Castle Point & Rochford CCG

NHS Continuing Healthcare

Operational Policy

1st January 2017

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Contents

1 Introduction

This Operational Policy is for the delivery of a NHS Continuing HealthCare (NHS CHC) service across Castle Point & Rochford. The service will be delivered by Castle Point & Rochford Clinical Commissioning Group (CP&R CCG), CP&R CCG NHS Funded Health Care Team (FCT) also known as CHC team, in line with the National Framework for NHS Continuing HealthCare and funded nursing care (revised 2012), which sets out the principles and processes for the implementation of NHS Continuing HealthCare & NHS funded-nursing care and it provides national tools to be used in assessment applications and for Fast Track cases. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

The Department of Health (DH) published the revised Framework in November 2012, which does not change the basis of eligibility decisions for NHS Continuing HealthCare and NHS funded-nursing care, or the overall principles, but seeks to provide greater clarity in the descriptions within the needs domains of the Checklist and the Decision Support Tool, giving greater clarity about the levels and types of need to be considered, as well as changes to the wider information that needs to be recorded and the Fast Track Pathway Tool.

This policy describes the processes that will be followed in CP&R CCG and should be read in conjunction with other supporting documents, such as:

- The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (DH, 2012, revised)
- NHS Continuing HealthCare Practice Guidance
- Who pays? Establishing the Responsible Commissioner (DH 2013)
- The National Health Service Commissioning CCG and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013
- National Framework for Children and Young People's Continuing Care (DH 2016)
- Essex-wide policies; such as Disputes policy, Children & Young People's Continuing Care policy, Without Prejudice.

2 Purpose and scope

This policy sets out the roles, eligibility and responsibilities for health for the delivery of the National Framework for NHS Continuing HealthCare & NHS funded-nursing care within the CP&R CCG area. It provides the process for determining eligibility for CHC funding and the procedures to be followed. The policy also sets out the responsibilities of CP&R CCG in those situations where eligibility for NHS CHC has not been agreed, and for the management of situations that may arise as a result of NHS CHC eligibility decisions.

The policy describes the way in which CP&R CCG will commission care in a manner that supports patient choice and preferences, whilst balancing the requirement that CP&R CCG work with the financial limit allocated to the organisation.

This policy applies to all NHS CHC applications for adults 18 years or older who are registered with a CP&R General Practice or who are resident within the area covered by CP&R CCG NHS Funded Health Care Team (FCT) and are **not** registered with a General practitioner elsewhere. This includes all care groups including:

- Physically Disabled
- Older People
- Learning Disabilities
- Young people in transition
- People with an organic mental health condition
- Functional Mental Health
- Acquired Brain Injury

These procedures do not apply to:

- Children (below age 18)

3 Definitions

Continuing care	Care provided outside of a hospital to patients with long-term health or social care needs; may include joint health and social care funding.
NHS Continuing HealthCare (CHC)	Care provided and solely funded by the NHS
Care packages	Suite of intervention services (nursing, therapies, home care etc.) that are designed to match the assessed needs of a client/patient.
Care plan	Plan drawn up by a clinician/Carer to meet the needs of a patient/client, centered on the DST outcomes, which establishes the Primary health needs, NHS Funded Care Team to monitor quality of care provider documentation at review.
Health Needs Assessment HNA	An assessment undertaken by a registered Nurse, that identifies individual patient needs, including issues, frequency and stability. The output of a HNA can be used to inform Care Planning.
CHC Checklist	A standardised National Tool used to identify whether someone's needs warrant consideration against the eligibility criteria, or not. A positive Checklist outcome does not indicate CHC eligibility, but that the person has some level of need, which warrants a formal assessment against the eligibility criteria.
Decision Support Tool (DST)	A standardised National tool used by clinicians to collate the needs of a patient. The outcome of the Decision Support Tool is used to consider the eligibility of a client/patient to a NHS funded package.
CHC Panel	A Panel of Health & Social Practitioners, coordinated by the CCG, that review the MDT recommendations of eligibility for CHC funding, based on the Decision Support Tool and the overall assessed level of need. The panel may invite a family representative to join the panel in an advisory capacity. This panel will be arranged when required; it is anticipated that most issues should be resolved prior to this level of escalation.
Case manager/ Nurse Assessor	An NHS employed registered nurse to coordinate drawing-up a care plan; monitoring the needs of the clients/patients receiving a care package and assessing the suitability of the package.

4 Responsibilities

4.1 Function/ Responsibilities
Health & Social Care staff referring clients for consideration of eligibility

• Complete the required documentation; Needs Assessment Checklist, Fast Track and Decision Support Tool (DST) on time and in line with national timelines, including the provision of supporting evidence; in most situations this should be considered to be:
  • Copy of assessment undertaken to inform Checklist/DST
  • Copy of any risk assessments undertaken
  • Checklist of DST should contain indications of frequency; dates/number of incidences

NHS Trusts (Acute/Community)
• Complete the required documentation, Checklist, Fast Track and Decision Support Tool (DST) on time and in line with national timelines, including the provision of supporting evidence in line with National Health Service Act 2006 The Delayed Discharges (Continuing Care) Directions 2013
• Provide appropriate supporting information, such as care plans, risk assessments etc. to evidence care needs
CP&R CCG NHS Funded Care Team (CCG FCT) Clinical
• Receive and review all Checklists and Fast-Track Tools to ensure the standards required are met and that they recommend against eligibility for receipt of service or further assessment for eligibility. All submitted documents must be accompanied by Mental Capacity Assessment and completed consent form.
• Maintain the CHC allocation lists, patient files (including Electronic Patient Records) and data base ensuring all referrals are recorded and that all correspondence is kept in an electronic format, for each individual patient.
• CHC Case Manager/Nurse Assessor allocated to each case and liaises with the referrer, A Multi-Disciplinary Team (MDT) meeting is arranged and evidence may be collected prior to the meeting to support the assessment process. The CHC Case Manager/Nurse Assessor facilitates a Health Needs Assessment, Care Plan and Checklist/DST, including identification of a primary health need, a recommendation for eligibility and ensuring case is ready for ratification.
• Ratification of completed DST in accordance with the National Framework supported by robust clinical evidence and in an appropriate manner and that it has a clearly stated recommendation from the MDT who have completed it seeking further clarification as required.
• Ensure a social care practitioner has had the opportunity to be involved in the assessment, either as part of the MDT, or via secondary involvement, such as dial-in at the time and has signed the recommendation or that it is recorded on the database why they have not done so.
• Validation of Checklists, DST's and Fast Tracks will be completed within 48 hours with most being validated within 24 hours.
• If the MDT recommendation is validated; as part of 'Business As Usual'(BAU), or by the CHC panel, the CCG FCT will arrange the package of care, based on the needs of the individual and provide costing's of the package of care to the Chief Nurse for approval, where required; subject to agreed
• If the individual is not eligible for NHS CHC but is entitled to NHS Funded Nursing Care (FNC), the CCG FCT will arrange for the payments to be made to the care home in a timely manner.
• Record all eligibility/panel recommendations in individual's electronic patient records and ensure all communication of validated recommendations is undertaken in a timely and professional manner.
• Ensure patient case management arrangements are in place.
• Ensure reviews are undertaken in line with identified patient needs and national policy, as required.
• Undertake regular audit to ensure service is meeting agreed KPIs including patient, staff and customer feedback.
• Ensure CP&R CCGs Quality and Safeguarding professionals are alerted to issues with care providers which may compromise quality of care.

CHC Panel
• Consider all referred recommendations for CHC eligibility in a timely and robust manner where required (Complex cases where a recommendation cannot be agreed) focusing on the clinical evidence supporting the MDT recommendation.
• Consider all referred recommendations for CHC eligibility , where local resolution has not resolved an appeal by the patient, their representative or the Local Authority
• Provide the CCG FCT with written output, which outlines the nature of evidence considered, the discussion which took place and the consideration of the MDT recommendation. Where the panel does not validate the MDT recommendation, a clear rationale should be provided as to why the panel did not validate the recommendation and which areas may require further exploration or consideration. The panel cannot overturn a decision and make an alternative recommendation; unless exceptional circumstances (National Framework NHS funded CHC and funded nursing care 2012, Practice Guidance 41 pg 82).
CP&R CCG NHS Funded Care Team Business Manager/Clerical.
• As much as is possible, to try to ensure that an appropriate selection of packages are offered to each patient, based on their individual Health Needs or care plan
• Review all complex packages of care ensuring the most efficient and safe has been considered.
• Approve the placing of contracts for packages up to the manager's delegated limit.
• Seek assurances that providers are fit and proper organisations to provide care.
• Seek waivers to Standing Financial Instructions where this is necessary.
• Ensure that a database of clients and packages is maintained.
• Authorise invoices up to the manager's delegated limit.
• Agree the cost of the NHS share of joint funded packages.
• Approve one-off payments up to the manager's delegated limit, or escalate as appropriate.
• Consider opportunities to commission differently, to maximise the effectiveness for NHS funded care.
• Maintain a database of accredited providers.
• Seek assurances that the providers on the list have CQC accreditation.
• Negotiated prices and terms and conditions for services offered by providers on the list.
• Monitor the usage of Personal Health Budgets ensuring quality of provision and value for money
• Develop contracts with providers that ensure high quality care delivery, meets the needs identified in the care plan and is value for money.
• Monitor all contracts.
• Forecast likely spend for each year based on historic trends.
• Arrange for the DST to be presented to the CHC Panel, by the author of the DST, along with any supporting information. Quality monitoring must be in place to ensure that the CHC process is robust.
• Write to referrer and patient or their representative with the outcome and how to appeal if non eligible.
Chief Nurse
• Periodically review delegated limits for managers working in this area
• Review and approve requests for waivers from Standing Financial Instructions
• Periodically authorise counter-fraud audits

- Initiate audit-monitoring of systems and processes, based upon Team output, activity, but no less frequently than annual

5 Principles

5.1

Continuing Care means care provided over an extended period of time to a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness.

NHS Continuing HealthCare means a package of continuing care arranged and funded solely by the NHS. (National Framework for NHS Continuing HealthCare & funded- nursing care. 2012, DoH)

5.2

An individual who needs "continuing care" may require services from NHS bodies and/or from Local Authorities. Clinical Commissioning Groups have responsibility to ensure that the assessment of eligibility for NHS CHC is completed within 28 days from the receipt of the CHC Checklist and in a consistent fashion.

5.3

CP&R CCG and Essex County Council (ECC) are committed to working in partnership to review and monitor these timeframes, together with local provider services.

5.4

The principles underlying this policy are that the residents of Castle Point & Rochford have fair and equitable access to NHS funded Continuing Healthcare. These principles are:-

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

- If the individual lacks the mental capacity either to refuse or consent, a 'best interests' decision should be taken and recorded in line with the Mental Capacity Act 2005 as to whether to proceed with assessment for eligibility for NHS Continuing Healthcare. A third party cannot give or refuse consent for an assessment of eligibility for NHS CHC on behalf of a person who lacks capacity, unless they have valid and applicable Lasting Power of Attorney for Welfare or have been appointed as a Deputy by the Court of Protection for Welfare only. CP&R CCG will act in the best interest of the individual and convene best interest meeting if there is a dispute and no one has power of attorney.

- The NHS Funded Care Team will work in partnership with individual patients, their families and social care professionals, throughout the process.

- All individual patients and their representatives will be provided with information to allow them to participate in the process, as much as is practicable. However, where there is a clinical need, the need for review/assessment will take precedence over representative availability.

- CP&R CCG will support the use of advocacy for individuals through the process of application for NHS Continuing Healthcare, as in other services where advocacy is required.

- The process and mechanism for making decisions about eligibility for NHS CHC will be clearly set out for individual patients and their representative and for partner agencies.

- Once an individual has been referred for a full assessment for NHS Continuing Healthcare, following the completion of a Checklist, all assessments will be undertaken ensuring, as much as possible, a comprehensive multi-disciplinary assessment of an individual's health and social care needs.

- Assessments and decision making about eligibility for NHS CHC will be undertaken within 28 days of the completion of the CHC Checklist to ensure that individuals receive the care they require in the appropriate environment and without unreasonable delays

6 Procedures

6.1 Eligibility for NHS Continuing HealthCare (CHC)

The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (revised, 2012) provides a consistent approach to establishing eligibility for NHS Continuing Healthcare. This is achieved through the use of the revised National Tools and Guidance developed to assist in making decisions about eligibility for continuing healthcare.

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

Where a person is identified as having a "primary health need" , they are considered to be eligible for NHS Continuing Healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs from the assessment process. Where an individual has a primary health need, the NHS is responsible for providing all of the care to meet that need, including accommodation, if that is part of that need.

Consideration of primary health need includes consideration of the characteristics of need and their impact on the care required to manage the needs. In particular to determine whether the quantity or quality of care is more than the limits of responsibility of Local Authorities (as in the Coughlan Judgment).Consideration is given to the following areas:-

- **Nature and type of need:** the particular characteristics of an individual's needs and the overall effect of those needs on the individual, including the type of interventions required to manage them
- **Intensity of need:** both extent (quantity) and severity (degree) of the needs, including the need for sustained care (continuity)
- **Complexity of need:** how the needs present and interact to increase the skill required to monitor and manage the care. This may arise with a single condition or the interaction between numbers of conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs
- **Unpredictability of need:** the degree to which needs fluctuate, creating difficulty/challenges in managing the need. It also relates to the level of risk to the person's health if adequate and timely interventions/care are not provided

To minimise variation in interpretation of the principles and to inform consistent decision making, the NHS CHC Decision Support Tool has been developed for use by practitioners to obtain a full picture of needs and to indicate the level of need that could constitute a primary health need. The Decision Support Tool combined with the practitioners own experiences and professional judgment should enable them to apply the primary health needs test in practice in a way which is consistent with the limits on what can be legally provided by a Local Authority.

Eligibility for NHS CHC is based on an individual's assessed health and social care needs. The

Decision Support Tool provides the basis for decisions on eligibility for NHS funded continuing healthcare. The Decision Support Tool must be completed by the multi-disciplinary team, which as a minimum should include a health professional and a social care practitioner, or two healthcare practitioners from different specialties. Wherever possible, Social care staff should be involved in the completion of the Decision Support Tool. Specialist staff and mental health staff should also be involved, dependent on the individual's needs.

The multi-disciplinary team will make recommendations on eligibility of the individual patients/clients for NHS funded CHC to the NHS CP&R CCG. The CCG will consider the MDT recommendation and can make the following decisions with regard to recommendations about eligibility for NHS Continuing Healthcare:-

- Validate the recommendations of the multi-disciplinary team
- For cases where a decision has not been agreed, pass recommendation to CHC Panel for consideration
- To ensure the appropriate cessation of CHC funding from an individual who is currently in receipt of it, if the multi-disciplinary team recommendation is no longer eligible for NHS Continuing Healthcare.
- Where the evidence provided does not support the level of need indicated in the Decision Support Tool, the CCG will not validate the recommendations of the multi-disciplinary team. A full written detailed explanation of the decision will be provided to the applicant and/or their representative
    - Defer the decision and request further evidence to support recommendation and consequently decision on eligibility
    - Or request the MDT reconsider the recommendation, in light of the supporting evidence and comments from the eligibility panel.

Alternatively, where the information provided is insufficient to validate a DST, but the recommendation is for eligibility, the CCG FCT may choose to reject the CHC assessment, but agree to fund the care until a community-based assessment has been undertaken (NHS Funded Discharge Process)

6.2 <u>Application for eligibility process</u>

The first step in the process for the majority of people will be the screening process using the NHS CHC Checklist. The purpose of the Checklist is to encourage proportionate assessments so that resources are directed towards those people who have a higher level of need and therefore may be eligible for NHS Continuing Healthcare.

Before applying the Checklist, it is necessary to ensure that the individual and their representative, where appropriate, understand the Checklist cannot identify that the individual will be eligible for NHS Continuing Healthcare, only that they are entitled to consideration for eligibility. At this stage, the threshold is set deliberately low to ensure that all those who require a full consideration of their needs get the opportunity.

A nurse, doctor or other qualified healthcare professional or social care practitioner can apply the Checklist to refer individuals for a full consideration of eligibility from within the community or hospital setting. Whoever applies the Checklist will have to be familiar with, and have regard to, the National Framework for NHS Continuing HealthCare & NHS funded- care (DoH 2012) and the Decision Support Tool.

All appropriately completed NHS CHC Checklist with a consent or MCA and best interest assessment, should be sent to the NHS Funded Care Team at:

Castle Point & Rochford NHS Funded Care Team, Castle Point & Rochford CCG, 12 Castle Road, Rayleigh SS6 7QF

Secure email: cprccg.chc@nhs.net

The CP&R CCG NHS Funded Care Team currently operates Monday to Friday only; 09.00-17.00.

Receipt of the completed Checklist and consent is the start of the 28 day target for eligibility decisions and will ensure that monitoring of timelines and activity takes place.

In a hospital setting, before a NHS body gives notice of an individual's case to a Local Authority in compliance with the Care Act (2014), it must take all reasonable steps to ensure that NHS CHC is considered in all cases where it appears to the body that the patient may have eligibility for such care. The Checklist should therefore be considered, where relevant, as part of the discharge process.

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 consideration of eligibility, consideration must be given to the person's further potential for rehabilitation and for increased independence to be achieved, and how the outcome of any treatment or medication reviews may affect on-going needs.

If completion of the screening Checklist indicates that the individual patient is entitled to a full assessment to determine their eligibility for NHS funded continuing healthcare, a health needs assessment and care plan should be undertaken to inform the completion of the Decision Support Tool.

The completed Decision Support Tool provides practitioners with a framework to bring together and record the various needs in the 'domains' specified within the tool. The multi-disciplinary team use the Decision Support Tool to apply the primary health needs test, ensuring that the full range of factors which have a bearing on the individual's eligibility are taken into account in making their recommendation.

The Decision Support Tool should be used following a comprehensive multidisciplinary assessment of an individual's health and social care needs and their desired outcomes. If a multidisciplinary assessment has recently already been completed, this may be used but care should be taken to ensure that it provides an accurate reflection of current need.

The Decision Support Tool is not an assessment in itself. Rather, it is a way of bringing together and applying evidence in a single practical format, to facilitate consistent, evidence-based decision-making regarding NHS continuing healthcare eligibility. The evidence and the decision-making process should be accurately and fully recorded.

Once the multi-disciplinary team has reached agreement they make their recommendation on eligibility, recorded on the Decision Support Tool, to NHS Castle Point & Rochford CCG.

CP&R CCG reviews the applications they receive to ensure consistency and quality of decision making processes and to ensure governance of the decision making on eligibility. This process ensures equity of access to NHS funded CHC and consistent decision making for all applications.

A person only becomes eligible for NHS CHC once ratification of the recommendation has been completed by the NHS Funded Care Team, or CHC Panel, informed by the completed Decision

Support Tool or Fast Track Tool. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment.

Where individuals are found to be eligible for NHS funded continuing healthcare, funding will be agreed from the date of the decision of the DST assessment. Fast Track applications will be funded from the introduction of the agreed package of care.

6.3 Fast Track Applications

The Fast Track application is there to ensure that individuals who have a "**rapidly deteriorating condition,** which may be entering a terminal phase", get the care they require as quickly as possible. No other test is required.

The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2012. DoH) provides the Fast Track Tool for use in these circumstances. The Fast Track Tool needs to be completed by an 'appropriate clinician' described in the National Framework as:

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

The completed Fast Track Tool should clearly state the patient's **diagnosis, prognosis and current condition**, as this will enable approval to take place immediately upon receipt of the document.

Others involved in supporting those with end of life needs, including those in the voluntary and independent sector organisations may identify the fact that the individual has needs for which use of the Fast Track Tool would be appropriate. They should contact the appropriate clinician.

CP&R CCG supports the direct involvement of hospital 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.

Once the required care provision is deemed to be in place, the purpose for the Fast Track will have been discharged. A CHC Case Manager/Nurse Assessor should arrange for a follow-up review to ensure that the provided care is meeting the identified needs. Where the nature of provided care does not appear to indicate a primary health need, a formal CHC assessment should be considered.

The CP&R CCG NHS Funded Care Team currently operates Monday to Friday only; 09.00-17.00.

The procedure for Fast Track applications covering Monday to Friday is set out in Appendix 3, and ensures that same day decisions about eligibility for NHS funded CHC can be made to support the preferred priorities of the individual for their end of life care, where possible. For patients discharged from hospital over the weekend under the Fast Track guidance Castle Point & Rochford CCG will require the fully completed Fast Track Tool on the next working day

Use of Fast Track applications will be closely monitored by CP&R CCG and action taken where improper use of the process is felt to have occurred.

7 Management of Appeals

7.1

The decisions of CP&R CCG are communicated to the individual patients, or their representative, in writing and to lead health and social care professionals making the application. The decision is

communicated in writing within 5 working days of the validation. The patient, or their representative, and the lead health and social care professionals making the application can be informed verbally of the decision, if they have not been present and pending receipt of the formal correspondence.

7.2
Where an application has been recommended to be not eligible, individual patients can appeal the decision in writing within 6 months of the notification of eligibility decision. A request for an appeal can only be made once the recommendation has been validated by CP&R CCG. The decision will remain unchanged until such time as it is overturned.

When an appeal is received this is acknowledged and the evidence is reviewed by a senior Lead Nurse and if the appeal cannot be resolved at this stage an offer of an informal resolution meeting with the individual patient or their representative is made to go through the process of decision and rationale for the decision.
Appeals in the first instance should be sent to:-

NHS Castle Point & Rochford CCG
NHS Funded Care Team
Pearl House 12
Castle Road
Rayleigh
Essex SS6 7QF

Email: cprccg.chc@nhs.net

If, as a result of the Local Resolution process the decision is overturned, NHS funding will normally be back dated to the date when the date of the DST MDT recommendation was undertaken to which the appeal period relates to was completed.

- Any refund will be in line with the Refunds Guidance incorporated in The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care, 2012.
- A copy of this procedure will be sent to all those who wish to challenge a decision regarding eligibility.

7.3
If following informal resolution the patient or their representative remains unhappy with the CCG's decision, a hearing will be arranged of the CP&R CCG CHC Local Review Panel. The members of the Review Panel will not have been involved with the initial decision makers that reviewed the eligibility application.

7.4
The individual patient, or their representative, will be invited to submit evidence as to why they disagree with the CCG's decision and to specify those areas of disagreement. Families and individuals are encouraged to attend Local Review Panel meetings to participate in the discussions.

7.5
Where an individual remains dis-satisfied by the Panel outcome they can request an Independent Review by writing to the NHS Commissioning CCG at:

NHS England Midlands and East
Victoria House
Capital Park
Fulbourn
Cambridge

CB21 5XB

Tel: 0113 825 5320

The Independent Review (IR)'s key tasks are, at the request of the CCG, to conduct a review of the following:

a) The procedure followed by a CCG in reaching a decision as to that person's eligibility for NHS Continuing Healthcare; or
b) The application of the primary health needs decision by a CCG.

They are also required to make a recommendation to the CCG in the light of its findings on the above matters. It is particularly important that, before an IR is convened, all appropriate steps have been taken by the relevant CCG to resolve the case informally, in discussion with the CCG where necessary. The CCG should have a named contact, which is the first port of call for queries from partner organisations for the relevant locality.

No individual should be left without appropriate support while they await the outcome of the review. The eligibility decision that has been made is effective while the independent review is awaited.

7.6
The CCG will continue to fund the package of care pending the outcome of the Local Review Panel, or sooner, if the complainant is unable to agree to attend the panel within a reasonable time frame. If the CCG decision is upheld and the patient is deemed no longer eligible for NHS CHC funding, the CCG will cease funding care within a 2 week notice period.

7.7
The Local Authorities and their employees are not able to appeal against a decision made by NHS Castle Point & Rochford CCG on behalf of a client. Appeals may only be made by individual applicants themselves or their representative. If Essex County Council disagrees with the CCG outcome, they should use the jointly agreed **Continuing Healthcare Disputes Agreement**.

8 Complaints

If an individual patient or their representative is dissatisfied with the manner in which the overall process has been conducted rather than specifically the outcome regarding eligibility for NHS Continuing Healthcare, they may make a complaint to CP&R CCG through the NHS Complaints Procedure.

Complaints should be sent to:-

CP&R CCG Complaints
Manager NHS Castle Point
& Rochford CCG
Pearl House
12 Castle Road
Rayleigh
Essex SS6 7QF

Email:
cprccg.complaints@nhs.net

9 Disputes raised by the Local Authority

9.1
ECC Adult Social Care services are invited, wherever possible, to participate in all NHS CHC assessments as a means of ensuring full health and social care assessment takes place within the nationally stipulated timeframes.

9.2
Where ECC-invited attendance is not available for any reason, the CCG will maintain its responsibility to the patient and ensure the assessment is undertaken at the agreed time. The Social Worker will be offered the opportunity to participate via dial-in. Once completed, the assessment will be shared with ECC for comment regarding the assessment information and the recommendation based upon it. This will ensure the CHC process remains in line with National Guidance. **(*National Framework 2012. p.75 31.2 / 31.3*)**

9.3
For ECC dispute for a decision that is validated by CP&R CCG, in respect of an application for NHS Continuing Healthcare. This also applies to other Local Authorities that may have submitted an application to NHS CP&R CCG.

9.4
In these circumstances the CP&R CCG Disputes policy for the resolution of Disputes for NHS funded CHC will be implemented. (**Continuing Healthcare Disputes Agreement – Appendix X**)

9.5
CP&R CCG and ECC subscribe to the principle that there should be no delay in the provision of services due to disagreements or disputes on the assessment recommendation or outcome of eligibility. Should such situations arise, the National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2012, DoH) is explicit in stating that any existing funding arrangements cannot be unilaterally withdrawn without the agreement of the other organisation.

9.6
Therefore anyone in their own home, or care home funded by the Local Authority must continue to be financially assisted by the Local Authority until the dispute is resolved. Similarly, anyone in hospital, or funded by the NHS must remain funded by the NHS until the dispute is resolved.

9.7
CP&R CCG and ECC agree to adopt a **"without prejudice"** approach to such situations whereby the final outcome of the dispute will be backdated to the time of the date of disputed Decision Support Tool. **(Annex F: Guidance on responsibilities when a decision on NHS CHC eligibility is awaited or is disputed, National Framework 2012)**. This means if ECC has continued to fund an arrangement that was subsequently decided to be NHS Continuing Healthcare, CP&R CCG funding should be backdated to the date of the DST recommendation and the individual should also be reimbursed any charges that they have paid during the interim period.

9.8
Similarly, where CP&R CCG has continued to fund an arrangement that subsequently is decided to have been a Local Authority responsibility, The Council will reimburse CP&R CCG to the date of CHC recommendation.

10 Discharge Planning

10.1
In a hospital setting, before an NHS Trust, NHS Foundation Trust or other provider organisation gives notice of an individual's case to ECC, it must take reasonable steps to ensure that an assessment for NHS CHC is considered in all cases where it appears to the body that the patient may have a need for such care. This should be in consultation, as appropriate, with the relevant LA or CCG.

10.2
Completion of the screening Checklist and, where relevant, the Decision Support Tool should be undertaken as part of the assessment and care planning process for discharge arrangements for individual patients. This should be commenced as early as possible once the patient is being considered for discharge to reduce inappropriate placements, multiple patient moves and minimal need for interim funding and associated administration costs.

10.3
Where eligibility for NHS CHC should be considered but for whatever reason this has not been possible, or CP&R CCG NHS Funded Care Team has not yet reviewed the application for eligibility and the patient is ready for discharge from hospital, the discharge of the patient from hospital should not be delayed.

10.4
NHS CP&R CCG is responsible for funding the package of care for individuals discharged from hospital pending assessment and decision on NHS CHC eligibility and funding. In certain circumstances, where it is felt that the available information does not support the recommendation, or the method of referral may be inappropriate, the CCG reserves the right to not accept the CHC assessment, but to fund the package as an interim measure and undertake a formal CHC assessment in the community, one the care provision has been established. (NHS Funded Discharge)

10.5
In order to progress discharge arrangements for individuals in the circumstances, where a decision has not yet been made on eligibility for NHS funded continuing healthcare, agreement for CP&R CCG to fund the care arrangements must be agreed with the NHS CP&R CCG CHC lead as soon as possible.

11 Section 117 Aftercare

11.1
Under section 117 of the Mental Health Act 1983 (s117), CCGs and LAs have a duty to provide after-care services to individuals who have been detained under certain provisions of the Mental Health Act 1983, until such time as they are satisfied that the person is no longer in need of such services. S117 is a freestanding duty to provide after-care services for needs arising from their mental disorder and CCGs and LAs should have in place local policies detailing their respective responsibilities, including funding arrangements.

11.2
Responsibility for the provision of s117 services lies jointly with LAs and the NHS. Where a patient is eligible for services under s117 these should be provided under s117 and not under NHS CHC. 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 CHC or any other powers, irrespective of which budget is used to fund those services.

11.3
It is not, therefore, necessary to assess eligibility for NHS CHC if all the services in question are to be provided as after-care services under section 117. However, a person in receipt of after-care services under s117 may also have ongoing care/support needs that are not related to their mental disorder and that may, therefore, not fall within the scope of section 117.

11.4
A person may be receiving services under s117 and then develop separate physical health needs (e.g. through a stroke) which may then trigger the need to consider NHS CHC only in relation to these separate needs, bearing in mind that NHS CHC should not be used to meet s117 needs. Where an individual in receipt of s117 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.

12 Additional Support; over and above the commissioned package of care

From time to time, there may be the need to commission additional interventions, due to presenting issues.

12.1
Where care is provided in a Care Home:

- There is an initial expectation that the home will manage within existing resources to ensure this is not a short-term fluctuation.
- If the needs have demonstrably changed and are now likely to be on-going, the Care Home should request a formal CHC review – this will be managed by the NHS Funded Care Team.

12.2
Additional 1:1 support, to manage challenging behaviour cannot be considered to be a long-term solution. Where 1:1 care is initiated within a care home, the home should be informed that the provision is as a short-term provision and generally would not be expected to continue beyond **12 weeks**.

The NHS funded Care Team will commence regular monitoring and will request diary sheets are maintained.

12.3
If at **week 8**, no significant progress has been achieved by the care home, the NHS Funded Care Team will have to consider whether the care home has the appropriate skill mix or facilities to continue to manage the patient. There may require a best interest decision to transfer the patient to a facility with a more appropriate skill mix or facilities to manage the person without high levels of 1:1 support

12.4
The NHS Funded Care Team may issue the Care Home with notice, due to concerns about the ability to continue to manage the patient in that facility and will arrange transfer to a more suitably appointed care facility.

12.5
Where care is provided within the Patient's own home:

As much as possible, the NHS Funded Care Team will try to maintain people within their preferred place of care. However, there may be occasions where the level of support required in the long-term becomes unsafe and/or unaffordable. The National Framework for Continuing Healthcare and Funded Nursing Care (2012) requires the CCG's to fund 'what is reasonable'. Therefore, the NHS

Funded Care Team need to be mindful that the cost to maintain someone in their own home does not increase disproportionately against provision in a more suitable environment. (CP&R CCG Equity and Choice policy)

12.6
Where it becomes clinically or logistically inappropriate to continue to manage care in a 'preferred' environment, there will need to be discussion regarding alternative methods of provision to meet the need, or alternative placement may need to be considered.

12.7
The CCG is under no legal obligation to fund **any** care in **any** environment.

13. Deprivation of Liberty Safeguards.

13.1
The Mental Capacity Act 2005 contains provisions that apply to a person who lacks capacity and who, in their own best interests, needs to be deprived of their liberty in a care home or a hospital, in order for them to receive the necessary care or treatment. The fact that a person needs to be deprived of his/her liberty in these circumstances does not affect the consideration of whether that person is eligible for NHS Continuing Healthcare.

14 Previously un-assessed periods of care – PUPoC.

14.1
CP&R CCG can only consider requests for retrospective reviews where it is satisfied that one or more of the following grounds for the review exist:

- CP&R CCG, or local NHS or Local Authority providers failed to carry out an assessment of the claimant's eligibility for NHS CHC funding when requested to do so.
- Family request for a retrospective review for periods of un-assessed care.
- Requests for the period 1/04/2004 - 31/03/12 are no longer accessible, following the NHS England 'Closedown'.
- If alive, the patient can make a request via a questionnaire or their representative who holds LPA (registered with the Court of Protection). If patient deceased the CCG will need evidence they are executor or named within the deceased person's will.

14.2
In the absence of evidence of any of the above, CP&R CCG is not obliged to undertake a retrospective review of claimant's eligibility for such funding.

14.3
Where a retrospective review of eligibility for NHS funded CHC is approved, appropriate arrangements will be made for financial recompense in accordance with the NHS Continuing Healthcare: Refreshed Redress Guidance (NHS England 2015). Pension and benefits payments will also be taken into account in any calculation of sums reimbursed.

14.4
Calculation of interest payments will be in line with national guidance and CCG policies.

15 Commissioning of Care Packages

15.1
It is the responsibility of CP&R CCG to:

- Plan strategically
    - Monitor trends with provision and to plan in order to ensure sufficient appropriate resources continue to be available
- Specify outcomes
    - Placement contracts will have key performance indicators, based on patient centered approach which maximises their potential.
- Procure services
    - Commissioned services will adhere to procurement guidelines and reflect strategic planning requirements.
- Manage demand
    - Monitor volume and nature of requests, to ensure that there are sufficient in-house resources to manage demand
    - Develop a training programme to support other Health or Social Care Practitioners to help to support a standardised approach to CHC assessment and processes.
- Manage provider performance for all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare
    - Arrange for periodic reviews of provider activity, outcomes and achievements
    - Undertake periodic patient focused audit, to gauge the quality of provided services (FFT)
    - Liaise with Adult Social Care (ASC) contract management colleagues
- Manage provider performance for the healthcare component of joint packages of care.
    - Arrange for periodic reviews of provider activity, outcomes and achievements
    - Liaise with ASC contract management colleagues

15.2
The services commissioned will include on-going case management, by a designated named CHC Case Manager/Nurse Assessor, for all those entitled to NHS Continuing Healthcare, as well as for the NHS elements of joint packages of care, including the assessment and review of individual patient needs.

15.3
As well as service contracts, CP&R CCG FCT as commissioner is responsible for monitoring quality, access and patient experience within the context of provider performance.

15.4
CP&R CCG takes a strategic as well as an individual approach to fulfilling their NHS CHC commissioning responsibilities within the context of quality, innovation, prevention and productivity agenda.

15.5
Care packages will be commissioned from care homes, domiciliary care providers and from nursing agencies, where a NHS contract is in place for CHC provision. When a care package is commissioned by NHS CP&R CCG, where there is no agreement in place, a spot contract purchasing arrangement will be agreed in order to ensure that there are quality standards in place to meet the requirements of the provision of NHS services.

15.6
Care will not be commissioned from those care providers where there are concerns raised about the quality of the care provided or where they are known not to meet the Care Quality

Commission minimum standards for care homes. CP&R CCG will work in partnership with Essex County Council and other Local Authorities as required, to ensure the quality of care in care homes meets the required standards.

15.7
Where concerns about standards are raised, the owners of the care home provision will be informed that commissioning arrangements for NHS funded CHC will be suspended until improvements have been made to achieve the Care Quality Commission minimum standards of care and the quality standards within the CHC spot purchasing contract. This may be undertaken in collaboration with Essex County Council ASC team. Where care is already commissioned for patients in a care setting, a risk assessment currently called 'care review' will be undertaken in partnership with the individual patient and their family to ensure appropriate controls are in place to assure the individual's safety and the quality of care provided.

16 De-commissioning of care packages

16.1
Neither the NHS nor a LA should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement. It is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding, in order to ensure continuity of care. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If agreement between the LA and NHS cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding and care management responsibilities should remain in place until the dispute has been resolved.

The CHC service will notify the Local Authority that the patient is no longer eligible for NHS funding and may require a community care assessment. When it is agreed following assessment and recommendation by the MDT that a patient is no longer eligible for NHS CHC, NHS funding will cease from the date the DST for which the MDT recommended "no longer eligible". Without prejudice joint agreement will apply (Currently.

Any funding paid by the CCG for care while the Local Authority is setting up a care package, will be reclaimed by the CCG from the appropriate Local Authority to the date of the no longer eligible decision.

16.2
If the individual declines a community care assessment or following a community care assessment is not eligible for local authority funding e.g. because they are responsible for funding their own care, the CCG will continue to fund care costs pending a new care package being put in place by the individual/carer who will then be charged for the care costs paid by the CCG from the date of the no longer eligible decision. The CCG will fund for a maximum of 4 weeks.

17 Choice

17.1
The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2012, DoH) states:-

"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 social care needs."

17.2
CP&R CCG will commission the provision of NHS funded CHC in a manner which reflects the choice and preferences of individuals as far as is reasonably possible, ensuring patient safety, quality of care and making best use of resources. Cost has to be balanced against other factors in each case, such as a patient's desire to live at home. Funding decisions should be made in line with the CP&R CCG Equity & Choice Policy.

17.3
Patient safety will always be paramount in planning a care package and will not be compromised. Therefore in circumstances where there are concerns about the quality of care in a care home or CP&R CCG cannot commission care in a preferred home at that time, CP&R CCG will work with individuals and their families to commission an alternative package of care elsewhere.

17.4
CP&R CCG is required to balance the patient's preference alongside safety and value for money, consequently patients will have a choice from providers that have a contract with CP&R CCG and have agreed CP&R CCG quality and pricing structure. This applies equally to Domiciliary Care packages.
Cost of care packages should be identified in accordance CP&R CCG's Equity & Choice policy 2016.

18 Case Reviews

18.1
When the NHS CP&R CCG commences funding or providing any part of an individual's care, a case review will be undertaken to ensure that their care needs are being met and to an agreed standard. CP&R CCG will review case reviews in partnership with ECC for both NHS funded CHC and NHS funded nursing care reviews.

18.2
At all times, whether an initial assessment, follow-up review, or an annual assessment, the CHC Case Manager/Nurse Assessor will undertake a formal CHC assessment in a consistent manner; eligibility will be based upon the presenting circumstances and on-going health and care needs and not be based upon any previous decision making.

18.3
Case reviews will be undertaken for individual's no later than 12 weeks, but sometimes sooner, following the eligibility decision and thereafter on an annual basis, unless indicated earlier depending upon circumstances. People identified as eligible for CHC funding have an identified primary Health need, due to complexity or intensity of the care needs, and therefore it is reasonable to expect timely and appropriate reviews to be undertaken, this will ensure that individual patients are receiving the care they need and that they remain eligible for NHS CHC funding.
NHS CHC funding will generally be withdrawn should a CHC assessment show that the patient no longer meets the criteria and is therefore no longer eligible to receive NHS CHC funding.

18.4
The CCG will make every effort to ensure that the delivery of care to the individual is not unreasonably impacted upon, by transfer of funding responsibility, following the outcome of a CHC assessment.

18.5
It is the responsibility of the initial referrer to ensure that the patient and their family/carer are aware that these reviews occur and that NHS CHC funding may be removed should the patient's level of health need change. The initial referrer should provide the patient and their family/carer with the NHS CHC and NHS Funded nursing care: Information Leaflet.

19 Jointly Funded Packages of Care

19.1
The National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2012, DH) states that if a person does not qualify for NHS CHC fully funded care, the NHS may still have a responsibility to effectively contribute to that person's health needs. This is known as a 'joint package of care'. The most common way in which this is provided is by means of the Funded Nursing Care (FNC – Previously the Registered Nurse Contribution of Care – RNCC), in a nursing home setting. Practitioners should draw on their knowledge and skills regarding the assessed needs and their organisation's powers to meet them and work together to agree respective responsibilities for care provision in a joint package.

19.2
Joint packages of care may also be provided through the provision of NHS commissioned services such as Community nursing, Community Psychiatric Nurses or Community Physiotherapy, for example. A joint package of care with the Local Authority will only involve joint funding where there is a particular identified health need requiring an identified care package to be commissioned. In these circumstances CP&R CCG will fund the care costs for the identified health element of the package. Joint packages of care can be provided in any setting as appropriate to the assessed needs of the individual.

19.3
Care should be taken to ensure that it is clearly recorded what aspect of care the NHS is funding and why, to enable any follow-up assessment is able to determine whether the joint funded aspect continues to be appropriate or requires increasing or decreasing, based upon presentation.

20 Personal Health Budgets

20.1
CP&R CCG is required to be able to offer personal health budgets to people in receipt of NHS CHC funding, in order to give patients better flexibility, choice and control over their care. A personal health budget helps people to get the services they need to achieve their agreed health and wellbeing outcomes (agreed between the patient and clinician). Financially, personal health budgets can be managed in a number of ways, including:

- A notional budget held by the CCG commissioner
- A budget managed on the individual's behalf by a third party, and
- A cash payment directly to the individual (a 'healthcare direct payment').

20.2
Since October 2014, people in receipt of NHS CHC funding have had the right to request a personal health budget if they so choose.

20.3
People newly in receipt of NHS CHC funding for home care packages will be introduced to the concept of personal health budgets, preferably at the initial point of assessment, but certainly before or during their first CHC Review undertaken within 12 weeks. If they would like to investigate this option, based on the outcome of the individual's DST, an indicative budget will be produced and shared with the patient during an introductory meeting to explain the personal health budget process. The CHC Case Manager/Nurse Assessor supported by the CCG Business Manager will then liaise with the patient to fully consider this option.

20.4
The CHC Case Manager/Nurse Assessor, or other commissioned organisation, will work with the individual and/or their carer or representative(s) to agree health and wellbeing outcomes. They will then also work with the individual to think creatively about how they could best make use of their available budget to meet their health and wellbeing outcomes.

20.5
The CHC Case Manager/Nurse Assessor, or other commissioned organisation will then create a final budget and care plan which will be reviewed by the CCG. Going forward, the approval will be carried out by a Lead Nurse, unless there is anything in the care plan which suggests an unacceptable risk to the patient, an unacceptable financial risk, or where the final budget is greatly above or below the indicative budget. In this case, the care plan will be reviewed by the CCG. The patient and their representatives will be invited to take part in the meeting. Once a care plan has been agreed the nurse coordinator (or other commissioned organisation) will work to put the care plan in place. Support services will be provided to help people with direct payments, and support and advice will be provided for those wishing to employ personal assistants directly.

20.6
Care plans will be reviewed as per the National Framework guidance; within 3 months after the care package has been put in place and no later than every 12 months thereafter.

20.7
CP&R CCG will encourage this approach when an individual who was previously in receipt of a Local Authority direct payment begins to receive NHS CHC to avoid unnecessary changes of provider or of the care package.

20.8
Since April 2016, People who are not assessed as eligible for NHS funded CHC also have the right to be considered for a Personal Health Budget. Where patients are known the CHC team with joint funded packages of care, but where CHC eligibility has not been identified, these people may now be considered for a personal Health budget; based upon their existing allocated budget as a personal health budget.

21 Transition from Children's Services to Adult Continuing HealthCare Services

21.1
The National Framework for NHS Continuing HealthCare & funded-nursing care (2012, DH) and the supporting guidance and Tools only applies to people aged 18 years or over. It is important that both the Adult and the Children's Frameworks consider transition.

- Participate in and engage where appropriate, in timely discussions with relevant Adult and Children's Services managers/commissioners regarding all proposed placements / support packages funded by Children's Services that may require Adult Services funding post 18 (for example residential school placements) prior to any formal agreements being made from 14 years of age.
- Liaise where appropriate, with relevant children and Adult Services to assist them to ensure that all necessary planning and financial negotiations are completed in good time, enabling the transition from Child to Adult Services to be as seamless as possible for all concerned.
- Liaise with Adult and Children's Services where appropriate, to assist with the prevention of any legally binding financial commitments or contractual agreements being made by Children's Services that will impact on Adult Services budgets when the person reaches

eighteen without prior formal agreement from the relevant manager(s) within Adult Services eligibility criteria Consider eligibility for NHS CHC and inform Children's Services of need to initiate application process where necessary. Share information and participate in joint planning meetings such as MAP

21.2
CP&R CCG will ensure that it is actively involved in the strategic development and oversight of the local transition planning processes with their partners, and that their representation includes those who understand and represent adult NHS Continuing Healthcare. CP&R CCG will ensure that adult NHS CHC is appropriately represented in all transition planning meetings regarding individual young people whenever the individual's need suggest that there may be potential eligibility.

21.3
CP&R CCG recognise as best practice that future entitlement to adult NHS CHC should be clarified at as early a stage as possible in the transition planning process, especially when the young person's needs are likely to remain at a similar level until adulthood. Continuing Care practitioners (CC – Children, CHC – Adult) responsible for children's transition into NHS CHC, should identify those young people for whom it is likely that NHS CHC will be necessary, and should notify CP&R CCG NHS Funded Care Team, who may have responsibility for them as adults. This should occur when a young person reaches the age of 14. This should be followed up by a formal referral, completed Checklist for screening at age 16 to the NHS Funded Care Team.

22 Joint commissioning for special educational needs and disability (SEND)

22.1
Since September 2014, under section 26 of the Children and Families Act 2014, a new framework for children and young people **(up to age 25)** with SEND will apply in England. All new entrants to the system will be supported via these arrangements, and children and young people with existing statements of special educational needs will transfer to the new arrangements over a three year period. At the heart of the arrangements is an integrated Education, Health and Care plan (EHC plan).
It should be noted that CC arrangements are generally tripartite; Social Care, Education & Health, whereas the definition for CHC is solely the responsibility for Health. Consequently, whist identified need continues to require education; the person cannot be considered to be solely the responsibility and therefore cannot be CHC eligible. In these cases, it is the expectation that the CC health component will be transferred to the NHS Funded Care team, but education and Social Care responsibilities will continue; The NHS Funded Care Team will not take over aspects of care previously funded by either Social Care or Education.

22.2
The CCG has worked with their local authority, to develop and publish a Local Offer, setting out in one place information about the range of Personal Health Budget option for people who are eligible for CHC, but also those who are not.

22.3
A child or young person with a continuing care need will often also have SEND. Where this is the case, the child or young person's continuing care needs, and package of care should at the very least feature as part of the integrated package of care in their EHC plan. There are many children and young people with special educational needs or disability without a continuing care need, and their health needs should of course be reflected in the EHC plan. The EHC plan process has at its heart a coordinated assessment of a child or young person's needs, based on multi-professional input, and focused on the outcomes which make the most difference to the child or young person and their family. The views and aspirations of the child or young person, and of their family, are central to developing a holistic view of the child's needs.

22.4
Given the elements common to both the EHC plan assessment, and the continuing care process, commissioners and local authorities should consider how the two processes can be brought together, to articulate a single set of needs and outcomes.

22.5
Local authorities and CCGs must work together to make EHC plans work, and their joint arrangements should include an agreement as to how continuing care fits with the EHC process. The EHC plan assessment has a longer-timetable than the NHS continuing healthcare assessment; 20 weeks as opposed to 28 days, and the process is led by the local authority rather than the CCG. It will not therefore usually be of benefit to completely integrate the two processes; certainly, not appropriate if it delays a decision on a package of continuing care.

22.6
The information needed to make a decision on the continuing care package will be very similar to that needed for the health element of the EHC plan. Some form of pre-screening or decision making could determine the pathway for the process. A rapid assessment of whether or not a child is likely to have a continuing care need, could trigger the health assessor undertaking responsibility for social care and health input to the coordinated process.

22.7
A decision by the deciding panel could be secured within 28 days on the continuing care element of the EHC plan, and the package of care commence, to be integrated subsequently with the other education and social care elements of the EHC plan as it takes shape. The health assessor's role would help facilitate the health input to the EHC plan. This would also allow a three month review to take place when the full EHC plan was considered for sign-off.

22.8
As the new SEND arrangements extend up to age 25, there will be young people aged 18-25, who are assessed as having a primary health need under the NHS CHC framework. This means that the NHS is responsible for providing the individual's entire assessed health and social care needs – including accommodation, if that is part of the overall need. The local authority may not have any responsibility towards the young person. The local authority would still take the lead in coordinating the EHC plan but the services they were ultimately responsible for securing would be negligible.

CCGs and local authorities may wish for the same oversight arrangements to apply to both the CHC process and EHC plans.

23 Training

23.1
CP&R NHS Funded Care Team will work towards developing training opportunities to hospital staff, community staff and adult social care staff involved in the implementation and application of the National Framework of NHS Continuing HealthCare & funded-nursing care. Training will focus the use of the National Tools, the identification of a 'primary health need', the concept of 'nursing services being considered to be ancillary and incidental to the provision of care', 'Greater than a Local Authority can be reasonably expected to provide' and the application/referral process and the timescales for completion of assessments.

23.2
Training will be delivered by the NHS Funded Care Team in a planned programme and in various venues.

23.3
All those using the Checklist and DST must have suitable knowledge and understanding in the use of these documents. A link to e-learning for NHS CHC is provided below which all staff can use to gain greater understanding of the process.
http://www.e-lfh.org.uk/projects/nhscontinuinghealthcare/

24 Governance

24.1
Implementation and delivery of the requirements of the National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2012, DoH) will be monitored through performance reports to NHS CP&R CCG.

25. Monitoring

Currently CHC process monitoring is being developed.

26. Quality Assurance, Compliance and Review

The CCG will monitor both the effectiveness of the complaints process and how complaints information is being used to improve services and the delivery of care.

The Executive who has overall responsibility for monitoring the policy is the Accountable Officer for the CCG.

The Care Quality Commission's regulatory framework, introduced by the Health and Social Care Act 2008, set requirements for all providers of health and social care in terms of complaints handling.

This Policy will be reviewed every two years by the Designated Complaints Manager.

If only minor revisions are made then the policy can be approved by the Quality and Governance Committee and the version number for the policy will be updated by ".1" e.g. from version 1.0 to 1.1.

If significant amendments need to be made then the policy will need to be approved by the CCG Governing Body. In this case the version number would increase to the next whole number e.g. from version 1.1 to 2.

27. Equality Impact Assessment

The CCG is committed to carrying out a systematic review of all its existing and proposed policies to determine whether there are any equality implications.

This policy has been assessed using the CCG's Equality Impact Assessment framework and identified as having the following impact/s upon equality and diversity issues:

	Age	Disability	Gender & Pregnancy	Race	Marital status	Sexuality	Religion	Human Rights	Total Points	Impact
Complaints and Concerns Policy	2	0	0	0	0	0	0	0	2	Low

References

1. National Framework for NHS Continuing HealthCare & NHS funded-nursing care (2012): www.gov.uk/government/publications/national-framework-for-nhs-continuing- healthcare-and-nhs-funded-nursing-care-funded-nursing-care

2. The National Health Service Commissioning CCG and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

3. Copies of the National Framework for NHS Continuing HealthCare and Funded Nursing Care (2012) and the tools below are available from the DoH Website at: www.gov.uk/government/publications/national-framework-for-nhs-continuing- healthcare-and-nhs-funded-nursing-care

4. Who Pays? Determining responsibility for payments to providers (2013): www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

5. http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted. See also *Special educational needs and disability code of practice: 0 to 25 years. Statutory guidance for organisations who work with and support children and young people with special educational needs and disabilities* (2014).

6. S.E.N.D: Code of Practice https://www.gov.uk/government/publications/send-code-of-practice-0-to-25
   For full details of the transition arrangements, see *Transition to the new 0 to 25 special educational needs and disability system. Statutory guidance for local authorities and organisations providing services to children and young people with SEN* (2014).

7. S.E.N.D; managing changes to legislation https://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014--3

8. NATIONAL HEALTH SERVICE ACT 2006 THE DELAYED DISCHARGES (CONTINUING CARE) DIRECTIONS 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254680/Delayed_discharges_directions.pdf

9. Documents and tools applied

   NHS Checklist

   NHS Decision Support Tool

   NHS Fast Track Tool

   CP&R Equity & Choice Policy

   CP&R Disputes Policy

Appendices

Appendix 1

NHS Castle Point & Rochford Clinical Commissioning Group
Referral Procedure for Continuing HealthCare Assessment
NHS Continuing HealthCare Checklist

The process for referral for CHC assessment is identified within the National Framework for NHS CHC and NHS-funded Nursing care, November 2012 (revised). The use of the Fast Track Pathway Tool for NHS CHC and the NHS CHC Checklist will be the only acceptable routes into the CHC service within NHS CP&R CCG. The assessment may proceed straight to a DST if there is evidence that the individual would checklist above the threshold, however should notify the NHS Funded Care Team that they are doing so as soon as possible.

The Checklist is to help practitioners identify people who need a full CHC assessment, although referral for a CHC assessment does not in itself indicate eligibility for continuing healthcare.

The Checklist is based on the NHS CHC Decision Support Tool, which is used for full CHC assessment, and the National Framework for NHS Continuing HealthCare & NHS Funded Nursing Care guidance.

NHS CHC Checklist:

1. Any health or social care professional with training can use the Checklist to refer individuals for full consideration of eligibility for NHS CHC from the community, care home or hospital setting. Staff completing the Checklist must be familiar with, and have regard to, the Decision Support Tool

2. The Checklist must be completed with the full understanding of the process explained to the individual or their representative, who should be invited to fully participate in the process and to express their views. It should be explained to the patient and their family that the completion of a checklist may not result in eligibility for NHS CHC. A copy of the DH information leaflet should be given to patient and/or representative.

3. Informed consent should be obtained before the process of completing the Checklist begins. Consent for the process from the individual or a person with lasting power of attorney, or action taken due to lack of consent, 'best interests' meeting, should be recorded clearly on the Checklist. If it is not recorded the Checklist may be returned to the referrer for further completion.

4. In the acute hospital setting, NHS staff are required to consider someone's CHC needs before giving notice of an individual's case under the Delayed Transfer of Care regulations and should involve the Local Authority's Department of Adults, Health and Wellbeing in such an assessment. Given that a hospital setting can sometimes poorly represent an individual's capacity to funded therapy or rehabilitation elsewhere may be appropriate. All staff should be aware of this requirement, and if additional therapy or rehabilitation is arranged, NHS CHC needs should be assessed at the end of these interventions.

5. Where a Checklist has been completed and indicates that the individual does not require a full CHC assessment, the Checklist should still be forwarded to the Funded Care Team for monitoring purposes and for future reference should the individual be referred at a later date.

   Completed Checklists should be sent by secure email: cprccg.chc@nhs.net

Procedure: Completion of the Checklist

The NHS CHC Checklist can be obtained from: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing- care

1. Process

1.1 Referrer
The referrer will ensure that consent is agreed and that the Checklist is completed fully in line with points 1 to 4 above. Clearly documenting their profession and contact details

1.2
If there is a concern that the individual may not have capacity to give consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice.

The referrer will email the completed Checklist, with consent/MCA/Best interests, to the NHS Funded Care Team on:

Secure email: cprccg.chc@nhs.net

2. Team and timeline

2.1 NHS Funded Care Team

The NHS Funded Care Team will review the Checklist and enter receipt onto the CHC database. If the Checklist indicates the need for full consideration of eligibility for continuing healthcare, then the NHS Funded Care Team will notify the referrer that the completion of a Decision Support Tool indicating full social and health assessments needs to be completed and the individuals name will be added to the allocation list .

Timescale for completion of the full assessment is within 28 days from the NHS Funded Care team receiving the fully completed Checklist.
Full consideration against the eligibility criteria is indicated where:

- Two or more ticks in column A; or
- Five or more ticks in column B, or one tick in A and four in B; or
- One tick in column A which has an asterisked domain (*). Asterisked domains are those which carry a Priority level in the Decision Support Tool. (Behaviour; Breathing; Drug Therapies and Medication-symptom control; Altered States of Consciousness)

2.2 If the NHS Funded Care Team agrees a full consideration for NHS CHC is not required, this decision, together with the reasons for it will be communicated clearly to the referrer, individual and their carers and/or their representatives. A written copy of this communication from the assessor to the patient will be placed on file**.**

Timescale: for decision: 2 working days
for Communication: 2 working days

2.3 If the NHS Funded Care Team agrees a full consideration for NHS CHC is required the result and the reasons for it will be communicated clearly to the referrer, individual and/or their representatives. A written copy of this communication will be placed on file.

Timescale: for decision: 2 working days
for Communication: 2 working days

2.4 The NHS Funded Care Team leader will be responsible for ensuring that a full assessment by the multi-disciplinary team using the Decision Support Tool, takes place in line with the process set out within the guidance and within the timescales identified.

Appendix 2

NHS Castle Point & Rochford Clinical Commissioning Group
NHS Continuing Healthcare
Procedure for completion of Decision Support Tool

1. The Decision Support Tool (DST)

1.1 The function of the DST is to summarise and collate key information from the Multidisciplinary Team (MDT) Health Needs Assessment (HNA) across the 12 domains and to consider the impact of the nature, intensity, complexity or unpredictability of health needs. The recommendation should also evidence the consideration of the primary health needs test; i.e. is the care being delivered greater than we could reasonably expect a local authority to provide?

The DST remains an aid to decision making and is not a substitute for professional judgment.

The MDT in the context of NHS CHC is described as;

- Two professionals who are from different healthcare professions or
- One professional who is from a healthcare profession and one person who is responsible for a assessing individuals for community care services under section 47 of the National Health Service and Care Act 2014 1990

1.2 As much as possible, CP&R CCG expects all DSTs to have Adult Social Care input and for the completed DST's to show this. The MDT recommendation should be signed by the social care practitioner involved in the assessment and if it is not for a written explanation to be provided as to why not.

1.3 Where Adult Social Care is unable to participate at the assessment, a copy of the HNA and DST, including the recommendation, will be shared with Social Care for comment within 2 working days.

1.4 The DST to be used by everyone is the national DST form, 2016; this is a DoH requirement.

1.5 The CHC lead will reject consideration of a DST if any of the following apply;

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

1.6 It is recommended that the MDT initially consider each domain in turn and agree the statements, throughout before considering tentative levels of need on the DST. The MDT should then consider the impact of nature, intensity, complexity or unpredictability (see 1.11 below) and then review the levels on the DST, amending these where necessary prior to completion.

1.7 The DST must contain all of the information used to decide on the scoring of each 'domain', clearly recorded within each section. This information must correlate with the MDT recommendation completed and signed on behalf of the MDT, including the rationale for the recommendation. If there is no signed recommendation and rationale it will be automatically rejected by the CHC lead and returned to the MDT for further work.

1.8 The NHS Funded Care Team based at Pearl House is available to provide support and guidance with CHC assessments and DST completion.

1.9 It is expected that the person signing the DST on behalf of the MDT will be available to discuss the case should this be necessary.

Nature, Intensity, Complexity and Unpredictability

1.10 These four elements continue to be an important part of the guidance and descriptors are included in the national framework.

1.11 Completion of the DST requires consideration of the four characteristics of need, Nature, Intensity, Complexity and Unpredictability. Guidance on the application of these characteristics are outlined below:

Nature	**Intensity**
This is about the characteristics of the individual's needs. Ask yourself questions like: • How would you describe the needs (rather than the medical condition leading to them)? • What adjectives would you use? • What is the impact of the need on overall health and wellbeing? • What types of interventions are required to meet the need? • Is there particular knowledge/skill required to anticipate and address the need? • Could anyone do it without specific training? • Is the individual's condition deteriorating or improving? • Is this greater than we would expect a Local Authority to provide?	This is about quantity, severity and continuity of needs. Ask yourself things like: • How severe is this need? • How often is intervention required? • How much care? • How many carers are required? • For how long is the care needed for each time? • Can the patient be left unattended in between interventions? • Does the care relate to needs over several domains? • Is this greater than we would expect a Local Authority to provide?
Complexity	**Unpredictability**
This is about the level of skill/knowledge required to address an individual need or the range of needs. Ask yourself things like: • How difficult is it to manage the need(s)? • Are the needs interrelated? • Do they impact on each other to make the needs even more difficult to address? • How much knowledge is required to address the need(s)? • How much skill is required to address the need(s)? • How does the individual's response to their condition make it more difficult to provide appropriate support?	This is about the degree to which needs fluctuate and There by create challenges in managing them. Ask yourself things like: • Are you able to anticipate when the need(s) might arise? • Does the level of need often change? • Is the condition unstable? • What happens if you don't address the need when it arises? • How significant are the consequences? • To what extent is professional knowledge or skill required to respond spontaneously and appropriately? • What level of monitoring/review is required?

1.12 The MDT having considered fully these characteristics as part of their discussions, determine whether someone is recommended eligible for CHC due to having a primary health need, or not eligible as no primary health need is evidenced.

1.13 Once completed the DST and all supporting evidence must be sent to the NHS Funded Care Team for review and quality check.

2. Time frame for completion of the Decision Support Tool.

2.1 The National Framework for NHS Continuing HealthCare and Funded Nursing Care states the following:

"The time that elapses between the Checklist (or were no Checklist is used, other notification of potential

eligibility) being received by the CCG and the funding decision being made should, in most cases, not exceed 28 days. In acute services, it may be appropriate for the process to take significantly less than 28 days if an individual is otherwise ready for discharge. CCGs can help manage this process by ensuring that potential NHS CHC eligibility is actively considered as a central part of the discharge planning process, and also by considering whether it would be appropriate to provide interim or other NHS-funded services.

Where there are valid and unavoidable reasons for the process taking longer, timescales should be clearly communicated to the person and (where appropriate) their carers and/or representatives". The CHC nurse assessor must clearly log any delays on the database

2.2 The timeline for completion of a CHC assessment is described for guidance only below. Different phase times may apply to individual cases; however the 28 day timeline is the specified target;

Phase of the continuing care process	**Stage of care pathway**	**Summary of key actions**	**Timescales/28 day target**	**Local Authority input were appropriate**
Assessment phase	Identify	Adult with potential CHC needs. Referred using Fast Track Tool (set up care) or Checklist to CHC Team.	**1 day**	Notify the Local Authority of need for assessment
	Assess	If full eligibility assessment is indicated a care coordinator is identified and commences gathering information for inclusion in the DST.	**8 days**	If no Local Authority input, notify on day 7.
Decision phase	Recommend	MDT considers the information gathered and makes a recommendation which is recorded in the completed DST. The completed DST is sent to the CHC Team for review quality check.	**21 days**	If no Local Authority input by day 14, send DST to local Authority
	Decide	The CCG considers the MDT recommendation and Validates	**28 days**	
Provision phase	Inform	Patient/referrer/family notified of decision verbally then in writing	**3 working days**	
	Deliver the package of care	CHC team identify provider/s for package of care based on care plan to meet needs and ensure care package is in place	Dependent on complexity of package this may take time, of which the patient should be kept informed.	

*completed within this time frame requires joint working across the whole system of health and social care. The timeframe identified is a performance indicator for NHS CHC and therefore is not optional. Delays and the reasons for delays in meeting this target will be required to be presented at when the eligibility consideration takes place and will be closely monitored and recorded.

Appendix 3

CP&R CCG Referral Procedure for Continuing Healthcare Assessment

Fast Track Pathway Tool

The process for referral for CHC assessment is identified within the National Framework for NHS Continuing HealthCare and NHS-funded Nursing care, 2012 (revised).

The use of the Fast Track Pathway Tool for NHS CHC and the NHS CHC Checklist will be the **only** acceptable routes into the CHC service within NHS CP&R CCG.

The Fast Track Pathway Tool.

The Fast Track Pathway Tool is used to request the CCG commissions a package of care and support, for an individual who has a rapidly deteriorating condition and needs to be discharged as a matter of urgency. This Tool bypasses the need for the Checklist and should only be used for individuals who may have a primary care need through a rapidly deteriorating condition that may be entering a terminal phase.

Completion of the Fast Track Tool

The Framework makes it clear that the Fast Track Pathway Tool can only be completed by an 'appropriate clinician', and the Responsibilities Directions define an 'appropriate clinician' as a person who is:

i. ***Responsible for the diagnosis, treatment or care of a person in respect of whom a Fast Track Pathway Tool is being completed***
ii. ***Diagnosing, or providing treatment or care to, that person under the 2006 Act, and iii. A registered nurse or is included in the register maintained under section 2 of the Medical Act 1983.***

Thus those completing the Fast Track Pathway Tool could include consultants, registrars, GPs and registered nurses. This includes relevant clinicians (registered nurses and doctors) working in end of life care services within independent and voluntary sector organisations if their organisation is commissioned by the NHS to provide the service.

Whoever the clinician is, registered nurse or doctor, completing the Fast Track Pathway Tool, they should be knowledgeable about the individual's health needs, diagnosis, treatment or care and be able to provide reasons why the individual meets the conditions required for the fast tracking decision.

The use of the Fast Track Pathway Tool and Care Plan is compulsory when an individual requires an urgent package of CHC due to a rapidly deteriorating condition that may be entering a terminal phase. No variations on the Tool should be used. It is only when the Fast Track Pathway Tool has been used that a CCG is required by the Responsibilities Directions to decide immediately that the person is eligible for NHS Continuing Healthcare.

Procedure: Fast Track Pathway Tool

1 Process

1.1 **Referrer**

Where a patient has a **rapidly deteriorating condition** which may be entering into the terminal phase and **requires an urgent care package to be set up** then the following must happen:

- The 'Appropriate clinician' (registered nurse or doctor) completes the Fast Track Pathway Tool setting out how their knowledge and evidence about the patient's needs leads them to consider that the patient has **a rapidly deteriorating condition,** which may be entering a terminal phase**.**

- Any necessary evidence should be included and must include **diagnosis, prognosis and current condition,** together with a completed care plan developed as part of the individual's end of life care pathway that describes the immediate needs to be met, and the patient's preferences, including those set out in any advance care plan.

- The completed Fast Track Pathway Tool should then be sent by secure emailed to the NHS Funded Care Team Secure email: CPRCCG.CHC@nhs.net

1.2 **NHS Funded Care Team**

The NHS Funded Care Team is responsible for ensuring the Fast Track Tool is completed correctly and that there is sufficient evidence that the patient meets eligibility for CHC funding.

- CHC clinician notifies the referrer of decision re; eligibility
- If the patient requires a hospital or hospice placement the CHC clinician will assist with arrangements in a Case Management/Coordination function.
- If the patient requires a Community placement, the NHS Funded Care Team will arrange the package of care to commence as soon as possible
- If Registered Nurses or Health Support Workers with additional skills, e.g. management of nebulisers, external ventilation, and/or complex medication regime is required, the NHS Funded Care Team will ensure this is arranged as soon as possible.

1.3 **Out of Hours**

Currently, there is not provision for CHC decision-making outside normal office hours.

1.4 **Review**

All patients placed on CHC following the application of a Fast Track Pathway Tool will be reviewed no later than 3 months, and preferably within 3-6 weeks, from the start of the care package by the NHS funded care team.

All Fast Track applications will be monitored to ensure compliance with the guidance and appropriate use of the Fast Track Tool

Appendix 4.

Continuing Healthcare Disputes Agreement

Background

There are three different kinds of dispute that may arise in relation to NHS continuing healthcare.

a) Challenges (including requests for reviews) by the individual or their representative in relation to the process or decisions made – this is not covered by this process and can be found in the Clinical Commissioning Groups (CCG) operating framework.
b) Disputes between two CCGs over which is the responsible commissioner for the patient.
c) Disputes between a CCG and a Local Authority (LA) regarding eligibility.

Points a) and b) are addressed in national guidance, and local arrangements are in place in each CCG, and fall outside the scope of this protocol. However Paragraph 6.83 of the Care and Support Statutory Guidance (DH 2014) makes it statutory requirement for LAs and CCGs to have a disputes resolution process in place that deals with disputes between CCGs and LA (point c), which must cover;

- Eligibility for Continuing Healthcare , and/or,
- The apportionment of funding, and/or,
- Operation of the refunds guidance.

Annex A and B of this paper sets out a draft memorandum of understanding and a protocol that is under development and is designed to discharge this duty. **Discussion**

1. At present there are no robust arrangements in place for dealing with the disputes between Essex County Council (Southend on Sea Unitary Authority and Thurrock Unitary may wish to sign up to agreement in the near future) and the CCGs relating to Continuing Healthcare and Funded Nursing Care. This situation means that presently we, and our partners, are not complying with the requirements of the Care and Support Guidance or with Continuing Healthcare National Framework.

2. From an operational perspective the absence of an agreed process across the LAs is resulting in a lack of clarity over the handling of disputes, and potentially in unnecessary expenditure in care and support costs for the LAs and CCGs.

Approach

3. A draft Memorandum of Understanding is being developed and is attached at **Annex A** to support a county wide approach to the handling of CHC and funded nursing care while the draft Protocol at **Annex B** sets out a defined process for dealing with disputes that;
    - Complies with our duties under the Care and Support Guidance 2014.
    - Covers funded nursing care.
    - Addresses the issue of who will fund care and on what basis while the matter is under dispute.
    - Provides for reimbursement of the party who has been funding care if it is determined by the Panel that they are not responsible for paying for care.

Continuing Healthcare Disputes Panel

4. At the core of the approach is a proposal to establish a Continuing Healthcare Disputes Panel (CHPD). The Panel would be chaired by an independent person who has a background in Continuing Healthcare.

5. The membership of the Panel would always be made up of an odd number of people to ensure that the chair has a casting vote. The Panel's proposed structure and remit is set out at **Annex C** of this paper.

6. Referral arrangements are set out in the protocol, which proposes the use of deadlock letters, to ensure that the matter under dispute and the evidence relating to it are clearly stated between the parties ahead of the Panel date, thus providing a further opportunity for informal resolution between the parties.

Process for selecting and funding the Chair

7. It is proposed that the Chair is selected through a formal recruitment process and is paid on a sessional basis. Recent advertisements for similar roles suggest a reasonable rate for the role would be in the region of £500 a day. It is suggested that the cost is split in equal parts between the parties using the Panel.

8. A draft job advertisement, based on similar roles offered by NHS England last year, a) which sets out the role, and, b) puts it into context is attached at **Annex D** to support discussion of this aspect.

9. The selection process for the chair is not included in the body of the protocol on the basis that arrangements may change from time to time and it seems helpful for this to be able to happen without the need to formally review the whole structure.

Conclusion

10. The proposed approach is limited to disputes between Essex County Council (Southend on Sea Unitary Authority and Thurrock Unitary Authority may wish to sign up at a later date) and the CCGs and as such satisfies the requirement of Care and Support Guidance 2014. Processes are already in place to deal with individual disputes; these are set out in the relevant national guidance. It is also for CCGs to have arrangements in place dealing with disputes between them over CHC.

11. It is not envisaged that the formal process be used that frequently as it should only come into play when all other avenues to resolve the dispute have been exhausted. It is hoped that sharing the cost of the chair between the parties each time the CHDP is used will encourage appropriate use of the arrangements.

Annex A

Memorandum of Understanding on the provision of Continuing Health Care and Funded Nursing Care

between

Essex County Council
(Southend on Sea Unitary Authority and Thurrock Unitary Authority may wish to sign up at a later date).

and

Basildon and Brentwood Clinical Commissioning Group (CCG)
Castle Point & Rochford CCG
Mid Essex CCG
North East Essex CCG
Southend CCG
Thurrock CCG
West Essex CCG.

This memorandum of understanding (MoU) establishes a framework for co-operation between Local Authorities (LAs) listed above and the Clinical Commissioning Groups (CCG) listed above. It sets out the role of each body, and explains how they work together to discharge their responsibilities under the Care Act 2014, the Care and Support Guidance 2014, the NHS Framework for Continuing Healthcare 2012, and the Continuing Healthcare Operating Framework (DH 2015). The MoU is based on the following principles;

- Clear **accountability**. Each authority must be accountable for its actions and the discharge of its statutory responsibilities as set out in the relevant guidance.
- **Transparency**. Elected members, citizens of Essex and regulators must know who is responsible for what.
- **Avoidance of duplication**. Each authority must have a clearly defined role, to avoid second guessing, inefficiency, and, the unnecessary duplication of effort. This will help ensure proper accountability.
- **Regular information exchange**. This helps each authority to discharge its responsibilities as efficiently and effectively as possible.

Provision of care

It is agreed by all parties that in the event of a dispute between them over the funding of care no action will be taken by any party that could lead to a delay in provision of, or the withdrawal of care that has been provided to meet an assessed eligible need.

The responsibility of Essex County Council (Southend on Sea Unitary Authority and Thurrock Unitary Authority may sign up at a later date)

- The relevant LA will ensure that it fully discharges its responsibilities as defined in the Care and Support Guidance (Department of Health 2014). In particular it will ensure.
  It acts openly and in good faith in all dealings with its health partners.

- It deals with any disputes that arise between it and any of its health partners relating to the provision of Continuing Healthcare and/or Funded Nursing Care in line with the local agreement governing disputes between the Council and the relevant health partner.
- In all cases where the LA is funding the adults care and support at the time the dispute arises it will continue such funding on a "without prejudice" basis until such a time as the dispute is resolved.

The responsibility of the Clinical Commissioning Groups

The CCGs will ensure that they provide Continuing Healthcare and Funded Nursing Care in full compliance with the Care Act 2014, the Care and Support Statutory Guidance 2014, National Framework for NHS Continuing Healthcare and NHS funded nursing care (Department of Health 2012), CHC Operating Framework (Department of Health 2015). In particular each CCG will ensure;

- It acts openly and in good faith in all dealings with the local authority partner(s).
- It deals with any disputes that arise between it and its local authority partner(s) relating to the provision of Continuing Healthcare and/or Funded Nursing Care in line with the local agreement governing disputes between it and its local authority partners.
- In all cases where the CCG is funding the adult's care and support at the time the dispute arises it will continue such funding on a "without prejudice" basis until such a time as the dispute is resolved.

Review of this Memorandum of Understanding (MoU)

This MoU will be kept under regular review to ensure it is fit for purpose.
Formal reviews will take place at 12 month intervals.
All parties will be invited to participate in the review process.

REFERRAL AND PROCESS FLOWCHART (NATIONAL FRAMEWORK 2012)