Assess ("D2A") process and in line with locally the agreed protocol, a registered health professional within the integrated discharge team will screen patients in the acute hospital for the appropriate D2A pathway.

However, a Checklist may not be completed at this point. The patient will be referred to the CHC team for a full assessment once discharged into the D2A Pathway and screened using the Checklist. The CHC team will assess patients where a positive checklist and consent has been received.

7.2 Checklist triage and Responsible Commissioner

On receipt of a completed referral with valid consent, positive checklist and supporting evidence, the CHC team will allocate a clinician to act as coordinator for the assessment. The clinician will not only coordinate the assessment but support the patient and their representatives in understanding the process and encourage them to contribute.

Prior to carrying out any assessment the CCG will undertake routine responsible commissioner checks as well as ensure that there are no current appeals or disputes with other CCGs. Where checks indicate another commissioner is responsible the CCG will direct the applicant or their representative and Local Authority to that commissioner. Where there is a current appeal or dispute in progress the CCG will be unable to progress any assessment until such appeals or disputes have reached full resolution. In addition, CHC assessments cannot be progressed in situations where the individual's location is thought to be impacting on their health needs or they have not reached their baseline and therefore health needs are unclear.

CHC assessors, where possible, will aim to work in partnership with health and social care professionals, patients and their representatives throughout the process. Where this has not been possible, CHC assessors will demonstrate that reasonable efforts have been made to support partnership working.

If on referral to the service it is deemed that an individual's care provision is insufficient to meet needs, this must be addressed by the responsible commissioner and not delayed until outcome of the CHC assessment. If the individual is at risk due to environment, breakdown of care package or other welfare concerns the assessment *may* not be completed and appropriate liaison will be undertaken to support the required interventions by health and social care teams. Once these interventions have been made and the individual is no longer considered to be in "crisis", a new referral will be undertaken and sent to the CHC team for consideration.

Likewise, if the individual is showing signs of a period of acute ill-health or symptoms requiring investigation, diagnosis, therapy or rehabilitation, the CCG will liaise with the referrer to ensure these are addressed appropriately. The health or social care professional will be invited to refer the patient back to the service once considered medically stable, to have reached their baseline and with no outstanding therapies. This will ensure that an accurate assessment of need can be undertaken.

8 CHC Assessment Process

8.1 Assessment and consent

Although consent for the referral is gained by the originating referrer, the CHC clinician will obtain, and record further consent at the point of full assessment. For those patients who lack capacity to consent, the principles of the Mental Capacity Act will be applied.

Patients, their representatives and advocates will be provided with information to enable them to participate in the process, with a good basic knowledge of the purpose and processes being followed. BNSSG CCG will provide written information, verbal explanation and signposting for more information as required.

The CCG will support the provision of advocacy where this is required and/or requested, to individuals through the process of application for CHC.

The assessment process, information gathering and eligibility decision will be evidence based and transparent throughout. It will result in a comprehensive assessment of need using all available evidence which will be clearly documented in the DST and completed within 28 days of referral. If it exceeds the time frame a clear reason will be communicated to all parties and a record of this kept on the patient database.

Any delay in decision making whether through third party delay, inability of the CCG and LA to agree a recommended outcome at time of assessment or other reason will not disadvantage the patient either financially or through care provision. The CHC team will use the Responsible Commissioner guidance to ensure that care provision and support is in place whilst eligibility is determined.

Assessments will, where possible, be undertaken jointly with the relevant LA and care providers to support a comprehensive MDT assessment of an individual's health and social care needs. Where LA has not been able to provide a representative for the assessment a trusted assessor model will be adopted. This Trusted Assessor (TA) model ensures that the CHC progress with the health assessment and the findings and supporting evidence will be jointly considered with the LA to enable effective and timely decision making.

The Framework highlights that a practical approach to eligibility for CHC is required which considers certain characteristics of an individual's need and the impact on the care delivery. The Framework requires consideration of the nature, intensity, complexity and unpredictability of needs, called the "4 key characteristics", and is clear that identification of one of the characteristics in the health needs of an individual evidences a 'Primary Health Need'.

Deliberation of these issues may help determine also whether the 'quality' or 'quantity' of care required by the individual is greater than the limits of a Local Authority's responsibility as set out in The Care Act. As such the CCG will ensure that its assessing staff understand and apply the Framework guidance and knowledge of the Coughlan test to all eligibility recommendations and decisions.

On allocation of the case to a clinician, they will request additional supporting information from health and social care professionals involved in the individual's care. This will be used to ensure the MDT can work jointly to make a professional judgement on eligibility and this will be reflected in the recommendation. Ideally, supporting evidence should up to date and cover the 3 month period prior to the referral. It is expected that care providers release this information in a timely manner and accept the consent gained during to referral process to facilitate this.

8.2 Multi-Disciplinary decision making

In constituting the MDT, the clinician will consider which health and social care professionals are required to be present, taking into consideration the identified health needs recorded in the documentation. The representatives will be recorded in the documentation. Conflicts of interest will be identified at the start of the MDT and appropriate action taken. The MDT are responsible agreeing the level of needs in each domain, drawing up the 4 key characteristics to describe the totality of need and applying the primary health need test (paragraph 58 Framework) to provide a clear rational for the recommendation on eligibility.

When the MDT has completed their recommendation, this will be submitted to a senior and experienced clinical manager who will ratify the recommendation of eligibility. Senior clinical managers have a good knowledge and understanding of not only the framework but also CCG responsibilities.

Local Authorities must, as far as it is reasonably practicable, provide timely advice and assistance when consulted by the CHC team. 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 LA has carried out an assessment under the Care Act it must (as far as it is relevant) use information from this assessment to assist the CCG in carrying out its responsibilities.

Under local arrangement the LA will be informed by the CHC team of a referral for CHC assessment on day of receipt giving them maximum time to research the patient and identify any social needs that have been highlighted to the LA previously. Further, to support effective partnership working the CHC team will request involvement from the LA using the agreed request format and provide a minimum of a 5 working day notice period, unless under extreme circumstances where the CCG will liaise with the LA and explain the need to expedite the assessment.

Where no MDT assessment has been possible, under the TA model of working, the clinician will contact the LA to discuss the findings and a recommendation. Where a recommendation can't be agreed, the clinician will present the case to an MDT comprised of senior CHC clinician and LA representative who will discuss the recommendations further and act as decision makers. This will follow the decision-making process and be a documented meeting to ensure clear audit trail.

The CHC team seek ratification of cases via the clinical lead nurses and will only use MDT verification in circumstances where a joint recommendation has not been achieved. The following outcomes will be considered:

- Where evidence is poor or clearly omitted, defer the decision pending more information to support the recommendation.
- Where the evidence is contrary to the assessing MDT recommendation, they will be asked to apply further consideration and analysis of the available evidence.
- Validation of the recommendation of the assessing MDT.
- Determine eligibility where the assessing MDT have presented a split recommendation and there are no clear rationales for deferment and all evidence is present.

Professional judgement should apply in all cases and although indicative guidance within The Framework details when eligibility should be expected in relation to agreeing the level of need in each of the domains. The MDT will consider all aspects of need and care provision to provide a clear rationale for decision making.

Once eligibility is established NHS funding will begin, however it is expected that the LA will facilitate transition and support in handing over of the case and will not unilaterally withdraw support. Likewise, if an individual is considered to be no longer eligible for CHC funded care, 28-days' notice will be given to the LA , during which time the CHC team will undertake to ensure the care provided is appropriate and not excessive in nature and facilitate handover to the LA.

In exceptional circumstances and in liaison with the CHC team, the LA may request an extension to the handover period to establish a safe and effective care provision for a patient coming off NHS funding, whether FT or CHC. This is on a case by case basis and exceptional and not standard practice.

8.3 Verification of MDT recommendations

A person only becomes eligible for NHS CHC once a recommendation has been verified by CHC team which is informed by a completed DST or Fast Track Pathway Tool, health assessment and supporting evidence. Accountability will remain with the LA who will remain responsible for coordination and provision of care until

eligibility has been established and effective handover completed. The Funded Care Team may agree to support in specific needs ahead of eligibility decisions, but this will be considered on an individual basis and not become standard practice.

8.4 Disputes

BNSSG CCG has a disputes protocol which has been agreed with LA's across the BNSSG area.

The National Framework gives a clear expectation that there should be a jointly agreed local process for resolving inter-agency disputes about the eligibility of patients for CHC. Such procedures should be conducted with the best interests of the patient in mind and follow clear timescales to avoid protracted periods of uncertainty. It should be noted that NHS England has no formal role in disputes between LA's and CCG's and therefore all disputes will be managed through this disputes protocol.

9 Fast Track CHC

There may be circumstances where an individual not already in receipt of CHC funding has end of life care needs, is presenting with a rapidly deteriorating condition and may be entering the terminal phase of their illness. These individuals may need Fast Track funding to enable their increasing health needs to be urgently met. In these circumstances the application will require 'Fast Tracking' for the immediate provision of NHS funded care rather than following a 28-day CHC process.

It is noteworthy that not all individuals at end of life will need Fast Track funding and many will have their needs met through other pathways. These pathways may include the provision of community nursing services, Marie Curie, Funded Nursing Care in care homes, hospice care or hospital care. These are separately commissioned or funded aside from CHC or FT services.

9.1 Fast Track Pathway Tool

The Framework states the Fast Track Pathway Tool must be applied by an "appropriate clinician". That is clinicians who are responsible for an individual's diagnosis, treatment or care such as a registered medical practitioner and or registered nurse. These can include senior clinicians employed in the voluntary and independent sectors that have a specialist role in end of life needs where the organisation's services are commissioned by the NHS.

Others may identify the fact that the individual has needs for which use of the Fast Track Pathway Tool would be appropriate. In such cases a health or social care professional should be contacted to discuss referral. The Fast Track tool will be used to outline the reasons for the Fast Track referral. The Funded Care team supports the direct involvement of hospital nursing and medical staff in this process to ensure

the timely discharge for these patients, supporting end of life care decisions and providing clear accountability for decision making.

9.2 Fast Track Team triage

Fast Track applications will have a same or next day decision about eligibility made where possible. This is dependent on the application containing appropriate consent, sufficient evidence to support identification of a Primary Health Need due to a rapidly deteriorating condition and clear identification of the correlated increase in needs so a clinically appropriate package of care can be arranged.

9.3 Arranging care and support

Individuals will be supported wherever possible to reside in a place of their choice so that their wishes are respected in line with 'End of Life Care Choice Commitment'. However, the Fast Track team expect that the referrer will have discussed care provision with the patient and / or family as part of the consent process and to support expectations in line with the CCG's Commissioning Policy for Individual Funded Care. This care provision should meet identified needs, sustainable and equitable for all patients across the BNSSG area ensuring a person-centred approach.

The Fast Track team will endeavour to support the patient or their representatives in their preferred options for an individual's end of life care. However, the Funded Care team reserve the right to make decisions about environment, care delivery and provider when there are concerns identified

When the Fast Track application is approved, all care costs including accommodation within care homes should be supported as they would be under normal CHC funding criteria.

9.4 Review of Fast Track

A review of the individual care needs should be undertaken regularly to ensure that care delivery is safe and effective to meet identified needs. 10 weeks following the original funding decision, a full review will be undertaken by a nurse within the FT service to determine if an individual continues to deteriorate and if Fast Track funding is still required. It may be that for some people, their needs have changed and/or stabilised and that they would benefit from a full CHC review to determine continued eligibility. This will be fully explained to the patient and their representative at the time of the review. In line with the framework and the process described above, the LA will be invited to participate in the MDT assessment.

10 Section 117 Aftercare

Section 117 Aftercare is a statutory duty for CCGs and LA's to provide after-care for people who have been detained under the certain specific sections of the Mental Health Act (MHA 1983/2007) and who have needs arising from or related to their mental disorder.

Services provided under Section 117 are specifically intended to reduce the prospect of compulsory or informal readmission to hospital on mental health grounds.

The duties to provide after-care services continue until both authorities are "satisfied" that the person no longer needs after-care services.

An individual can be considered for either Care Act funding or NHS funding if they present with an additional physical need that is not related to their mental disorder covered under Section 117 after care. NHS funding will apply only if that additional health need cannot be met through existing NHS commissioned services. In such circumstances NHS funded or part funded care may be appropriate to ensure that that specific health need can be met.

Therefore, BNSSG CHC team do not expect checklist applications routinely for patients that are under Section 117 aftercare, without a clear indication of the unmet physical health need to be considered.

11 Management of Individual Requests for a Review of an Eligibility Decision

In cases where the eligibility criteria for CHC funding is not met, individual patients or their representative have the right to appeal against the decision within 6 months of receipt of the outcome letter.

When an appeal is received the CHC team will acknowledged this by letter and contact them by telephone to discuss the applicants concerns and to further understand their rationale for requesting a review of the outcome. At this point a clinician will review the case to ensure process has been followed and there are no clear omissions which would've impacted on effective decision making or the validity of the outcome. If process errors or omissions are identified the CHC team may offer a reassessment of needs.

If there is no indication for reassessment at this stage the CHC team will offer an informal local resolution meeting with a senior clinician. If this is declined by the applicant this will be documented and the clinician will proceed to next stage. Notes from the meeting will be sent to the applicant within 15 working days.

Should the informal meeting not provide resolution, the next stage is for this to proceed to a formal resolution meeting where a senior representative from the Funded Care team and a clinician will review the case and the rationale given by the applicant. The applicant may attend to discuss their concerns and reasoning for believing the original decision to be incorrect. The panel will consider relevant existing and new information for the period that is being reviewed. and the decision of the review panel will be formally recorded in writing and shared with the applicant.

The CHC team aims to resolve these cases within 3 months of an application. Once the decision of the formal resolution meeting has been sent out in writing, if an individual or their representative remains dissatisfied they can make an application to NHS England for an Independent Review within 6 months of CCG's decision. The CHC will offer support with this part of the process.

Where both a local resolution request and a dispute from the LA have been received, the dispute will be progressed before the management of any local resolution process as per the local resolution procedure.

In circumstances where there is interagency dispute, the LA will be requested to provide any additional information they may have that is relevant to the period of assessment. A meeting will be convened with the CCG and LA representative to review the presented evidence and will follow the dispute protocol.

12 Retrospective Reviews / Previously Unassessed Periods of Care (PUPoC)

There may be circumstances where an individual not previously screened for CHC believes that they may have had health needs that would warrant consideration for CHC.

In these circumstances the individual or their representative can request a retrospective review of the individual's care needs and eligibility for NHS CHC for cases after 2012.

Retrospective reviews are not subject to the standard 28-day timescale for completion of CHC referral and the CHC team are expected to complete a review within 12 months of receiving the application. The applicant will be informed of the timescale as part of the process explanation to ensure the patient or their representatives know what to expect and understand the process.

The CHC team will only consider requests for retrospective reviews where it is satisfied that one or more of the following grounds for the review exist:

- The CHC team failed to carry out an assessment of eligibility for CHC funding when requested to do so.

- It appears that the patient developed needs after the completion of a checklist.
- No previous assessment of needs was undertaken and there is evidence of health needs requiring care provision.

In the absence of evidence to support any of the above, the CHC team is not obliged to undertake a retrospective review of the patient.

Where a retrospective review is agreed the CHC team will endeavour to gather relevant health and social care records for the period of review. If records cannot be obtained, the CHC team will determine eligibility based on the evidence available and any supporting information the patient or their representative can provide.

Where a retrospective review is undertaken and eligibility agreed, appropriate arrangements will be made for financial recompense in accordance with the Department of Health Guidance for Continuing Care Redress (2015). Reimbursement of all care fees for the agreed period will be made together with interest payments as set out within this guidance.

If a retrospective review is undertaken and patient or their representative is dissatisfied with the outcome, they follow the standard appeal process within 6 months of the decision.

13 Complaints

The CHC team welcome and commit to learn from feedback, keeping the patient central to all processes.

Patients or their representatives can provide feedback about their experience with the CHC team directly by discussing their concerns with a member of the team. This will be managed informally with themes and learning being identified and discussed at monthly Funded Care risk, Audit and Governance meetings. Additionally, individuals may raise a formal complaint in line with the CCGs complaints policy and by contacting the Customer Services Team. Customer Services contact details are available on the CCG website.

14 Deprivation of Liberty Safeguards (DoLS) / Liberty Protection Safeguards (LPS)

The Mental Capacity Act (2005) contains provisions that apply to a person who lacks capacity and who, in their own best interests, needs to be deprived of their liberty in a care home or a hospital, in order for them to receive the necessary care or treatment.

The fact that a person needs to be deprived of their liberty in these circumstances does not affect the consideration of whether that person is eligible for CHC.

There is a set process for this authorisation and legal teams do not usually need to be involved. Where an individual is eligible for NHS Continuing Healthcare and living in their own home and is subject to restrictions that may constitute a deprivation of liberty, the CHC team will complete a Deprivation of Liberty Safeguards (DoLS) assessment and apply to the Court of Protection for authorisation.

The CCG may involve its nominated legal team in this process. Whilst the CCG is responsible for its own associated legal costs it is not responsible for the legal costs of the individual concerned. However, the CCG can signpost to legal advice if desired.

The Department of Health and Social Care plans to implement Liberty Protection Safeguards (LPS) to replace DoLS. This change will incorporate MCA revisions and be a streamlined approach to deprivation of liberty which will be the responsibility of the CHC team for CHC funded individuals.

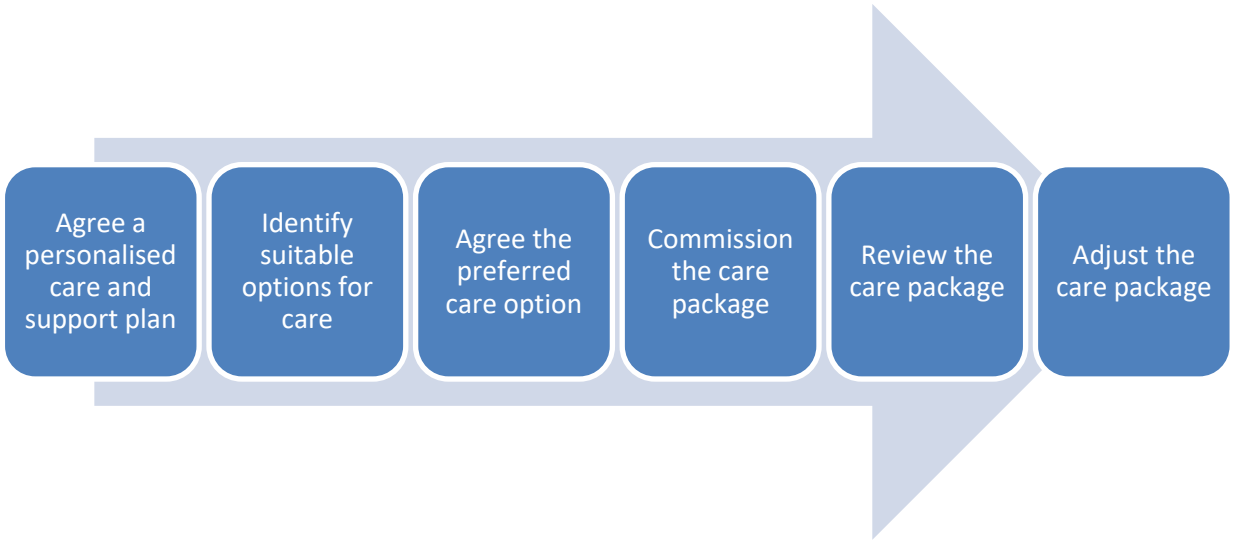
15 Commissioning of Care and Support

The NHS is committed to giving people more choice and control over their healthcare, but must balance this with its financial obligations to the whole population. CCGs also must consider their financial responsibilities when making decisions about whether they will pay for specific care or treatment.

BNSSG CCG will commission healthcare in a manner that reflects the choice and preferences of individuals, whilst ensuring a balance between choice, safety and the effective use of finite NHS resources.

The BNSSG CCG Commissioning Policy for Individual Care ("**Commissioning Policy**") sets out the process the CCG will follow to commission and make provision for equitable, safe and effective care, for individuals who have been assessed as eligible for fully funded NHS CHC**.** The content of the Commissioning Policy is not replicated within this policy, however an overview of the process is included below:

Image 1: Overview of the CHC commissioning process



In view of the need to balance individual preference alongside safety, sustainability, and value for money, BNSSG CCG has developed the Commissioning Policy to support consistent, transparent decision making, and an equitable distribution of NHS resources.

Application of the policy will ensure that decisions about care will:

- be person-centred;
- be robust, fair, consistent and transparent;
- be based on an objective assessment of the individual's clinical need(s), safety and best interests;
- have regard for the safety, sustainability and appropriateness of care to the individual and those involved in care delivery;
- involve the individual and their appointed representative wherever this is possible and appropriate;
- take into account the need for the CCG to allocate its financial resources in the most cost effective way; and
- support individual choice to the greatest extent possible in the light of the above factors.

In instances where more than one suitable care option is available, the Funded Care Team will need to balance consideration of the individual's circumstances with the CCG's responsibility to provide care equitably for its entire population.

For more detail on this please see the Commissioning Policy which can be found on the CCG's website.

16 Equipment

Where a patient in receipt of CHC funding requires equipment to meet their assessed needs, this should be initially sought elsewhere within previously commissioned services. Equipment requests will not routinely be considered by the CHC team, and any deliberation made in full awareness of the following points:

- If the individual is or will be supported in a care home setting; the care home will be required to provide certain standard equipment as part of the regulatory standards.
- Accordance with the principles of eligibility, individuals who are entitled to CHC have an entitlement, on the same basis as other patients to home loan community equipment service which is separately funded.
- PHB's are available for specialist wheelchair services.
- It is acknowledged that some individuals may require specialist equipment not available through the above sources. Therefore, the CCG will consider on an individual basis whether equipment can be purchased in order to meet specific assessed health needs e.g. specialist supported seating. In such instances, a full assessment is to be carried out by the relevant community service. The details of the assessment, recommendations and cost will then be provided for a full funding decision to the exceptional funding stream aside from the CHC service.

17 Reviews

The CHC team will ensure that all individuals in receipt of CHC funding will have a named case manager who will be responsible for ensuring supportive communication with the patient and/or their representative at a frequency determined by clinical need and risks identified. These risks will be highlighted to the clinical leads who will discuss an approach to mitigating risks and ensure proactive case management of any arising concerns. An escalation and reporting route is established to ensure clinical assurance of safety and wellbeing for patients.

The CHC team is also responsible for ensuring all patients have a clear and agreed Care Needs Plan ("**CNP**") detailing their identified health needs and how they should be met by a provider. This CNP will be informed by current assessments including those under the Care Act 2014 as well as the individual preferences, where possible. They will detail how their assessed needs can be safely and effectively met.

The CNP will be informed and agreed by the patient or their representative. Then as part of its commissioning arrangements the CHC team will contract with providers to ensure they draw up a detailed plan of care that meets the assessed needs.

As part of Standing Regulations, if the NHS is commissioning, funding or providing any part of an individual's care, a case review will be undertaken to reassess that

care needs are being met and to a standard expected by the NHS. In terms of CHC eligible patient's this will be done in conjunction with their regular CHC reviews or on identification of any significant change in need.

The CHC team will complete such reviews for patients in receipt of both CHC and FNC contributions. In cases where a joint funding agreement applies, the LA will lead on reviews and invite CCGs to attend, however the CCG will be responsible for reviewing any specific provision of care.

CHC reviews are undertaken at 3 months following the initial eligibility decision and then as a minimum standard on an annual basis. The main aim of the review is to ensure that health needs are understood, and that individual is receiving the care that they require to meet these needs effectively. However, if the assessing nurse feels there has been a significant change in needs, a full MDT assessment and DST will be completed to review CHC eligibility.

CHC eligibility is based on identification of a primary health need and it is recognised that as a patient's needs change, their eligibility for CHC may need to be reviewed. In some circumstances, an individual's needs may change to the point that they no longer display a Primary Health Need. Therefore, the CHC team has a responsibility to ensure that patients and their representatives are aware that funding will be reviewed and removed if indicated and that CHC eligibility is not a permanent decision. Patients and their representatives need to be supported to understand this from first referral to the service to help shape their expectations and provide transparency.

Some cases will require more frequent review in line with clinical judgement and changing needs, but patients should also be reassured that these reviews are primarily needs based and not eligibility focused.

The framework is clear that should a review result in cessation of either CHC or joint funding, neither the CCG team or the LA should unilaterally withdraw funding without allowing for assessment and alternative arrangements to be made within a reasonable timeframe. Therefore, patients will never be without care whilst assessments are being undertaken. To ensure this, CHC team will provide 28-day notice in writing to the LA to allow time to initiate further assessment and expects the relevant LA to engage in an active handover process within this time to ensure seamless support for the patient. Any exceptions to this timescale are to be discussed on individual basis.

18 Jointly funded packages of care

The Framework references the responsibilities of both health and social care to work in partnership to maximise effective care and support for the patient.

This jointly funded provision may be delivered through NHS services such as district nursing, physiotherapy, speech and language and other NHS commissioned services, or a joint package of care with the Local Authority may be agreed if there is a particular identified health requirement which cannot be met through commissioned care.

It may also be applied to those who are found to be no longer eligible for CHC on review but with an identified health need. This may be met if resident in a registered nursing home by the provision of FNC. The decision may be made that an individual meets the criteria for FNC following an assessment of need and the generation of a negative checklist with no requirement for full CHC consideration, or as an outcome of the CHC assessment process where an individual is found not eligible for CHC.

In cases where individuals are awaiting the outcome of the CHC process the CHC team may decide to pay FNC prior to a CHC decision being reached if the process has become protracted and this decision supports the ongoing stability of the care arrangements in the interim.

Requests for consideration of joint funding for an unmet health need should be presented to the CCG for discussion at the Joint Funding Panel, following the agreed joint funding process.

19 Responsible Commissioner

Where there is uncertainty around the responsible commissioner status for a patient, guidance will be sought from the 'Who Pays? Determining responsibility for payments to Providers' 2021 document. This guidance sets out a framework for establishing responsibility for commissioning a patient's care within the NHS and helps to determine which CCG should be responsible for the patient. If further clarity is needed aside from this guidance, the case will be escalated to NHS England for further direction.

20 Funded Nursing Care

Where patients are resident in a registered care home with nursing provision and have identified health needs and are not CHC eligible, consideration should be made by the CCG as to whether they are eligible for FNC contributions towards the cost of their nursing care whilst in the home.

The Framework states that FNC contributions should only be agreed after responsibility for full funding is considered.

If there is a delay in application for FNC from the care home, the Funded Care team will only routinely backdate 3 months from date of application. However, the CHC team will review this on an individual basis upon evidence of exceptional circumstances.

FNC will be reviewed at three months on receipt of a negative checklist and then annually. If a patient has had a full CHC assessment and been considered for CHC funding the reviews will take place annually.

21 Transition from Children's Services to NHS Continuing Healthcare Adult Services

BNSSG acknowledge that legislation, guidance and responsibilities are different in child and adult services. For example, there is no parental responsibility to be considered in adult care and capacity and consent issues are different for children and young people.

It is acknowledged that CCGs and LA's should work together to ensure planning and appropriate referrals are made to support the transition of children to adult services. However, it is also important to note that eligibility for Continuing Care under the Children and Young People's Framework does not mean automatic eligibility under the adult CHC Framework and the young person and their representatives needs to be supported to understand this from point of referral to adult services.

Children's Services should make known to the CHC team those children whom they believe may have need of CHC from the age of 14. This should be followed up by the LA formally referring to the CHC Team when the child or young person is 16.

The CHC team will assess for an indication of eligibility following a young person's 17th birthday and this will be verified by review as near to their 18th birthday as possible so that funding status can be confirmed. The health and social care plans developed as part of the transition process will provide key evidence to be considered in the decision-making process and CHC eligibility will only take effect from their 18th birthday and will not be used to support services or fund care prior to this.

In all cases where there are overlapping responsibilities and regardless of eligibility the Funded Care team and LA will work together to support the transition from child to adult services.

22 Training requirements

Recruitment of registered nurses or allied health and social care professionals to work in this role will be undertaken through verified CCG recruitment processes. Staff will have an enhanced DBS check on appointment arranged by the Recruitment Manager and be able to evidence a recognised registration with the NMC (or relevant regulatory body). This will be rechecked by CHC management team at intervals throughout their employment.

The service will seek to employ staff with a wide range of experience in both physical and mental health conditions and who can demonstrate good communication style, empathy, attention to detail and commitment for the role.

All registered staff will be trained to carry out their role competently starting with a robust local induction programme where core competencies are embedded, supported by online CHC training provided by NHSE and experiential learning supported by mentors and clinical lead. There is also the CCG's mandatory training program to ensure statutory training is completed at agreed intervals.

Quality assurance is supported by Clinical Leads who will undertake spot checks of documentation, verification of each decision against evidence, clinical supervision of the individual staff and group training / support to the teams within the service.

The Framework identifies that the CHC decision making process, from assessment through to recommendation should be multidisciplinary (MDT) in approach. This MDT would usually consist of a Social Worker and a Registered Health Professional such as a nurse or occupational therapist (however, the framework does allow for the MDT to be constituted from two health professionals on different parts of the register). What is clear is that all participants of the MDT should have experience in CHC.

Whilst the CHC team aims to ensure that where possible, all assessments are multidisciplinary, the DST will be completed by the clinician following assessment and review of the health evidence provided. The DST will show evidence and rationale for levels in each domain, consideration of the 4 key characteristics, the primary health needs test and recommended outcome.

Specific training on completion of the assessment process and DST will be provided by the CHC team to each member of staff undertaking this role. However, the LA has a duty to ensure that their staff sent as representatives to MDT assessments and participating in recommendation discussions also have a good working knowledge of the CHC framework and processes. This will ensure that both health and social care professionals are able to effectively discuss levels and application of the 4 key characteristics in order to seek evidence of a Primary Health Need.

Students or Support Workers are welcome to attend and contribute to the MDT process, if the patient and their representative agree, but are not able to make eligibility recommendations as a decision maker as this accountability sits with the health and social care professionals involved who have received CHC training. LA's may delegate this decision-making responsibility to assistant practitioners who work within their CHC services under supervision.

CHC Training is facilitated by the CHC team and LA. This is offered to all hospital, Care Home, community staff and adult social care staff in the BNSSG area. This training includes an overview of the framework, identification of who to refer and when, use of the national tools, the identification of primary health need and the local application process for NHS CHC and Fast Track.

23 Equality Impact Assessment

EIA screening has been completed. Individuals referred into the CHC pathway may present with many of the protected characteristics. The assessment process takes a comprehensive approach to understanding the full picture of needs that an individual has. The process itself places importance on engaging with the individual, their family, and/or representatives throughout.

If eligible, this policy, in conjunction with the Commissioning Policy for Individual Funded Care, and the Personal Health Budgets Policy, enables the CCG to support eligible persons in a highly personalised way, that is tailored to their individual and cultural needs.

24 Implementation and Monitoring Compliance and Effectiveness

The Funded Care Team will ensure that mechanisms are in place to provide assurance on service delivery to include:

- That patient outcomes can be measured against identified need
- Performance standards against NHS England benchmarking
- Internal audits to review quality of service delivery
- Fiscal responsibility and equity in approach
- Peer reviews of decision making (inter-CCG agreement in place)
- Monitoring of risks and incidents arising within the Funded Care team
- Monitoring of feedback, compliments and complaints to show patient experience
- Feedback from NHS England about adherence to CHC framework.

25 Countering Fraud

The CCG is committed to reducing fraud in the NHS to a minimum, keeping it at that level and putting funds stolen through fraud back into patient care. Therefore, we have considered fraud and corruption that may occur in this area and our responses to these acts during the development of this policy document.

In the case of misuse or fraud related to a direct payment, the CCG will seek to recover all appropriate funds. Further detail on this in included within the Commissioning Policy for Individual Funded Care, and the Personal Health Budgets Policy.

26 References, acknowledgements and associated documents

This operational policy should be read in conjunction with:

The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (Department of Health) 2022 (revised)

National framework for NHS continuing healthcare and NHS-funded nursing care - GOV.UK (www.gov.uk)

NHS Continuing Healthcare Checklist (Department of Health) October 2018 (revised)

NHS continuing healthcare checklist - GOV.UK (www.gov.uk)

NHS Decision Support Tool for Continuing Healthcare October 2018 (revised)

NHS continuing healthcare decision support tool - GOV.UK (www.gov.uk)

Fast Track Pathway Tool for NHS Continuing healthcare 2018 (revised)

NHS continuing healthcare Fast Track pathway tool - GOV.UK (www.gov.uk)

NHS England Operating Module for NHS Continuing Healthcare (2015)

NHS England » NHS Continuing Healthcare

Mental Capacity Act 2005

Mental Capacity Act 2005 (legislation.gov.uk)

Who Pays? Determining responsibility for payments to providers

NHS England » Who Pays? Determining responsibility for NHS payments to providers

NHS Continuing Healthcare and NHS-funded Nursing Care *Public Information Leaflet*

Public information leaflet: NHS continuing healthcare and NHS-funded nursing care - GOV.UK (www.gov.uk)

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996

https://www.legislation.gov.uk/uksi/2012/2996/contents/made

National Health Service (Direct Payments) Regulations 2013/1617

https://www.legislation.gov.uk/uksi/2013/1617/contents/made

BNSSG Personal Health Budget Policy.

https://bnssgccg.nhs.uk/library/personal-health-budgets-policy/

Guidance on the legal rights to have personal health budgets and personal wheelchair budgets;

https://www.england.nhs.uk/publication/guidance-on-the-legal-rights-to-have-personal-health-budgets-and-personal-wheelchair-budgets/

Bristol Centre for Enablement Wheelchair & Special Seating

https://www.nbt.nhs.uk/bristol-centre-enablement/referral-centre/wheelchair-special-seating-referral

Guidance on Direct Payments for Healthcare: Understanding the Regulations;

https://www.england.nhs.uk/publication/guidance-on-direct-payments-for-healthcare-understanding-the-regulations/

NHS Continuing Healthcare: Quick guide about personal health budgets and Integrated Personal Commissioning;

https://www.england.nhs.uk/publication/nhs-continuing-healthcare-quick-guide-about-personal-health-budgets-and-integrated-personal-commissioning/

National Framework for Children and Young People's Continuing Care 2016

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499611/children_s_continuing_care_Fe_16.pdf

Section 117 Further Information

Mental Health Aftercare (S117)

https://www.nhs.uk/conditions/social-care-and-support-guide/care-after-a-hospital-stay/mental-health-aftercare/

BNSSG CCGs Commissioning Policy for Continuing Healthcare
https://media.bnssgccg.nhs.uk/attachments/bnssg_commissioning_chc_policy_hTQNWgb.pdf

Policy on the management of Compliments, PALs enquiries and Complaints

https://media.bnssgccg.nhs.uk/attachments/bnssg_complaints_policy_c7Y4GQB.pdf

Exceptional Funding Requests

https://bnssgccg.nhs.uk/individual-funding-requests-ifr/exceptional-funding/

BNSSG CCG Mental Capacity Act & Deprivation of Liberty Safeguards Policy

https://bnssgCCG.nhs.uk/library/mental-capacity-act-and-deprivation-liberty-safeguards-policy/

BNSSG CCG Fraud and Bribery Policy

https://intranet.bnssgccg.nhs.uk/index.php/resources/policies/corporate-policies/1205-bnssg-ccg-fraud-and-bribery-policy-july-2019/file

27 Appendices

Appendix 1. Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
CCG Funded Care Staff	To ensure that all Funded Care Team members are fully briefed on the Operational policy and trained in the processes outlined within it.	Training sessions to be embedded in induction training and cascaded to all existing staff to ensure understanding and application of policy,	Renata Jerome / Donna Witchard	On publication	Within 3 months of publication	Training will be delivered by Funded Care leads and trainers within the team.
External provider staff	To ensure that staff within key partner organisations are aware of the Operational policy.	The Operational policy will be distributed to health and social care agencies involved in CHC work.	Renata Jerome / Donna Witchard	On publication	Within 3 months of publication	Electronic copy of policy and published to CCG website.