Hertfordshire and West Essex Integrated Care System

NHS Herts and West Essex Integrated Care Board (ICB)

NHS Continuing Healthcare and Funded Nursing Care Operational Policy 2023 V1.4

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Responsible Director	**Director of Nursing and Quality**
Directorate	**Nursing & Quality**

Staff Audience	**The CHC Operational Policy is aimed at Hertfordshire & West Essex CHC Teams and provider organisations in relation to individuals registered with a Hertfordshire & West Essex ICB General Practitioner.**
Description	**The Operational Policy for NHS Continuing Health Care (CHC) and Funded Nursing Care (FNC) details the process which the Hertfordshire and West Essex Integrated Care Board (ICB) and partner agencies will follow for referring, assessing, and agreeing eligibility for NHS CHC and for providing that care. This policy ensures that the model and processes are consistent with national policy and robust and timely in their response.** **The policy sets out the operating basis for NHS Continuing Health Care to ensure that the teams work in accordance with the National Framework for NHS Continuing Healthcare & NHS funded-Nursing Care (DH, July 2022 (Revised)), referred to as the 'Framework' and The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2022. (see Appendix 1 for reference details). It also outlines the requirement to develop and maintain close working arrangements with colleagues in Hertfordshire and Essex County Councils, provider NHS Trusts, and the Integrated Care Board (ICB).**
Superseded Documents (if applicable)	

Document Control

Version	Page	Details of amendment	Author
1.0		November 2021- Operational Policies from the 3 originating CCG's brought together into a single operating policy to cover the ICB footprint	Elizabeth Hall
1.1		February 2022- Reviewed and updated ahead of ICB alignment	Elizabeth Hall, Peggy West, Faith Mhangami, Belinda Kangausaru
1.2		March 2022- Reviewed and updated ahead of ICB alignment	Elizabeth Hall, Peggy West, Faith Mhangami, Belinda Kangausaru
1.3		April 2022- Addition of MDT statement to 5.8.5 to following NHS England guidance.	Elizabeth Hall
1.4		August 2023- Updates to reflect current working practices now ICB team is aligned. Changes to Local Resolution Process (20.4) to align with NHS England expectations.	Elizabeth Hall

CONTENTS

1. Introduction

1.1 From the 1st April 2013 East & North Herts, South & West Herts and West Essex Clinical Commissioning Groups (CCGs) have held statutory responsibility for delivering NHS Continuing Healthcare for the local registered population. From April 2022 this passed to the Hertfordshire & West Essex Integrated Care Board (ICB).

2. Purpose

2.1 Principles and processes for the implementation of NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC) are outlined in the National Framework along with the tools to be used in screening, assessment, and applications for both CHC and Fast Track referrals. This policy describes the processes that will be followed by Hertfordshire & West Essex ICB and should be read in conjunction with the following documents:

- National Framework for NHS Continuing Healthcare & NHS funded-Nursing Care. Incorporating the NHS Continuing Healthcare Practice Guidance. (DH, July 2022 (Revised))
- Who pays? Determining which NHS commissioner is responsible for making payment to a provider (June 2022)

2.2 This policy details the process for referring, assessing, and agreeing eligibility for NHS CHC and for providing that care, whilst ensuring consistency with national requirements along with providing robust and timely responses. It also ensures that teams are working in accordance with Framework requirements while developing and maintaining close working relationships with NHS Provider Trusts and colleagues in Hertfordshire and Essex County Councils.

2.3 This policy applies to all NHS CHC applications for adults 18 years or older who are registered with a General Practice within the Hertfordshire & West Essex ICB area, or who are resident within the area covered by NHS Herts & West Essex ICB Continuing Healthcare Service 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
- Mental health

3. Definitions

3.1 **'NHS continuing healthcare'** (CHC) means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a 'primary health need' as set out in the National Framework. Such care is provided to an individual aged 18 or over, to meet needs and associated social care needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS Continuing Healthcare is not determined by the setting in which the package of support can be offered or on the type of service delivery.

3.2 **'NHS-funded nursing care'** (FNC) is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS-funded Nursing Care has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS Continuing Healthcare before a decision is reached about the need for NHS-funded Nursing Care.

3.1.0 Principles and Values

3.1.1 Eligibility for NHS CHC is based on an individual's assessed needs and is not disease specific, nor determined by either the setting where the care is provided, or who delivers the care. Access to consideration and assessment is non-discriminatory; it is not based on age, condition or type of health need diagnosed.

3.1.2 The aim of NHS CHC is to implement the NHS CHC eligibility criteria in order to provide appropriate care. To achieve this, the implementation of the criteria and local application for NHS CHC, in conjunction with the Local Authority, provider Trusts and other agencies, should meet the following principles:

- Needs led
- Equitable
- Culturally sensitive
- Person centred
- Robust and transparent
- Easily understood
- Adheres to guidance and best practice

3.1.3 The intention of the Department of Health in developing the National Framework was to improve consistency of approach, and ease of understanding of NHS Continuing Healthcare. The principles underlying this policy support the provision of a consistent approach, and fair and equitable access to CHC. All agencies involved in delivering the CHC pathway will work to the following principles:

- The individual's informed consent will be obtained before starting the process to determine eligibility.
- Where an individual lacks mental capacity to either refuse or consent to an assessment, a "best interests" decision should be undertaken in accordance with the Mental Capacity Act 2005 (see Appendix 1 for reference details) as to whether to proceed with the assessment of eligibility. A third party cannot give or refuse consent for an assessment of eligibility on behalf of a person who lacks capacity, unless they have a valid and registered Lasting Power of Attorney for Health and Welfare or have been appointed as a Deputy for Health and Welfare by the Court of Protection.
- The ICB clients will support the provision of advocacy throughout the application process where appropriate.
- All individual patients and their families will be provided with information to enable them to participate in the process this will include the Department for Health CHC public information leaflet.
- Health and Social care professionals will work in partnership with individual patients/clients and their families throughout the process.
- Individual's preferences and wishes will be taken into account whilst giving consideration to any risks posed as to how and where care will be delivered.
- The process for decisions about eligibility will be transparent for individual patients/clients and their families and for partner agencies.
- Protect individuals in vulnerable situations and work with partner agencies to address any safeguarding concerns.

- All professionals will work in partnership with individual patients/clients and their families throughout the process.
- All those involved in CHC assessment will have a good working knowledge of the National Framework for NHS CHC 2022. Each organisation has responsibility for ensuring their staff are competent in this field of practice. Individual practitioners will be accountable for their own actions both organisationally and professionally.
- Ensure any identified deficits are rectified: this will be achieved by a commitment to clinical and managerial supervision, reflective practice, training, and adherence to risk management procedures.
- Ensure that any decision regarding eligibility for NHS CHC or FNC is based on the person's assessed needs: this is the primary indicator - decisions on eligibility should not be financially led.
- All decision-making will be informed by an appropriate Multidisciplinary Team (MDT) assessment.
- Once an individual has been referred for a full assessment for CHC (following use of the Checklist or a direct referral); a Multidisciplinary Team (MDT) assessment of the individual's health and social care needs will be conducted. Those who have completed the individual assessments should then convene as part of an MDT to complete the Decision Support Tool (DST) and establish if a primary health need can be evidenced.
- Assessments and decision's regarding eligibility will be undertaken within 28 working days of the completion of the CHC checklist to ensure that individuals receive the care they require in the appropriate environment, without unreasonable delays.
- To provide thorough and effective mechanisms for responding to and managing appeals, complaints and disputes as per the Local Resolution Policy and national guidance.

4.0 Roles and Responsibilities

Party	Key Responsibilities
Health care staff referring clients for consideration of eligibility	• Obtain appropriate documented consent in line with policy and a Mental Capacity Assessment as required. • Complete the required documentation including a professional assessment, CHC Checklist or CHC Fast Track and an appropriate care plan fully and in line with the CHC National Framework. • Ensure full engagement and co-operation in completing the DST within 28 days of the ICB receiving the Checklist. When required lead the DST process as the MDT Coordinator (see section 5, the NHS Continuing Healthcare Process)
Social care staff referring clients for consideration of eligibility	• Obtain appropriate documented consent in line with policy and a Mental Capacity Assessment as required. • Complete the required documentation including a professional assessment or CHC Checklist in line with the CHC National Framework. • Ensure full engagement and co-operation in completing the DST within 28 days of the ICB receiving the Checklist. (see section 5, the NHS Continuing Healthcare Process)
Continuing Healthcare Team	• Receive and review all CHC Checklists and CHC Fast Track applications within two working days to ensure the standards required are met and that they indicate

	eligibility for receipt of service or further assessment for eligibility. • Maintain the CHC database ensuring all referrals are recorded and that all correspondence is kept for each individual patient. • Facilitate the appointment of a Case Co-ordinator to oversee the assessment process. • Review completed DST's to ensure they are completed fully in accordance with the National Framework, supported by robust clinical evidence presented in an appropriate manner and that the MDT has clearly stated a recommendation. • To ensure a social care practitioner has been invited be part of the MDT/DST process. If a social care practitioner is not available to take part this must be recorded in the DST or the person's file. • Verification of Checklists and Fast Track Assessments ensuring appropriate consent has been obtained and the documents are adequately completed. • Arrange for the DST to be verified by either an in-office verification process or presented to the Decision Making Panel (DMP) along with any supporting information and invite the Co-ordinator of the DST to the panel. The DMP will review a random selection of cases for auditing and consistency checking purposes. • Write to referrer and patient or their representative with the outcome and how to appeal if they are dissatisfied with the decision. • Once a person has been found eligible for CHC or CHC Fast Track to arrange the package of care based upon the assessed needs of the individual. The CHC team are responsible for the clinical oversight and suitability of the care plans to safely meet the individuals care needs. The CHC Placement Team are responsible for sourcing a placement or package of care. • If the individual is found to be not eligible for NHS CHC but is entitled to NHS FNC, arrange for the payments to be processed and made to the care home in a timely manner. • Record all eligibility decisions in the individual's case records and ensure all communication of these decisions are undertaken in a timely and professional manner. • Ensure patient case management arrangements are in place with relevant CHC and provider organisations. • Ensure reviews are undertaken in line with national policy and at other times as required on a priority basis.

	• Undertake regular audits to ensure service is meeting agreed KPIs including patient, staff and customer feedback • Ensure the ICB is alerted to issues with Care providers which may compromise quality of care.
Decision Making Panel (DMP)	• Consider applications for continuing healthcare eligibility in a timely and robust manner and verify the recommendation in line with the CHC framework. • Consider a random audit of cases to monitor for consistency of decision making and quality assurance. • Verify the MDT recommendation for CHC eligibility in accordance with the submitted evidence. • Panel will consider CHC applications that have been twice deferred back to the MDT for review under the exceptional decision guidance in line with the CHC framework. • Support the ICB Resolution Process and Retrospective CHC review process through the DMP.
CHC Placement Team Contracting /Commissioning Responsibilities	Technical Commissioning: • Maintain a database of providers. • Seek assurances that the providers have CQC accreditation. • Negotiate prices and terms and conditions for services offered by providers with consideration of local agreements. • Develop contracts with providers that ensure high quality care delivery and value for money. • Monitor all contracts. • Finance/resources: Forecast likely spend for each year based on historic trends. • Completion of ICB financial assurance process to ensure best use of financial resources. • To monitor for potentially fraudulent activities in accordance with the Anti-Fraud and Bribery Policy.
Finance Director	• 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.

5. The Continuing Healthcare Department

5.1 The Hertfordshire & West Essex ICB, (delivered through the Continuing Healthcare Department) lead statutory responsibility for ensuring the application of the requirements of the National Framework and CHC process for all people over the age of 18 throughout ICB area. The team also works with children's services to manage the transition process.

5.2 The aims and objectives of the department are:

- To establish and maintain operational and governance arrangements for CHC that ensure consistency in the application of the National Framework within a robust evidence-based approach.
- To ensure the completion of a comprehensive assessment of need for eligible individuals.
- To monitor the quality of assessments received and liaise with referrer as required to resolve any issues.
- To work in partnership with a range of agencies to achieve standard procedures for assessing eligibility, decision-making and review for individuals eligible for CHC.
- To co-ordinate the CHC assessment process, liaising with the individual, their family, and the Multidisciplinary Team (MDT). This may also be supported by a provider service as per agreed contracts.
- To commission and procure appropriate care packages that represent good quality and value for money.
- To manage a system to resolve complaints, disputes, and appeals.

5.3 The department will undertake the following responsibilities:

- Ensuring policy and legal guidance is interpreted and implemented in line with requirements.
- Provide an assessment service and decision-making process in line with the National Framework and Standing Rules and Regulations.
- Offer a single point of contact and manage relationships between patients, relatives, health and social care professionals, other NHS organisations and the public sector.
- Work closely with MDT colleagues to take responsibility for agreeing packages of care.
- Oversee the procurement and provision of care to patients with a range of presenting conditions and provide contract and finance management to ensure quality services are provided that represent value for money.
- Ensure that people who are eligible are appropriately assessed, managed, monitored, evaluated, and reviewed. Individuals and families will be made aware that eligibility for NHS CHC is not indefinite as needs may change and will be regularly reviewed.
- For individuals accommodated in a Nursing home, where the decision is that the person is not eligible for NHS CHC, the need for care from a registered nurse and eligibility for FNC will be considered.
- Manage the ICB resolution process in line with the National Framework to resolve all appeals, complaints, disputes, and independent reviews.

- Ensure that all retrospective reviews of eligibility are compliant with requirements from NHS England and the Parliamentary and Health Service Ombudsman.
- Support the development and delivery of joint training programmes with the Local Authority and other providers regarding all process and policies, both local and national, regarding eligibility for NHS Continuing Healthcare and NHS Funded Nursing Care and the delivery of Personal Health Budgets.

Contact details for the Continuing Care Teams are as follows;

East & North Herts Charter House, Parkway, Welwyn Garden City, Hertfordshire, AL8 6JL Tel: 01707 685260 Email: hweicbenh.continuinghealthcare@nhs.net
South & West Herts Herts Valleys Clinical Commissioning Group, The Forum, Marlowes, Hemel Hempstead HP1 1DN. Tel: 01442 284130 Email: hweicbhv.continuinghealthcare@nhs.net
West Essex First Floor Kao Park 2 London Road Harlow CM17 9NA Tel: 01992 566137 Email: hweicbwe.thecontinuinghealthcareteam@nhs.net

6. The NHS Continuing Healthcare Process

6.1 The Standing Rules Regulations[1] require NHS Commissioners to take reasonable steps to ensure that individuals are assessed for NHS CHC in all cases where it appears to them that there may be a need for such care, and the Checklist is the only screening tool that can be used. Therefore, health and social care staff should consider screening using the Checklist (subject to consent) in all the following situations:

- Whenever it appears that an individual may potentially be eligible for NHS CHC.
- Prior to any NHS-Funded Nursing Care (FNC) recommendation, and at each subsequent FNC review.

6.2 The National Framework clearly states that “screening and assessment of eligibility for NHS Continuing Healthcare should be at the right time and location for the individual

[1] Part 6 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

and when the individual's on-going needs are known. The full assessment of eligibility should normally take place when the individual is in a community setting. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and on-going needs".

6.3 When not to assess:

6.3.1 The revised 2022 CHC Framework outlines situations where it is not necessary to complete a Checklist (Pg41, paragraph 121). These include:

- It is clear to practitioners working in the health and care system that there is no need for NHS Continuing Healthcare at this point in time. Where appropriate/relevant this decision and its reasons should be recorded. If there is doubt between practitioners, the Checklist should be undertaken.
- The individual has short-term health care needs or is recovering from a temporary condition and has not yet reached their optimum potential (although if there is doubt between practitioners about the short-term nature of the needs it may be necessary to complete the Checklist). See paragraphs 109-117 of the National Framework for how NHS Continuing Healthcare may interact with hospital discharge.
- It has been agreed by the ICB that the individual should be referred directly for full assessment of eligibility for NHS Continuing Healthcare.
- The individual has a rapidly deteriorating condition and may be entering a terminal phase – in these situations the Fast Track Pathway Tool should be used instead of the Checklist.
- An individual is receiving services under Section 117 of the Mental Health Act that are meeting all of their assessed needs.
- It has previously been decided that the individual is not eligible for NHS Continuing Healthcare and it is clear that there has been no change in needs.

6.3.2 It is clearly stated within this guidance document that if it is deemed unnecessary to screen for NHS Continuing Healthcare at this time, the decision not to complete the Checklist and its reasons should be clearly recorded in the patient's notes.

6.3.3 During the assessment process and prior to any application for NHS CHC the patient should have completed any active treatment and have reached their optimum potential for any rehabilitation. That is, the multidisciplinary team should consider whether any service could enable improvements that could alter the outcome of an eligibility decision in the short term, e.g.

- Re-enablement pathways
- Rehabilitation programmes
- Extended period of assessment placements (including Discharge to assess)

6.4 Referring to the CHC team and Requesting completion of a CHC checklist

6.4.1 A referral may take the form of a request to consider eligibility (e.g. a direct contact from an individual or their relative) and can be received by telephone, letter or email to the Continuing Healthcare Team. See Section 4 for relevant contact details.

6.4.2 The referral will be checked to ensure that all relevant details are available and correct, including a check for Responsible Commissioner. This will be completed within one working day. Where the ICB are not the 'Responsible Commissioner' (Who Pays? Determining which NHS commissioner is responsible for

commissioning healthcare services and making payments to providers (2022)) the referral will be redirected to where commissioning responsibility lies based upon GP registration.

6.4.3 A completed Checklist is the accepted form for use to consider whether someone should have a full NHS CHC assessment.

6.4.4 Referrals in the form of a completed Checklist will be checked to ensure that they are robust, with appropriate consent and make appropriate reference to supporting evidence. Where there are concerns about the quality of the referral or where there is significant missing or conflicting information the referrer will be contacted as soon as possible to respond to the queries. The CHC team will support all reasonable requests for a full assessment.

6.4.5 The Checklist should only be completed by NHS or Local Authority staff who have been trained in its use. However, if a professional who has not received training completes a Checklist appropriately, which indicates that the individual requires full consideration for NHS CHC, the CHC team will act on this and arrange for CHC process to be followed.

6.5 Exceptions: Section 117

6.5.1 Under section 117 of the Mental Health Act 1983 ('section 117'), the ICB and Local Authorities (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. Section 117 is a freestanding duty to provide after-care services for needs arising from an individual's mental health condition.

6.5.2 Responsibility for the provision of section 117 services lies jointly with LAs and the NHS. Where a patient is eligible for services under section 117 these should be provided under section 117 and not under NHS CHC.

6.5.3 It is important for the ICB 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, irrespective of which budget is used to fund those services. It is not necessary to assess eligibility for NHS CHC if all the services in question are being provided as after-care services under section 117.

6.5.4 However, a person in receipt of after-care services under section 117 may also have ongoing care/support needs that are not related to their mental health condition and that may, therefore, not fall within the scope of section 117. A person may be receiving services under section 117 and then develop separate physical health needs (e.g. through a stroke, long term conditions or cancer) which may then trigger the need to consider NHS CHC only in relation to these separate needs. In these cases, the needs covered within the section 117 after rights care plan must be established prior to assessment for NHS Continuing Healthcare.

6.5.5 Where an individual in receipt of section 117 services develops physical care needs resulting in a rapidly deteriorating condition, which may be entering a terminal phase, consideration should be given to the use of the Fast Track Pathway Tool.

6.5.6 NHS Continuing Healthcare should not be used to meet section 117 needs.

6.6 Children and Young People under 18 including transition to adult services.

The National Framework for NHS CHC applies only to adults aged 18 or over. There is a separate 'National Framework for Children and Young People's Continuing Care' which applies to children or young people under the age of 18. The framework is quite different for children and young people, but it is very important that consideration of potential eligibility for NHS CHC (when the person reaches 18) is considered early as part of the planning process for transition.

Children's Continuing Care Teams or other children's services, including those based within the Local Authority, should identify those young people for whom it is likely that adult NHS CHC will be necessary and should notify whichever ICB will have responsibility for them as adults. This should occur when a young person reaches the age of 14, with a formal referral for screening at 16 years. This will then follow the usual CHC eligibility assessment process.

At the age of 17, eligibility for adult NHS CHC should be determined in principle by the ICB so that, wherever applicable, effective packages can be commissioned in time for the individual's 18th birthday, or later if it is agreed this is more appropriate.

If it is deemed that a child in receipt of CHC will no longer be eligible as an adult, the right of appeal will follow the same review procedure as set out within the ICB resolution process.

6.7 Capacity to Consent to a CHC assessment

6.7.1 The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect vulnerable people who are unable to make their own decisions. The initial assumption will be that the person has capacity to make all or some decisions unless it is shown that they cannot. The MCA clarifies the rights and duties of workers and carers, including how to act and make decisions in respect of adults who may lack mental capacity.

6.7.2 The MCA aims to ensure that people are given the opportunity to participate in decisions about their care and treatment to the best of their capacity. It covers all aspects of health and social care. Individuals should be given all the appropriate help and support to enable them to make a decision.

6.7.3 Where the individual does not have the capacity to understand a particular decision then Herts & West Essex ICB will consider whether it is appropriate to involve an Independent Mental Capacity Advocate (IMCA) where it is considered that there is no one else willing and able, or appropriate, to be consulted or that appointing an IMCA will benefit the individual.

6.7.4 Individuals eligible for NHS CHC without mental capacity should be referred to the Independent Mental Capacity Advocate Service when;

- A decision is being made about serious medical treatment, or a long-term change in accommodation **and**
- The person lacks capacity to make that decision **and**
- They do not have friends or family with whom the decision maker feels appropriate to consult with about the decision.

6.7.5 Appointing an IMCA once the individual has been discharged from the Acute Trust setting will be done at the expense of Herts & West Essex ICB. In such cases the ICB is expected to undertake the following procedure:

- Document that it has established beyond reasonable doubt that the individual in question lacks mental capacity, according to sections 2 and 3 of the MCA, to make a decision on the specific issue. It is expected that this documentation will include a complete written capacity assessment from one or more clinicians.
- Establish and record that there is no Power of Attorney which extends to healthcare decisions.
- Document that it has made all reasonable attempts to contact any family, friends or representatives and, in cases where they can be involved, has sought their views.
- Decide if there is a need to appoint an Independent Mental Capacity Advocate in cases where no firm views from friends or family can be obtained.

6.7.6 The ICB may source an IMCA from the Local Authority or the agency that refers the patient in the first instance, who in some cases may provide advocacy services.

6.7.7 Where the individual lacks capacity to make the decision regarding where to live and there is no Lasting Power of Attorney, which extends to healthcare decisions, then the ICB is under a duty to act in accordance with the individual's best interests in accordance with the MCA.

6.7.8 Herts & West Essex ICB will take the decision based on consideration of the best interests of the individual, taking into account the views of their family/carers. In exercising this responsibility, the ICB will need to consider whether there is a requirement for a deprivation of liberty authorization (DOLs).

6.7.9 Herts & West Essex ICB will then make a decision on the best interests of the individual, in accordance with section 4 of the MCA. It is expected that any views obtained by family, friends or IMCA will be taken into account.

6.7.10 Where a personal welfare deputy has been appointed by the Court of Protection under the MCA or a Lasting Power of Attorney with powers extending to healthcare decisions has been appointed, then the ICB will consult with that person to reach a decision on the preferred care option

6.8 CHC Checklist and Decision Support Tool process

6.8.1 The first step in the CHC process is to screen the individual using the NHS Continuing Healthcare Checklist. The purpose of the Checklist is to encourage proportionate assessments so that resources are directed towards those people who are most likely to be eligible. Before applying the Checklist, it is necessary to ensure that the individual and their representative, where appropriate, understand that the Checklist does not indicate the likelihood of eligibility– 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 do get this opportunity.

6.8.2 A Nurse, Doctor, other qualified healthcare professional, or social worker should complete a CHC Checklist to refer individuals for a full consideration of eligibility from either a 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 and NHS-funded Nursing Care (DH 2022) and the Decision Support Tool (DST).

6.8.3 Where the Checklist has been used as part of the process of discharge from an Acute Hospital and has indicated a need for full assessment of eligibility,

consideration should also be given to the person's further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs. It is important to note that a checklist should only be completed at the right time and location for an individual and when an individual's needs are known.

6.8.4 If completion of the screening checklist indicates that the individual patient may be eligible for further assessment, the Decision Support Tool (DST) will be completed following the completion of the multidisciplinary assessment process. The DST provides the overall picture of need and interaction between needs which, together with the evidence from relevant assessments, supports the process of determining eligibility and ensures consistent and comprehensive consideration of an individual's health and social care needs.

6.8.5 The DST is completed by the multidisciplinary team and provides practitioners with a framework to bring together and record the various needs in care domains or generic areas of need. The practitioners use the DST to apply the primary health need tests, ensuring that the full range of factors which may have a bearing on the individual's eligibility are considered.

The Standing Rules Regulations define an MDT as: "a team consisting of at least –

Two professionals who are from different healthcare professions, or one professional who is from a healthcare profession and one person who is responsible for assessing persons for community care services under [section 9 of the Care Act 2014 (assessment of an adults needs for care and support)] And a healthcare profession as: "a profession which is concerned (wholly or partly) with the physical or mental health of individuals (whether or not a person engaged in that profession is regulated by, or by virtue of, any enactment)

6.8.6 The DST domains cannot directly determine eligibility, but it provides the basis from which decisions are made, exercising professional judgment and in consideration of the primary health need test. Once the multidisciplinary team has reached agreement, they make a recommendation regarding eligibility. This is then submitted to Herts & West Essex ICB for verification.

6.8.7 Herts & West Essex ICB reviews all applications for CHC received to ensure consistency and quality of decision making and provides governance to the decision-making process. This ensures equity of access to NHS Continuing Healthcare and consistent decision making for all applications.

6.8.8 A person only becomes eligible for NHS CHC once a decision regarding eligibility has been verified and agreed by the ICB, informed by a completed Decision Support Tool or Fast Track Pathway Tool. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue.

6.8.9 Where individuals are found to be eligible, funding will be agreed from the 29th day following the Screening Checklist except within exceptional circumstances attributed to an unreasonable delay from external parties.

6.8.10 The requirement for assessments to be completed within the 28-day time frame requires joint working across the whole system of health and social care. The time frame identified is a key performance indicator for NHS CHC and therefore is not optional. Delays in meeting this target and the reasons for them require presentation during the ICB verification process, when consideration of eligibility takes place and will be closely monitored and recorded.

7. Virtual Assessments

7.1 As a result of national guidelines following the Covid-19 pandemic virtual assessments have become part of normal practice and remain an option during all assessment processes. This may be due to preference of the patient or their representative or due to restricted visiting in place due to Infection Prevention and Control Guidance (IPC) protocols.

7.2 A virtual assessment can be conducted when necessary if it is not possible to complete this face to face or if this is a preferable method of communication for all parties involved.

7.3 Virtual assessments can minimise contacts, in line with IPC guidance and ensure in most circumstances individuals requiring assessment can be reviewed, along with providing the evidence required to undertake a fair and comprehensive assessment and ensure family/representatives have an opportunity to contribute in a safe way.

7.4 Assessments will be completed via MS Teams with the ICB coordinating electronic invites to maintain individual's confidentiality at all times.

7.5 All relevant information to support the assessment is to be circulated to all participants prior to meeting.

8. Continuing Health Care Verification Process

8.1 The purpose of the Herts & West Essex ICB CHC Verification Process is to enable the ICB to discharge its responsibilities in relation to the determination NHS CHC eligibility and to provide a forum for quality assurance and peer review of decision making. Completed applications for CHC will be verified either through the in-office verification process or at the Decision Making Panel (DMP). The DMP will review and verify a random audit of cases. They will also review appeal cases for the completion of the local resolution process, retrospective review cases and any cases requiring review under the exceptional circumstances rule as stated in the updated Framework practice guidance.

8.2 The terms of reference for the Decision Making Panel are attached as Appendix 3. The CHC Panel is chaired by a professional with extensive knowledge of the National Framework, the chair remains independent to the decision-making process and has had no prior involvement in the assessment of the submitted case.

8.3 The CHC verification process is an evidenced based process to ensure that the Framework has been fairly applied with evidence and professional assessments submitted to support decision making. The verification process will not consider financial issues and will not act as a financial gate keeper. All outcomes are evidence based, transparent and communicated to all stakeholders. Decisions will be made equitably, and individuals will not be discriminated against on the basis of age, disability, sex, race, religion and beliefs or any other protected characteristics.

8.4 The in-office verification process is completed by an experienced nurse working within the CHC team.

8.5 The verification process will result in the following outcomes:

- **Approval:** the MDT recommendation is approved.
- **Deferral:** more work is required on the Decision Support Tool or additional evidence is requested to support the statements within the Decision Support Tool. Approval is deferred until the information requested is available.
- **Rejection:** this is only to be actioned under the exceptional circumstances rule as stated in the updated Framework practice guidance and following previously deferring the submission for further information.

8.6 The decision and reasons for approval, deferral or rejection must be recorded and, if not approved, will be communicated to the referrer immediately with request for further information if required.

8.7 Following the ICB verification process, the CHC Team Panel Administrator will write to the referrer and the family/carer informing them of the panel's decision. The Key Co-ordinator will be informed by telephone or email of the decision made within 24 hours of the verification, followed by written confirmation within 5 working days.

9. Agreeing the Care Package

9.1 The ICB will commission the provision of NHS Continuing Healthcare in a manner which reflects the choice and preferences of individuals as far as possible but balances the need to commission care that is safe, effective, able to meet an individual's needs making best use of financial resources. Therefore, in circumstances where there are concerns regarding the quality of care in a care home and the ICB cannot commission care in the home at that time, the ICB will work with individuals and their families to commission a suitable package of care within an appropriate environment. Families may request that their relative is placed in a Care Home outside of the Hertfordshire & West Essex area. In these circumstances the family and the representative from the CHC Team will discuss the appropriateness of the placement to ensure the quality of care, safety of care and that the provider can meet the individuals assessed needs. The procurement of a care package outside of the Herts & West Essex ICB will be progressed in line with Responsible Commissioner Guidance. The ICB will also ensure a decision is made in the individual's best interest with a Mental Capacity Assessment if required.

9.2 In light of the need to balance patient preference alongside safety and value for money, the ICB is working towards integrated ICB wide procurement and the development of a procurement strategy. Consequently, patients will have a choice of providers that have a contract with Hertfordshire & West Essex ICB and have agreed the Trusts quality standards and pricing structure in accordance with the ICB policy.

9.3 Agreeing the placement or package of care will include:

- The commissioning of placements or care packages.
- Agreeing the care plan with the appropriate clinician and ensuring that care plans and risk assessments are received.
- Agreeing the care package and costings with the provider.
- Completing assurance checks with the Care Quality Commission (CQC) and when placing a patient out of area contacting the local ICB.
- Checking for any outstanding quality/safeguarding issues.
- Informing and updating the referrer, patient and if appropriate the family/carer.
- Agreeing and informing the provider and relevant others, the monitoring and review arrangements of the care package.

- The CHC placement Team are responsible for ensuring that the details and associated costs of the agreed packages are recorded accurately on the iChord database.

9.4 All new residential care providers and care agencies will receive a contract on completion of the financial negotiation and before the start of the placement or package. This is in accordance with the NHS Contract and service specifications.

9.5 In situations where it is necessary to revisit a previous decision of eligibility for NHS CHC, or where there has been undue delay in reaching a decision of eligibility, the CHC team alongside Hertfordshire & Essex County Councils will follow national guidance regarding refunds and redress with reference to local agreements.

9.6 The CHC team will work with the Local Authority to ensure that individuals are not disadvantaged during the assessment or commissioning process and their care needs continue to be met.

9.7 There will be some individuals who, although they are not entitled to NHS CHC, have needs identified through the Decision Support Tool, that are not of a nature that the Local Authority can lawfully or solely meet. These individuals may require a joint care package. The CHC team alongside Hertfordshire and Essex County Councils will work in partnership to agree their respective responsibilities in a joint package of care (for further details please refer to National Framework).

10. Monitoring and reviewing

10.1 All agreed health packages of care (both CHC and FNC) should initially be reviewed 3 months following the commencement of the placement/package of care and thereafter yearly or earlier if required.

11. Appeals process in relation to eligibility for NHS Continuing Healthcare

11.1 The CHC team operates a ICB Resolution Process in line with the National Framework. Where an individual is deemed not to be eligible for NHS CHC the decision will be communicated in writing together with copies of the verification report that provide the rationale for the eligibility decision. The applicant will be advised in writing of their right to appeal the decision, provided they do so within 6 months of the notification. If the individual or their representative seek a review this will aim to be completed within 6 weeks of receipt of their request. If the outcome of the local review is that the original decision of not meeting CHC eligibility was correct, the individual will have a further 6 months to request an independent review by NHS England.

11.2 If an individual wishes to challenge a negative checklist decision the CHC team will review the case and either offer to repeat the checklist by an alternative clinician or to process the case through to a Decision Support Tool completion. The individual also has the right to raise a complaint following usual NHS procedures.

12. Retrospective Reviews of CHC and Redress

11.1. A national Previously Unassessed Periods of Care (PUPOC) closedown occurred in 2012 for all cases dating back to 2004. Following this closedown, no retrospective reviews of NHS Continuing Healthcare funding can review a time period prior to the 31st March 2012.

11.2. The ICB can only consider requests for retrospective reviews where it is satisfied that one or more of the following grounds for the review exist:

- The ICB failed to carry out an assessment of the claimant's eligibility for CHC funding when requested to do so.
- When no assessment of CHC was completed during the requested time period however the applicant has grounds to believe a Primary Health Need may have been present.

11.3. In the absence of evidence of any of the above, the ICB is not obliged to undertake a retrospective review of the claimant's eligibility for such funding.

11.4. In order for the NHS to establish whether a full assessment of eligibility is necessary, a questionnaire and consent form is sent out to the claimant before the retrospective review request can be agreed. The questionnaire will support the CHC team to understand more about the individual's health care needs during the time of the claim and the agencies involved in the individual's care.

11.5. On receipt of the completed application and consent forms, the ICB is required to complete a number of preliminary checks to establish if a retrospective review should be undertaken, as set out below:

- The CHC team will first have to establish whether they are the Responsible Commissioner to deal with the request. If they are not the responsible organisation, the CHC team will inform the claimant of the correct Responsible Commissioner to contact.
- Where there has been a personal choice by the individual or their families not to accept NHS CHC funding (for example if this meant that they were unable to pick the home of their choice) then the NHS would not then be liable for this period of time if they later decided to claim retrospectively.
- Once the Responsible Commissioner has been confirmed as Herts & West Essex ICB, the CHC team will consider the following:
    - *Was the individual in receipt of NHS Funded Nursing Care?*
      An FNC assessment should have only taken place once it had been established that the individual was not eligible for NHS CHC. If there was a nursing assessment but no CHC assessment, or proper consideration of the need for a CHC assessment, then this indicates a previous assessment and a PUPOC assessment process should be considered.
    - *Was an NHS CHC assessment requested at any point?*
      If there was a recommendation for a CHC assessment at any stage but this was not carried out (and no valid reason provided) then this is strong evidence that a PUPOC assessment should be undertaken.

11.6. If, on completion of the initial tests, it is determined that a full assessment for CHC is necessary, then the CHC team will begin to collate the evidence relating to the claim period. This includes requesting records from care providers, community services, acute hospital trusts and local authority. This information will be detailed within the needs portrayal document and shared with the family for comments.

11.7. Once the needs portrayal document is finalised this will be submitted to a "Retrospective MDT" who will complete a Decision Support Tool document for the agreed time period and make a recommendation regarding eligibility by applying the

Primary Health Need test. This will then be verified, and the decision communicated to the applicant in the same way as with current CHC eligibility decisions. The decision may be that the individual is not eligible for CHC, eligible for CHC or eligible for part of the time period only. If the claimant wishes to appeal the ICB's decision the process is the same as with current assessments.

11.8. Where a retrospective review of eligibility determines that an individual was eligible for NHS CHC, appropriate arrangements will be made for financial recompense in line with the ICB's Redress Policy. The purpose of redress is solely to restore the individual to the financial position they would have been in had NHS Continuing Healthcare been awarded at the appropriate time. As set out in "Principles for Remedy" "remedies should not lead to a claimant making a profit or gaining an advantage". This principle also applies to the NHS.

12.1 **Funded Nursing Care Referral Process**

Where the decision is that the person is not eligible for NHS CHC, there may still be a need for care from a registered nurse. This should be considered, and the decision made as to whether registered nursing care in a care home providing nursing is the best option. In this circumstance the individual may be eligible to NHS Funded Nursing Care (FNC). NHS FNC is the funding provided to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS FNC has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS Continuing Healthcare before a decision is reached about the need for NHS Funded Nursing Care.

13. Requests for "Fast Track" funding

13.1 An individual may also have a primary health need because they have 'a rapidly deteriorating condition, which may be entering a terminal phase,' In such situations, where the individual needs a package of care to enable their needs to be met urgently (e.g. to allow them to go home to die in their preferred place of care or appropriate end of life support to be put in place), the Fast Track Pathway Tool should be completed, but this can only be done by 'an appropriate clinician', defined in Standing Rules Regulations as 'a person who is:

- responsible for the diagnosis, treatment or care of the person in respect of whom a Fast Track Pathway Tool is being completed, **and**
- a registered nurse or a registered medical practitioner.

13.2 When the CHC team receives a Fast Track tool accurately completed by an appropriate clinician evidencing a rapidly deteriorating condition, the ICB is obliged to accept the individual's assessment as eligible for NHS CHC without delay and without the need for a Checklist or Decision Support Tool to be completed. The CHC team will then commission and procure the necessary care or support as quickly as possible. It is vital, therefore, that the tool is used correctly and only in those situations for which it was intended. For this reason, the CHC team is working with key clinicians across Hertfordshire & West Essex to ensure that the Fast Track Tool is understood and used appropriately.

13.3 There are no specified time limits for life expectancy regarding the use of the tool – 'rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining. The appropriate clinician is not required to provide evidence alongside the completed Fast Track Tool in order for it to be actioned, but it should be supported by a prognosis and/or diagnosis if known. However, when care is not already in place, it is essential that a care plan is supplied to enable the appropriate placement/package of support to be identified.

13.4 The appropriate clinician must take into account the practicalities involved in procuring the care package to meet the patients' needs in Fast Track situations and not raise unrealistic expectations with the patient and family carers. This is particularly so where the needs are complex, the home situation is unclear, or the request is being made at a weekend or bank holiday. Whilst funding can be agreed quickly on receipt of the completed Fast Track it may not be possible to secure appropriate care immediately. It is essential to liaise directly with the CHC Team to discuss procurement options in such situations.

13.5 The Fast Track Tool must not be used instead of a full assessment because of service pressures, e.g. the need to discharge a patient from hospital, shortage of staff etc.

13.6 Where an individual's care is funded under the Fast Track Pathway the CHC team or the provider involved with their care will review the person's needs within 12 weeks or when a person's care needs stabilise (whichever occurs first) and are no longer considered to be rapidly deteriorating. The CHC Fast Track funding cannot be removed without a full Decision Support Tool being completed by a Multidisciplinary Team.

13.7 Where individuals are found to be eligible for Fast Track the care package will be funded from the date of introduction of the agreed package of care.

14. Case Management

14.1 Care reviews will be undertaken for individuals no later than three months following the initial assessment and annually thereafter. This will ensure that individual patients are receiving the care they need. The care review will also review the continuing eligibility of the individual patient for NHS CHC. The NHS has a responsibility to provide or commission care based on the needs of the individual being primarily for healthcare and, therefore, this may not be indefinite. In some circumstances an individual's needs might change and therefore so might their eligibility for NHS Continuing Healthcare. It is the ICB's responsibility to ensure that this is made clear to the individual and their family. Some cases will require more frequent review in line with clinical judgement and changing needs.

15. Deprivation of Liberty Safeguards (DOLS)

15.1 The Mental Capacity Act contains provisions that apply to a person who lacks capacity and who, in their best interests, needs to be deprived of their liberty in a care home or hospital, in order to receive the necessary care or treatment. The fact that a person who lacks capacity needs to be deprived of his or her liberty in these circumstances does not, in itself, preclude or require consideration of whether that person is eligible for NHS CHC. Herts & West Essex ICB is currently responsible for the assessment and coordination of DOLs applications for individuals living within their own home, that lack capacity and are deprived of their liberty.

16. Jointly Funded Packages of Care

16.1 The National Framework for Continuing Healthcare states that if a person does not qualify for NHS Continuing Healthcare, the NHS may still have a responsibility to effectively contribute to that person's health requirement. This is sometimes known as a "joint package" of care. The most obvious way in which this is provided is by means of the NHS Funded Nursing Care, in a care home setting with Registered Nurses present.

16.2 Joint packages of care may also be provided through the provision of commissioned NHS services such as district nursing or physiotherapy for example. A joint package of care with the local authority will only involve joint funding where there is a particular identified health requirement needing an identified care package to be commissioned, which cannot be met by already commissioned services. In these circumstances the NHS will fund the care package for the identified health element only.

16.3 Where the MDT recommendation is that the patient is not eligible for NHS CHC the MDT may consider any health element that may be present and if there would be a recommendation for joint funding. If the MDT recommend joint funding, then the Herts & West Essex ICB CHC team and the Local Authority will negotiate which elements of the care plan are to be funded by social care and which are the responsibility of the NHS. The local authority will remain the lead organisation and retain responsibility for commissioning the social care provision required and the case management of the client. Herts & West Essex CHC team and the Local Authority will continue to work in partnership and support the review process jointly, as per the national framework for CHC and FNC this would be initially at three months and annually thereafter unless an earlier review is indicated.

17. Equipment

17.1 Where an individual is in receipt of CHC and requires equipment to meet their care needs, there are several routes by which this may be provided:

- The care home setting may provide non-specialised equipment as part of their regulatory standards under the Care Quality Commission (CQC) or as part of the contract with Herts & West Essex ICB. Further details of the regulatory standards can be found on the CQC's website at www.cqc.org.uk .
- Some individuals may require bespoke equipment as assessed by an appropriate healthcare professional to meet specific assessed needs identified in their NHS CHC care plan. Herts & West Essex ICB will make appropriate arrangements to meet these needs. In the event of a short prognosis the ICB may not provide bespoke equipment however this will be assessed on a case-by-case basis.
- Individuals who are entitled to CHC have an entitlement on the same basis as other patients to equipment services. Herts & West Essex ICB should ensure that the availability to those in receipt of CHC is considered in the planning, commissioning and funding arrangements for the equipment service. In the interim CHC is required to ensure equipment is provided to the individual as identified in their assessed needs that is not currently provided as part of their care package by other means.

17.2 Any assessment for equipment needs to be carried out by NHS staff and appropriate authorisation channels. Stock items and non-standard equipment for daily living is provided by Hertfordshire Equipment Services (HES) or the Independent Living Centre. Adaptations and major adaptations are subject to Disabled Facilities Grants and are not the responsibility of the ICB to assess or fund.

17.3 For those in residential or nursing home in need of non-standard stock equipment in most circumstances these will be ordered and maintained by HES or the Independent Living Centre. In exceptional circumstances the care home may purchase the equipment. In such cases the home will retain responsibility for maintenance of this equipment. Where equipment has been provided and serviced by either HES or the Independent Living Centre it will be returned to the relevant supplier when no longer required.

18. Contracting arrangements

18.1 The Continuing Healthcare Department contributes to the ICB's responsibility to plan strategically and specify outcomes for people who are eligible for NHS Continuing Healthcare.

18.2 The department will manage provider performance for the services contracted by them to meet the needs of qualifying individuals.

18.3 They will contribute to the commissioning of services that include the on-going case management role from other providers, e.g., community services; discharge planning; for all those who may be entitled to NHS CHC; as well as commissioning the NHS elements of joint packages.

18.4 The CHC Department will monitor quality and patient experience within the context of provider performance for those contracts which it manages.

18.5 Care packages will be commissioned from care homes, from domiciliary care providers and from nursing agencies. Where an NHS contract for CHC is not already 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 for the provision of NHS services.

18.6 Care will only be commissioned from those care providers who have an adequate/satisfactory care rating from the CQC. Where a care provider has a poor rating, care packages will not be commissioned until an action plan for improvement has been put in place and the care rating has improved. Where care is already being commissioned for residents in the care setting, a risk assessment will be undertaken in partnership with the Local Authority and in consultation with the resident and their family to ensure appropriate controls are in place to assure the individual's safety and the quality of the care provided.

18.7 Safeguarding

18.7.1 All providers will ensure that they work to the standards identified in SET procedures for adult and children safeguarding.

18.8 Patients in receipt of compensation payments

18.8.1 The NHS Constitution, to which ICBs must (by statute) have regard, states that "access to NHS services is based on clinical need, not on an individual's ability to pay". However, each compensation case should be considered individually and the ICB will seek legal advice prior to progressing commissioning decisions for these cases.

19. Personal Health Budgets and Direct Payments

19.1 A Personal Health Budget (PHB) is an allocation of funding made available to people on the basis of their assessed health needs so that they can choose, arrange and pay for their own health care services. Since 2014 individuals in receipt of CHC have had a right to ask for a Personal Health Budget. A PHB (as described below) can be notional or actual funds. If the budget holder is unable to manage the budget themselves a responsible person or a nominated person may do it for them. The key principle is that patients know what their budget is, the treatment options and the financial implications of their choices, irrespective of the way the budget is

actually managed. Where patients manage services and their own budget this is the equivalent of direct payments in social care. There are three broad approaches in which a person can receive a personal health budget:

- **Notional personal budget:** Patients are aware of the treatment options within a budget constraint and of the financial implications of their choices. The NHS underwrites overall costs and retains all contracting and service coordination functions.
- **Personal budget held by a third party:** Patients are allocated a real budget, held by an intermediary on their behalf. The intermediary helps the patient choose services within the personal budget and based on the agreed healthcare outcomes.
- **Direct payments for healthcare:** Patients are given direct payments and expected to purchase and manage services themselves, including care coordinators and financial intermediaries. This would be the equivalent of direct payments in social care.

19.2 When an assessment is made as part of an application for CHC the individual will be offered the opportunity to receive a PHB. All individuals in receipt of CHC funding will receive information informing them of their right to request a PHB. If an eligible person chooses to have a Personal Health Budget a completed PHB consent form will be required to commence the process. Herts & West Essex ICB will then make arrangements for a support planner to visit the individual to discuss options available to them to meet their care plan. In collaboration with the individual a personalised support plan will be created to meet their care needs within the indicative budget set by the ICB. Focusing on outcomes contributes positively to care planning and subsequent regular review process. The support planner will also supply written information about the personal health budget scheme, employing staff, managing and coordinating care.

19.3 The indicative budget may be revised to reflect the proposed pattern of services to be purchased. Support and brokerage will be available to assist the person to plan care. The final support and budget plan is submitted to the ICB for review, verification and risk assessment prior to being agreed by the ICB before payments start. The spending plan will also specify minimum requirements for reviews. Generally financial reviews will be at least quarterly and health outcomes will be reviewed initially after three months and then determined by individual circumstances and progress.

19.4 The National Framework emphasises the importance of using models that maximise personalisation and individual control and that reflect the individual's preferences, as far as possible. The Framework also emphasises the value of using person-centred commissioning and procurement arrangements, so that unnecessary changes of providers or of the care package do not take place purely because the responsible commissioner has changed.

20. Funding Cessation

20.1 CHC funding will only cease after a formal review has been conducted, and a recommendation by the multidisciplinary team that the individual no longer has a primary health need, has been verified by the ICB in accordance with the CHC framework.

20.2 No funding will be withdrawn until 28 days have elapsed from the day on which the decision was notified in writing to the individual, their family/carer and to the local

authority. This is to allow the individual and the local authority time to make arrangements for their care, and to consider whether they, their family/carer wishes to appeal against the decision that they are no longer eligible for CHC.

20.3 In the event that an individual appeals against the decision to end their CHC funding, the decision made by the ICB remains in force until such time as it is overturned.

20.4 If the individual was previously eligible for CHC, Herts & West Essex ICB will provide 28 days notice in writing to confirm funding is ending from the date of the decision. Funding will not be reinstated during the local resolution process.

20.5 Once the ICB resolution process has been completed, should the individual, their family/representative choose to ask NHS England to review the matter, Herts & West Essex ICB is not responsible for the funding of care during the Independent Review Process. If following the independent review, the original eligibility decision is overturned the ICB will accept the NHS England's Independent Review Panel recommendation in all but exceptional circumstances and will reimburse costs associated with care needs in accordance with NHS England's recommendations.

21. Training

21.1 It is important that all staff, in both health and social care, involved in the Multidisciplinary Assessment of patients in respect of their eligibility for CHC is aware of the principles of the National Framework, the process of determining eligibility, the use of the Decision Support Tool and the application of the Primary Health Need test.

21.2 The ICB will work on an on-going basis with Local Authorities, NHS Trusts and other organisation's such as nursing homes and hospices to appropriately provide training to relevant staff.

21.3 It is vital that all staff, including social workers, involved in the completion of assessments should have undertaken all relevant national CHC training modules.

22. Complaints

22.1 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 Herts & West Essex ICB through the Trust Complaints process.

Contact details for complaints are as follows;

By email to hweicbwe.patientfeedback@nhs.net By telephone 01992 566122.

23. Disputes

23.1 Hertfordshire and Essex County Councils are represented on all Decision Making Panels and are part of the decision-making body. Hertfordshire and Essex County Councils and their employees are therefore not able to appeal against a decision made by the Herts & West Essex Continuing Healthcare Decision Making Panel on

behalf of a patient. Appeals may only be made by individual applicants themselves in accordance with the ICB Resolution Process.

23.2 However, Hertfordshire and Essex County Councils may dispute a decision that is made by the Herts & West Essex ICB Decision Making Panel, in respect of an application for NHS Continuing Healthcare. In these circumstances the Policy for the Resolution of Disputes for NHS Continuing Healthcare should be implemented in line with the National Framework for CHC.

23.3 Herts & West Essex ICB, Hertfordshire County Council and Essex County Council 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 the decision on eligibility. Should such situations arise, the National Framework for NHS-funded Continuing Healthcare is explicit in stating that any existing funding arrangements cannot be unilaterally withdrawn without the agreement of the other party. Therefore, anyone in their own home, or care home funded by the local authority or ICB must continue to be funded by that body until the dispute is resolved.

24. Appendices

APPENDIX 1 National and Local Reference List

National Documents:

- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care: July 2022 (Revised)
  Incorporating:
  - *NHS Continuing Healthcare Practice Guidance*
  - *NHS Continuing Healthcare Frequently Asked Questions*
  - *NHS Continuing Healthcare Refunds Guidance*

  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1170290/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care_July-2022-revised_corrected-July-2023.pdf

NHS CHC National Tools:

- NHS CHC Checklist: www.gov.uk/government/publications/nhs-continuing-healthcare-checklist
- Decision Support Tool: www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool
- Fast Track Pathway Tool: www.gov.uk/government/publications/nhs-continuing-healthcare-fast-track-pathway-tool

Legislation:

- Mental Capacity Act 2005: www.legislation.gov.uk/ukpga/2005/9/contents
- Data Protection Act 2018: www.legislation.gov.uk/ukpga/2018/12/contents/enacted
- Fraud Act 2006: www.legislation.gov.uk/ukpga/2006/35/contents
- Bribery Act 2010: www.legislation.gov.uk/ukpga/2010/23/contents
- Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers (2022): https://www.england.nhs.uk/wp-content/uploads/2022/06/B1578_i_who-pays-framework-final.pdf
- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2022: https://www.legislation.gov.uk/uksi/2022/532/regulation/2/made

APPENDIX 2 Process Diagrams

Figure 1: Flow diagram for NHS Continuing Healthcare

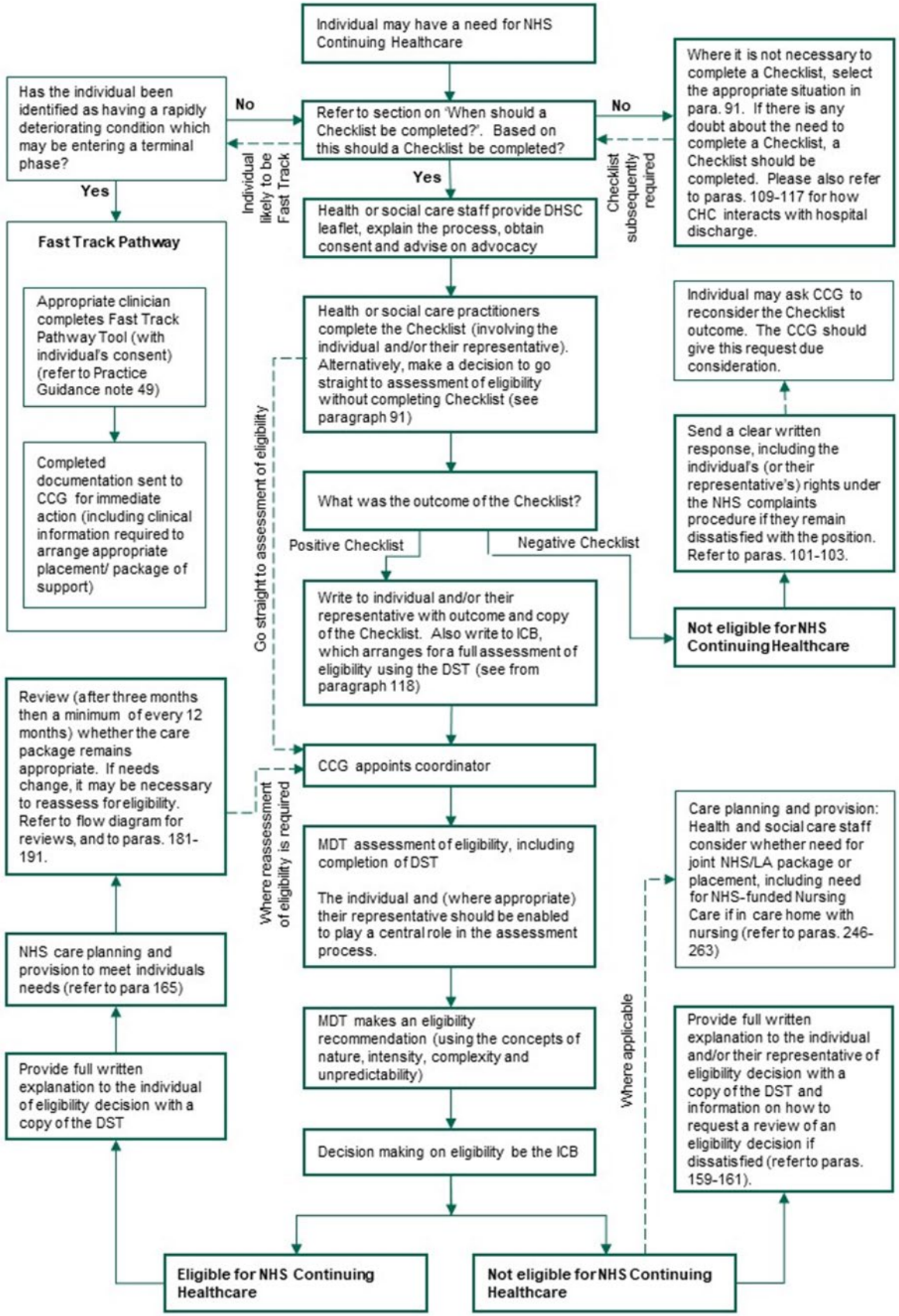


Figure 2: Flow diagram providing overview of referral process

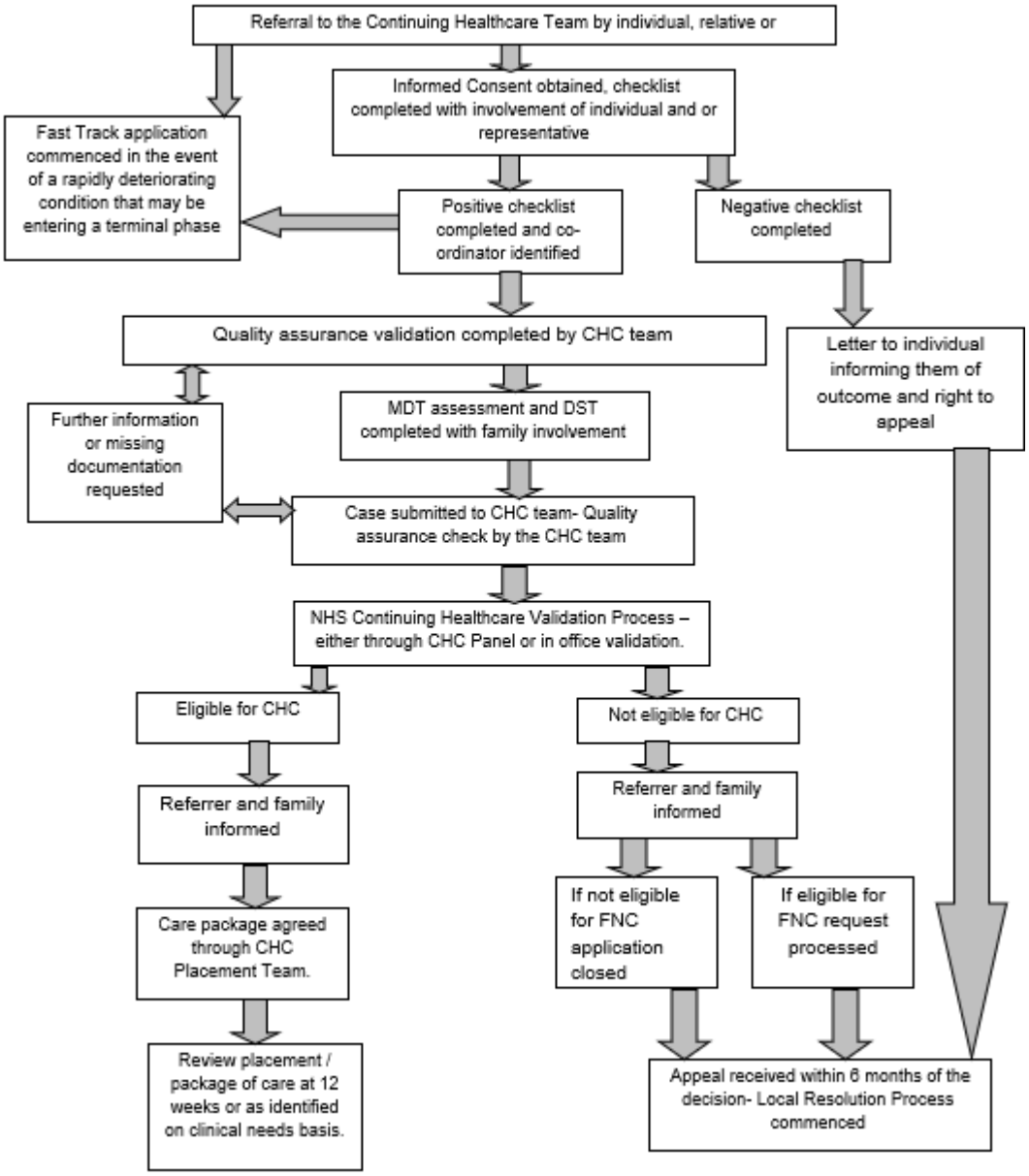


Figure 3: Flow diagram providing overview of the review process:

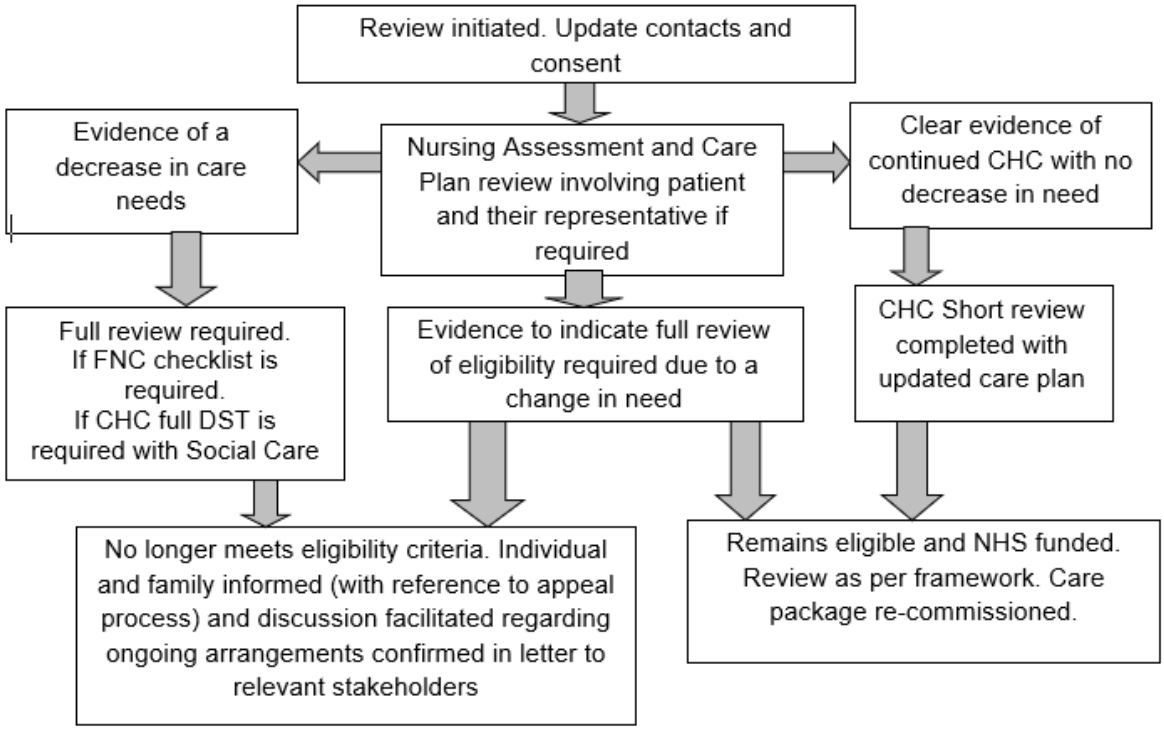
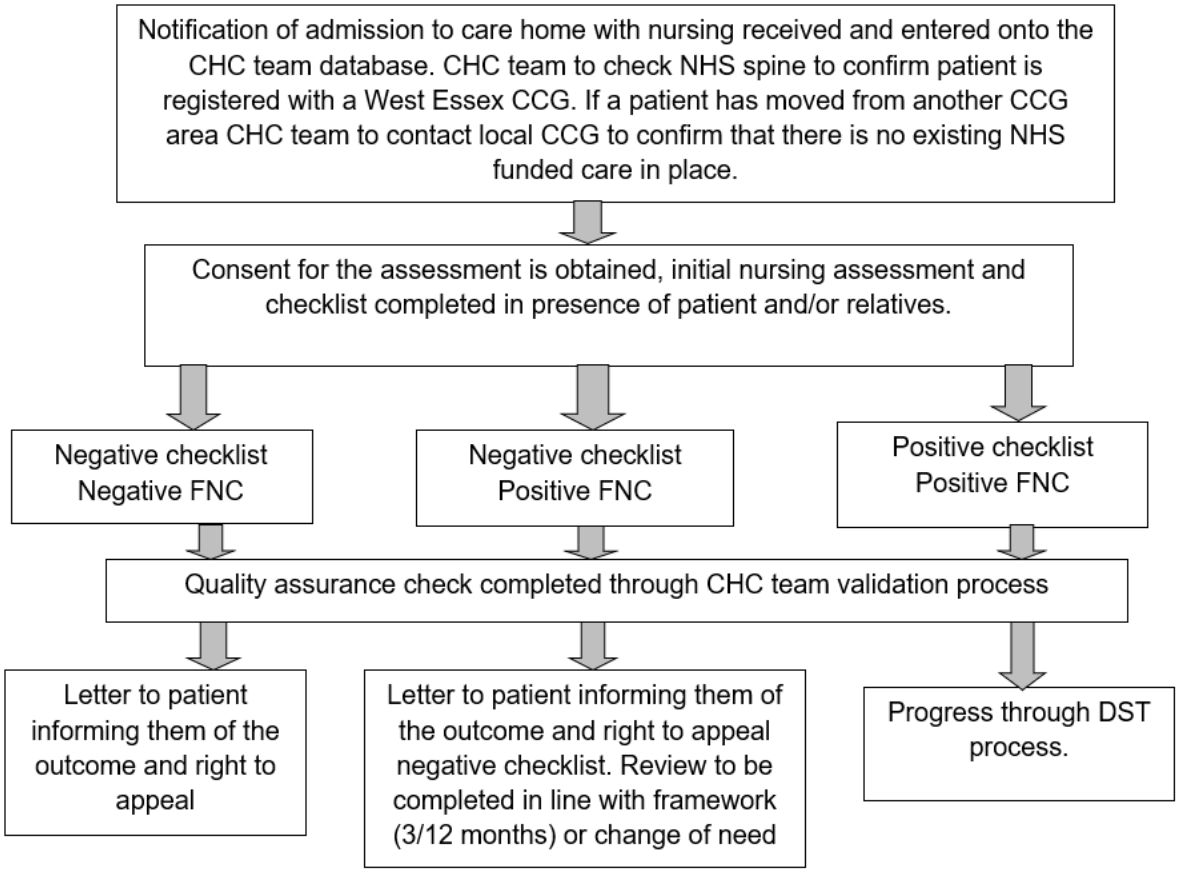
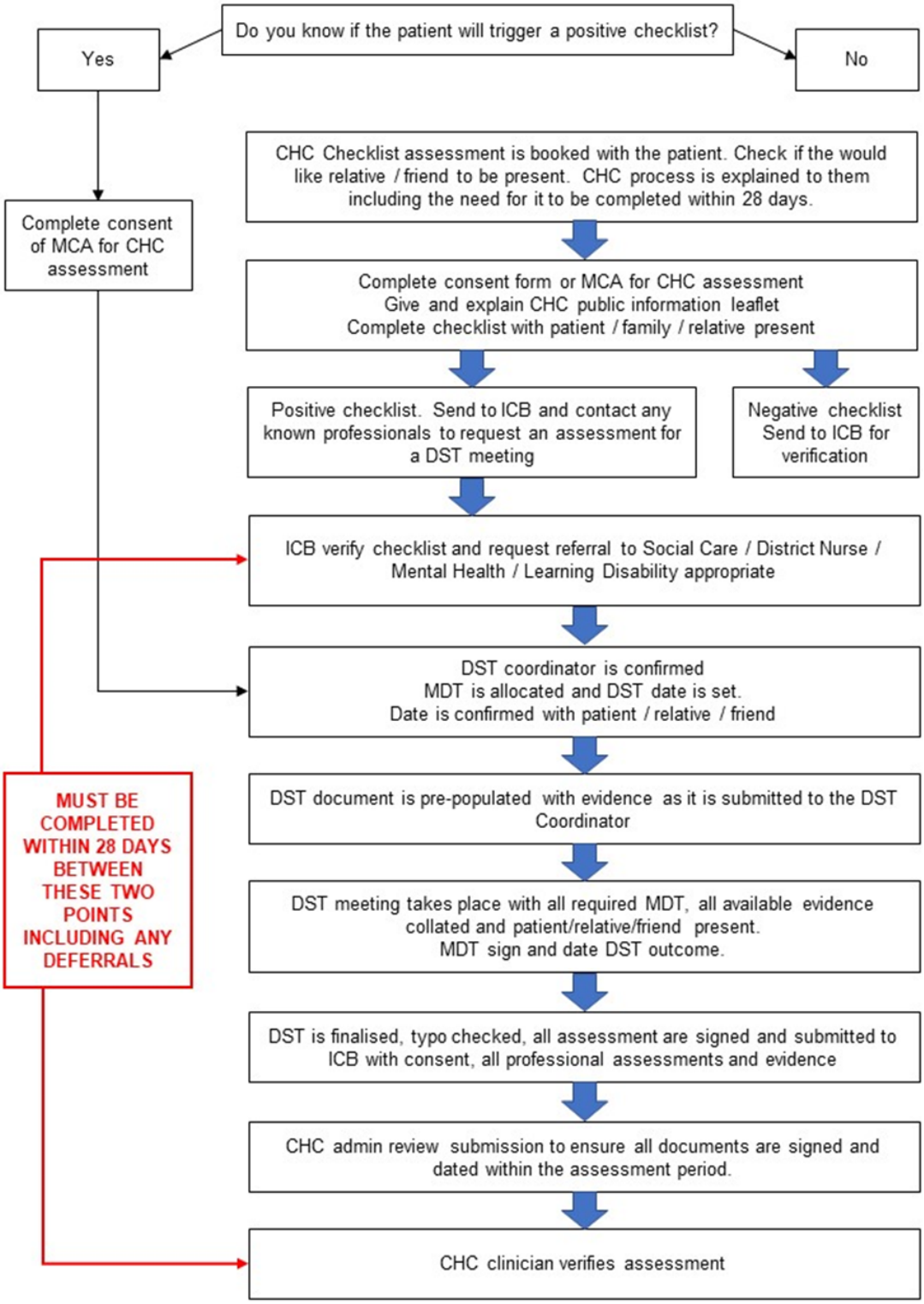


Figure 4: Flow diagram providing overview of funded nursing care process:



CHC 28 Day Assessment Process:



APPENDIX 3

HERTFORDSHIRE & WEST ESSEX INTEGRATED CARE BOARD
NHS CONTINUING HEALTHCARE
DECISION MAKING PANEL AND VERIFICATION PROCESS TERMS OF REFERENCE

1. Philosophy and Aim

1.1 The Hertfordshire & West Essex ICB Continuing Healthcare Team has a responsibility to verify the Multidisciplinary Teams recommendation for Continuing Healthcare (CHC) eligibility following assessment and completion of the Decision Support Tool (DST) for individual's registered with a Hertfordshire or West Essex General Practitioner and in accordance with the National Framework for NHS Continuing Healthcare and Funded Nursing Care (2022 Revised). Verification's may either be completed as an in office verification or as a quality assurance review by the ICB Continuing Healthcare Decision Making Panel.

1.2 The panel exists to oversee the consistent implementation of the National Framework and aims to support a clear, open and transparent decision-making process and consistent application of the eligibility criteria for NHS Continuing Healthcare, as set out in the Framework Guidance.

1.3 The panels aim is to ensure appropriate consistent application of the National Framework for all applicants, to work with integrity across agencies, strive for fairness and to verify eligibility based on the individuals assessed and evidenced needs. It is essential that the verification process is not driven by the individual financial priorities of contributory organisations. The panel should not fulfil a gate-keeping function and nor should it be used as a financial monitor.

2. Objectives

2.1 The Panel has been established to:

- Facilitate decision making
- To act as a quality assurance peer review forum
- To verify the Multidisciplinary Team's recommendation
- To ensure consistent application of the Primary Health Needs Test
- To support consistent decision making.
- To resolve any MDT disputes in a fair and equitable manner

2.2 This may include the panel considering:

- Cases which are no longer recommended as eligible for CHC
- Cases where the individual or their representative are appealing an eligibility recommendation in association with the ICB Resolution Process.
- The completion of a Decision Support Tool as part of a retrospective review of CHC eligibility
- A random auditing of cases where eligibility has been recommended for consistency and learning purposes.
- Utilising the exceptional decision rules in the event that a MDT has been unable to agree upon a joint recommendation as part of the dispute resolution process.
- Utilising the exceptional circumstances rules in the event that the DST has been incorrectly completed or the submitted evidence is mismatched.

2.3 It is the responsibility of the Herts & West Essex ICB to ensure that the assessment process as stipulated within the National Framework has been applied as in line with national guidance. Eligibility recommendations must be led by the practitioners who have met and assessed the individual.

2.4 MDT Assessment and Recommendation:

Good quality multidisciplinary assessment is essential to evaluate and evidence the individual's care and health care needs to inform the process DST. The panel require evidence that the process was:

- Comprehensive
- Holistic
- Evidence based
- Drawing on written and direct observations
- Include how needs interact
- Clearly documented
- Fully involve individual/representative/carer
- Identify desired/achievable outcomes for the individual
- Involvement of both LA and NHS in assessment is strongly recommended
- Signed and dated by the completing professional in accordance with professional standards of record keeping

The MDT Recommendation must include:

- Summary of needs within each domain is care including individuals' views
- Statements in relation to the 4 elements of the primary health needs test (PHNT)
    - Nature, intensity, complexity, and unpredictability including how these needs interact across domains
- Recommendation as to whether or not the individual has a Primary Health Need with reference to the 4 characteristics – (but note any one element is required to indicate a Primary Health Need). Rationale for MDT recommendation MUST be clearly documented, dated and signed by the MDT members.

2.5 The Panel will reach their decision by examining the evidence and the recommendations presented by the Multidisciplinary Team and determine whether or not the individual's primary need is for healthcare. Information provided to the panel should include:

- Valid Consent obtained prior to the assessment process
- Checklist
- DST with full recommendation
- MCA for the assessment process where the individual lacks capacity
- Any correspondence related to the case
- Multidisciplinary professional assessments (Nursing/ Social care etc)
- Specialist assessments if required
- Records may include:
    - GP / medical records
    - Hospital records
    - Nursing home records
    - Drug charts
- Information provided by the applicant, their family or representative

2.6 The panel will aim to engage stakeholders across appropriate organisations to promote consistency of application and ensure that all applications are based upon multidisciplinary and multi-agency assessments of need and that appropriate evidence is available to support the recommendation.

2.7 The Panel will act to exercise a quality control function in respect of applications to ensure that the correct process has been followed throughout and that the recommendations are in accordance with a consistent application and use of the Decision Support Tool.

2.8 The panel will examine the evidence submitted and the recommendation made to confirm whether or not the patient has a Primary Health Need and meets the eligibility criteria for CHC.

2.9 The panel will also receive and consider reviews for people currently receiving CHC and verify recommendations regarding their continuing eligibility or not.

2.10 The panel administrator will communicate decisions made using the agreed format for reports including the rationale for agreeing or not agreeing eligibility to the Continuing Healthcare Manager and Key Co-ordinator who presented the application.

2.11 There may on rare occasions be exceptional circumstances where the recommendations of the MDT are not accepted by the panel. These are likely to include:

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

2.12 In such cases the matter will be sent back to the MDT with a full explanation of the relevant matters to be addressed and a timeframe for completion that does not cause unnecessary delay. Where there is a need for urgent care/support interim arrangements will be made following discussion and agreement with all parties. Prior to any exceptional circumstances decision being made a case must have been deferred back to the MDT for review twice.

3. Membership

Panel Chair	As designated by the Head of Continuing Healthcare
Clinical representative	A Registered Nurse with CHC experience employed by either the ICB CHC team or a provider service.
Local Authority representative	Social Care Practitioner with CHC experience employed by the Local Authority.
(optional) Mental Health Clinician	A Registered Mental Health Nurse with CHC experience employed by the mental health trust
(optional) Learning Disability Clinician	A Learning Disability Registered Nurse with CHC experience
Panel Administrator	To take notes of the meetings deliberations
Substitutes	Permitted on a direct replacement basis only (Panel Administrator to be notified in advance of the meeting to confirm if the substitute is able to verify the booked cases).

3.1 Patients, their advocates or family members are not invited to attend the panel meeting however they are welcome to contribute their views regarding their current status and needs in writing as part of the DST document. In the event of an appeal case relatives are invited to present the case to the panel however they are not permitted to be present during the Panel's deliberations.

3.2 NB. Panel members must not include those who hold a budgetary responsibility within their individual organisation. The panel process should be based on professional evaluation of the persons assessed needs and application of the Primary Health Needs Test and should not be driven by financial consideration. Prior to every panel hearing, members will need to confirm they have no conflicting interests relating to the CHC process or the individual cases being heard on that day. The Panel Administrator will

keep a record of completed declaration of interest forms for every panel member from all organisations.

4. Meetings

4.1 The Panel will meet weekly. This may be virtually via Microsoft Teams or face to face dependant upon the needs of the cases to be heard and panel members.

5. Quorum

5.1 To be quorate, the Panel will require attendance of the Panel Chair and a minimum of 2 panel members from different disciplines (General Nursing, Mental Health Nurse, Social worker or Learning Disability). In cases where the patient has specific needs relating to either mental health or a learning disability, specialist practitioners from these disciplines may be required to be in attendance as panel members as deemed necessary by the panel chair.

6. Decision Making

6.1 The NHS, acting through the Herts & West Essex ICB Decision Making Panel, has the ultimate duty to make decisions on eligibility recommendations for NHS Continuing Healthcare.

6.2 Eligibility decisions may be one of the following;

- Eligibility is agreed and confirmed
- Eligibility is not agreed, and the case is deferred back to the MDT to review their submission
- Panel decision is deferred pending presentation of missing information or clarification of conflicting information
- Case may be rejected; however, this will only be in exceptional circumstances due to a significant concern regarding the information or evidence submitted.
- The MDT's recommendation may be overturned in line with the exceptional circumstances rule (PG39 of the National Framework)

6.3 The ICB should not make decisions in the absence of recommendations on eligibility from the MDT except where exceptional circumstances require an urgent decision to be made. The ICB's policy is for cases to be deferred back to the MDT twice before an exceptional decision can be made, this rule should apply in all but the most exceptional circumstances in which case the justification for this must be clearly documented. The final eligibility decision should be independent of budgetary constraints and finance officers should not be part of a decision making panel.

6.4 Panel decisions are binding for the ICB and Adult Social Care (subject to an appropriate challenge under the agreed ICB Resolution Process)

6.5 The Panel shall have joint and collective responsibility and decisions shall be reached by consensus wherever possible. Where a consensus has not been possible, the case will be processed in accordance with the ICB Resolution Process and the National Framework, alternatively panel may choose to defer the case back to the MDT for clarification of additional information.

7. Papers

7.1 The deadline for submission of applications for panel is at the discretion of the panel administrator.

8. Accountability

8.1 The Panel is accountable to the Head of Continuing Healthcare and the Panel Chair reports directly to this person.

8.2 The Head of Continuing Healthcare reports directly to the Director of Nursing and Quality and is accountable to this person for the conduct of the Panel and it business

8.3 The Terms of Reference and Panel membership will be reviewed by the Director of Nursing and Head of Continuing Healthcare annually.

(April 2022, updated August 2023)

APPENDIX 4

NHS Hertfordshire & West Essex ICB -NHS Continuing Healthcare Procedure for completion of Decision Support Tool (DST)

- The function of the DST is to summarise key information from the Multidisciplinary Team (MDT) assessment across the 12 domains and to consider the impact of the nature, intensity, complexity or unpredictability of health needs. The DST remains an aid to decision-making and is not a substitute for professional judgement.

- The Standing Rules Regulations define an MDT as: “a team consisting of at least – Two professionals who are from different healthcare professions, or one professional who is from a healthcare profession and one person who is responsible for assessing persons for community care services under [section 9 of the Care Act 2014 (assessment of an adults needs for care and support)] And a healthcare profession as: “a profession which is concerned (wholly or partly) with the physical or mental health of individuals (whether or not a person engaged in that profession is regulated by, or by virtue of, any enactment)

- NHS Hertfordshire & West Essex ICB requires all DSTs to have Adult Social Care input (unless in exceptional circumstances) and for the completed DST’s to evidence this. The MDT recommendation should be signed by the social care practitioner involved in the assessment and if it is not possible an explanation is to be provided.

- A Coordinator will be appointed to oversee the DST assessment; the Coordinator can also be a MDT member in line with the National Framework. A key duty of the Coordinator is to ensure the MDT makes a clear recommendation, to collate and submit the assessment on behalf of the MDT. There must be an appropriate separation between the co-ordinator role and those responsible for making a final decision on eligibility for CHC.

- The DST to be used by everyone is the national DST tool, this is a Department of Health requirement.

- As the verification process will reject consideration of a DST if any of the following apply, it is essential that these potential circumstances are noted by the MDT;

    - 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

- It is recommended that the MDT initially consider each domain in turn and recommend levels of need on the DST in accordance with the available evidence and professional assessments. The MDT should then consider the impact of nature, intensity, complexity or unpredictability within the Primary Health Need test fully documenting their statement for each of these 4 elements.

- The DST must reference all of the evidence used to decide on the weighting of each ‘domain’, clearly recorded within each section. This information must correlate with the Primary Health Need test and the MDT recommendation.

- The DST must contain a recommendation regarding eligibility and this section must be completed and signed by the MDT. If there is no signed recommendation and rationale it will be automatically rejected by the validation process and returned to the MDT for further work.

- The Continuing Healthcare Care Team are available to provide support and guidance with CHC assessments and DST completion.

Completion of the DST requires consideration of the four characteristics of a primary health need: Nature; Intensity; Complexity and Unpredictability. Guidance on the application of these characteristics is outlined below:

<table>
<tr>
<td><u>Nature</u>
This is about the characteristics of the individual's needs and the interventions required to meet those needs.

Questions that may help consider this includes:
• 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 type 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/improving?
• What would happen if these needs were not met in a timely way?</td>
<td><u>Intensity</u>
This is about quantity, severity and continuity of needs.

Questions that may help consider this includes:
• How severe is this need?
• How often is intervention required?
• For how long is each intervention required?
• How many carers/ care workers are required at any one time to meet the needs?
• Does the care relate to needs over several domains?</td>
</tr>
<tr>
<td><u>Complexity</u>
This is about the level of skill/knowledge required to address an individual need or the range of needs and the interface between two or more needs.

Questions that may help consider this includes:
• How difficult is it to manage the need(s)?
• How problematic is it to alleviate the needs and symptoms?
• 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?</td>
<td><u>Unpredictability</u>
This is about the degree to which needs fluctuate and thereby create challenges in managing them. It should be noted that the identification of unpredictable needs does not, of itself, make the needs "predictable" (i.e. "predictably unpredictable") and they should therefore be considered as part of this key indicator.

Questions that may help consider this includes:
• Is the individual or those who support her/him able to anticipate when the needs might arise?
• Does the level of need often change? Does the level of support often have to change at short notice?
• Is the condition unstable?
• What happens if the need isn't addressed when it arises? How significant are the consequences?
• To what extent is professional knowledge/skill required to respond spontaneously and appropriately?
• What level of monitoring/review is required?</td>
</tr>
</table>

Glossary of Terms including Abbreviations

Care Coordinator	A person who coordinates the assessment and care planning process. The Care Coordinator is usually the central point of contact with the individual/patient.
Care Package	A combination of care and support and other services designed to meet an individuals assessed needs
Care Plan	A document recording the reason why care and support and other services are being provided, what they are, and the intended outcomes.
ICB	Integrated Care Board
CHC	NHS Continuing Health Care
Commissioning	Commissioning is the process of specifying and procuring services for individuals and the local population, and involves translating their aspirations and needs into services that: deliver the best possible health and well-being outcomes, including promoting equality; provide the best possible health and social care provision; and achieve this with the best use of available resources and best value for the local population
DH	Department of Health
DST	National Framework Decision Support Tool
ECC	Essex County Council
FNC	Funded Nursing Care
Home Care	Care provided in an individual's own home
Individual	The person who has been assessed for and found to be eligible for NHS Continuing Healthcare
Key Co-ordinator	The main person who co-ordinates all care and paperwork for a patient and their representatives.
MDT	Multidisciplinary Team
Multidisciplinary	Multidisciplinary refers to when professional from different disciplines (such as social work, nursing and occupational therapy etc.) work together to assess and/or address the holistic needs of an individual, in order to improve delivery of care
PHB	Personal Health Budget
Representative	Any family member, friend or unpaid carer who is supporting the individual, as well as anyone acting in a more formal capacity (e.g. welfare deputy or done of a power of attorney, or any organisation representing the individual). Where an individual has capacity, s/he must give consent for any representative to act on his/her behalf.

Appendix 5 – NHS Herts and West Essex ICB Equality Impact Assessment Screening Form

Very occasionally it will be clear that some proposals will not impact on the protected equality groups and health inequalities groups.

Where you can show that there is no impact, positive or negative, on any of the groups please complete this form and include it with any reports/papers used to make a decision on the proposal.

Name of policy / service	Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Operational Policy
What is it that is being proposed?	Hertfordshire & West Essex Integrated Care Board (ICB) aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no-one receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability. Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the person requesting has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered. Herts & West Essex ICB embraces the four staff pledges in the NHS Constitution. This policy is consistent with these pledges. Eligibility for NHS CHC is based on an individual's assessed needs and is not disease specific, nor determined by either the setting where the care is provided, or who delivers the care. Access to consideration and assessment is non-discriminatory, it is not based on age, condition or type of health need diagnosed.
What are the intended outcome(s) of the proposal	The aim of NHS CHC Operational Policy is to implement the NHS CHC eligibility criteria in order to provide appropriate care. To achieve this, the implementation of the criteria and local application for NHS CHC, in conjunction with the Local Authority, provider Trusts and other agencies, should meet the following principles: • Needs led • Equitable • Culturally sensitive • Person centred • Robust and transparent • Easily understood Adheres to guidance and best practice
Explain why you think a full equality impact assessment is not needed	Completed with original CCG policy. No fundamental changes to this reviewed and combined policy

On what evidence/information have you based your decision?	Previous impact assessments completed for all 3 CCG's. Policy fundamental contents remains unchanged. Confirmed by email from Paul Curry 15/3/2022.
How will you monitor the impact of policy or service?	Continual monitoring on a monthly basis to ensure timely assessments and equitable decision making for all applicants
How will you report your findings?	Within routine monitoring reports

Having considered the proposal and sufficient evidence to reach a reasonable decision on actual and/or likely current and/or future impact I have decided that a full equality impact assessment is not required.	
Assessor's name and job title Date	Elizabeth Hall Assistant Director for CHC 10/6/2022