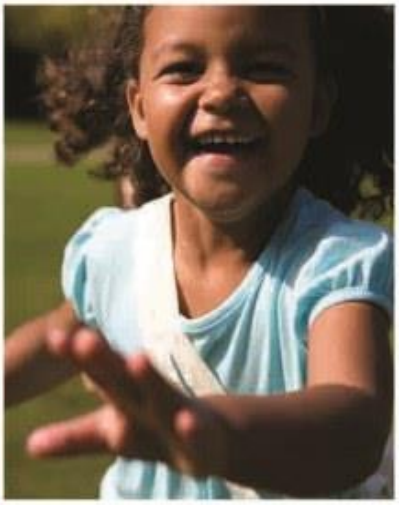
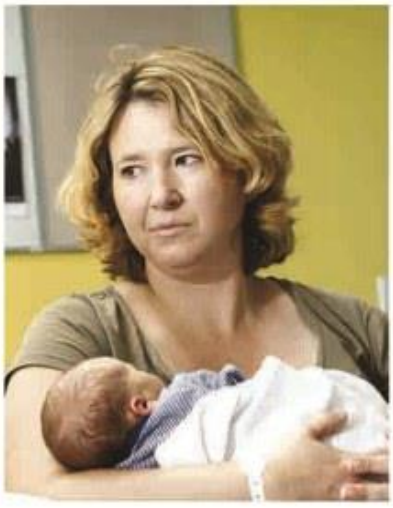
NHS

Central Eastern
Commissioning Support Unit

NHS England

Continuing Healthcare Service: Standard Operating Policy





THE NHS CONSTITUTION
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Continuing Health Care Service

Standard Operating Procedure

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Information Reader Box

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Contents

1 Introduction & Background

1.1 Context

Clinical Commissioning Groups (CCG) assumed statutory responsibility for NHS Continuing Healthcare from the 1st April 2013. The Central Eastern Commissioning Support Unit (CECSU) Continuing Healthcare (CHC) teams have been commissioned to deliver the service on behalf of the CCG's whom commission services from the CECSU.

The CSU CHC Teams will deliver the service in line with the National Framework for Continuing Healthcare and Funded Nursing Care (revised 2012), ensuring they are fully compliant with the legislation and promoting best practice.

2 Document Purpose

This document is intended to advise practitioners and managers in relation to NHS Continuing Health Care (CHC) and Funded Nursing Care (FNC) and sets out the roles and responsibilities for the process of referring, assessing and agreeing eligibility for NHS CHC as well as the commissioning and provision of that care. This policy ensures that the model and processes are consistent across the CCG's and are robust and timely in their response.

This policy is written in line with the documents below but is not inclusive of all finite details so must be read in conjunction with;

- National Framework for NHS Continuing Health Care and NHS-Funded Nursing Care 2012 (Revised)

REVISED 2012 FRAMEWORK.pdf

- Part 6 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

- Who Pays? Determining the Responsible Commissioner (August 2013)

who-pays-aug13...

This policy outlines the way in which CHC teams will commission and provide care, on behalf of the CCG's, in a manner that reflects patient choice and the preferences of individuals but balances the need for CCG's to commission care that is safe and effective and makes best use of resources.

This policy will also outline the roles and responsibilities of the CHC teams in those situations where eligibility for NHS CHC has not been agreed, and in such cases, the management of the appropriate appeals processes.

3 Continuing Healthcare Principles

NHS Continuing Healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital who have complex ongoing healthcare needs.

3.1 Eligibility

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.

The principles underlying this policy support the provision of a consistent approach, and fair and equitable access to NHS Continuing Healthcare and NHS Funded Nursing Care. In order to achieve this, the implementation of the criteria and local application for NHS CHC, in conjunction with the Local Authority, provider organisations, NHS Trusts and other agencies, should meet the following principles:

- Health and Social care professionals will work in partnership with individual and their families throughout the process.
- All individuals and their families will be provided with information to enable them to participate in the process.
- Where an individual lacks capacity, act in accordance with the Mental Capacity Act 2005
- The process for decisions about eligibility for NHS CHC will be transparent for individuals and their families and for partner agencies.
- Assessments and decision making about eligibility will be undertaken in a timely manner to ensure that individuals receive the care they require in the most appropriate environment, without unreasonable delays.

4 Continuing Healthcare Team Arrangements

4.1 Responsibilities

Adults

The CHC teams manage the current NHS CHC processes for all people over the age of 18, who are registered with a GP practice and for whom Responsible Commissioner Guidance 2013 (Who Pays/ Establishing the Responsible Commissioner) indicates an appropriate CCG responsibility to assess for and consider eligibility for NHS CHC and (if appropriate) subsequently provide funding for care.

Children's

The CHC teams will work with Children's services to identify young people for whom it is likely that adult Continuing Healthcare may be necessary and to support the transition process.

Honorary contracts are in place with CHC staff and CCG's

4.2 Team Function

The main functions of the CHC teams are to:

- Ensure the completion of a comprehensive assessment of need for each individual. This may occur in a number of ways such as:
- Monitoring the quality of assessments received, ensuring appropriate consent has been given and liaising with the referrer.
- Co-ordination of the assessment process, liaising with the Multidisciplinary team (**MDT), individual and family.
- Undertaking checklists and Nursing Needs Assessments as required
- Ensure that the MDT assessment is summarised into the National Framework DST and the MDT recommendation is supported by evidence and a robust rationale, prior to verification by Panel.
- Be responsible for informing the individual or their representative of the eligibility decision, and the local resolution process in a timely manner.
- Working closely with MDT colleagues the CHC team is responsible for agreeing packages of care, including placements.
- The CHC team will ensure that packages of care and placements for people who are eligible for fully funded healthcare are appropriately assessed, managed, monitored, evaluated and reviewed.
- For those people 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 should be considered.
- Support the development and delivery of joint training programmes.
- Promote awareness of NHS CHC and act as an impartial resource to the MDT and the individual on any policy or procedure questions that arise.
- Protect individuals in vulnerable situations and work in partnership with CCG's and partner organisation to address any safeguarding concerns.
- If the individual is not eligible for all or part of the period being considered, then the decision letter should be sent to the applicant with details of who to contact should the applicant disagree with the decision
- The local appeal process will then be implemented

***A MDT is a team of at least two professionals, usually from both the Health and social care disciplines who are knowledgeable about the individual's health and social care needs.*

5 Consent

As with any NHS assessment, examination, treatment or service, the individual's informed consent should be obtained in writing before the process begins of determining eligibility for NHS CHC**.**

If an individual does not consent to consideration of eligibility for NHS Continuing Healthcare, the potential effects on the ability of the NHS and Local Authority to provide appropriate services should be carefully explained to them.

Where there are concerns that an individual may have significant on-going needs and the level of appropriate support could be affected by their decision not to consent, the appropriate way forward should be considered jointly at a senior management level in the CCG and Local Authority.

5.1 Lack of capacity

If there is concern that the individual may not have the capacity to give their consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of Practice and in line with the five principles of the Act.


MCA Code of Practice.pdf

If the person lacks the mental capacity either to refuse or to consent, a best interest decision should be taken as to whether or not to proceed with assessment of eligibility for NHS CHC. A third party cannot give or refuse consent for an assessment of eligibility for NHS CHC on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney or they have been appointed a Welfare Deputy by the Court of Protection.

The Mental Capacity Act 2005 requires Local Authorities and the NHS to engage Independent Mental Capacity Advocates (IMCA's) in certain circumstances where individuals are assessed as lacking capacity to make specific decisions at the time that the decision needs to be made and where there is absence of appropriate representative. The Act defines the circumstances in which a referral should be made to an IMCA.

5.2 Best Interest' decision

Where a "best Interest" decision needs to be made, any relevant third party who has a genuine interest in the person's welfare must be consulted; this will include family and friends.

6 Referral and Application Process

6.1 Screening request

A request for a screen to consider eligibility may take the form of direct contact from an individual or their relative and can be received by telephone, letter, fax or email to the CHC teams. An individual cannot complete a checklist themselves.

The request will be checked to ensure all relevant details are available and correct for example: Responsible commissioner. This will be completed within 5 working days of the request. Where the CCG's are not the responsible commissioner, where appropriate, the request will be directed to the appropriate responsible commissioner.

In most circumstances it would be appropriate for a Checklist to be completed within 14 calendar days of such a request.

On receipt of a referral or request for a CHC Checklist, or a completed Checklist, the details in relation to the case will entered on the database.

6.2 Screening

The first step in the process for Identifying individuals who may be eligible for NHS CHC will be a screening process using the NHS CHC Checklist. Unless it is deemed appropriate for the Fast Track Pathway to be used (see point 9 fast track pathway).

Before applying the Checklist and in line with the framework guidance all referrers should have explored and considered whether the patient has any further rehabilitation or re-enablement potential. NHS Continuing Healthcare is only considered when any rehabilitation needs have been met and a period of rehabilitation completed.

The aim is that a variety of health and social care practitioners can complete the Checklist in a variety of settings. These could include NHS registered nurses, GPs, other clinicians or Local Authority staff (such as social workers, care managers or social care assistants) completing them in an acute hospital, an individual's own home or in a community care setting.

6.3 Mental Health Referrals

Referrals should not be accepted for individuals who are subject to a section of the Mental Health Act. Those on Sections other than S117 are entitled to NHS funding for their care, but not NHS CHC funding, and those on S117 are normally funded by the CCG and/or local authority through agreed negotiation between the two bodies. However, patients on S117, who may also have physical health requirements outside of those needs associated with their S117 after care plan may be entitled to consideration for NHS CHC subject to the usual assessments and decision making processes.

Where an individual is receiving services under 117 of the Mental Health act 1983 they will nonetheless be eligible for FNC as a universal service discreet from any 117 provision if they meet the relevant criteria

If the CHC teams have questions relating to any mental health patients and 117 services they should discuss this with the CSU Mental Health commissioning and placements team.

6.4 Checklist

Referrals in the form of completed Checklists will be checked to ensure that they are robust, make appropriate reference to supporting evidence and that the individual and/or their representative have been involved.


NHS-CHC-Checklist-FINAL.pdf

Where there are concerns about the quality of the referral or where there is a significant amount of missing or conflicting information the referrer will be contacted within 5 working days from receipt of the completed checklist to respond to the queries.

6.5 Rejected referrals

Where the outcome of the Checklist is not to proceed to full assessment of eligibility, the CHC team will write to the individual, giving them a copy of the completed Checklist and details on how to request a review of the decision within 28 days if they disagree with it.

Such request should be given due consideration, taking account of all the information available, including additional information from the individual and/or their representative. A full multi-disciplinary assessment and DST may need to be completed if there is evidence to suggest it should. If not, then a clear and written response should be given to the individual or their representative as soon as possible. The response should also give details of the individual's rights under the NHS Complaints procedure.

The individual and/or their representative will be advised to request the completion of a further Checklist should the individuals needs change.

If the individual is to be admitted to care home (with Nursing) a determination for Funded Nursing care must be completed by a Registered Nurse employed within the NHS as detailed in the FNC Practice Guide (DH 2013).

If the Checklist indicates a need for referral for full consideration for NHS CHC, this should be communicated to the individual or their representative by the lead coordinator.

7 Decision Making Process

The National Framework makes clear recommendations for the decision making process to sit as closely to the individual as possible, with local multidisciplinary teams collating the relevant assessments and supporting evidence, considering the health and social care needs of the individual using the Decision Support Tool (DST) and professional judgment, and making recommendations regarding eligibility.


Decision-Support-To
ol-for-NHS-Continuing

The National Framework outlines that there is a clear timetable for the decision-making process, having regard to the expectation that decisions ***should usually be made within 28 days*** of the Checklist being received. When there is a valid and unavoidable reason for the process taking longer this should be communicated to the individual or their representative.

7.1 Responsibility

A lead coordinator* should identify the appropriate professionals to comprise the MDT and liaise with them to complete the assessments and subsequently the DST. The DST should only be used following a comprehensive multidisciplinary assessment of an individual's health and social care needs and their desired outcomes.

* *A lead coordinator may also be part of the MDT*

7.1.1 Learning disabilities

Where the individual has a learning disability it will be important to involve professionals with expertise in learning disability in the assessment process as well as those with expertise in NHS Continuing Healthcare.

7.1.2 Local Authority (LA)

The involvement of LA colleagues as well as health professionals in the assessment process will streamline the process of care planning and will make decision-making more effective and consistent. It would be expected that there would be one representative from the local authority as a member of the MDT

Standing Rules 18 require that, as far as is reasonably practicable, the CCG should consult with the relevant LA before making any decision about an individual's eligibility for NHS Continuing Healthcare.

7.2 Individual/Representative

The individual or representative should be invited to be present and reasonable notice should be given to an individual and/or their representative to be present and fully involved in the assessment process and the completion of the DST.

The lead coordinator should explain the DST process to the individual or representative and support them in playing a full role in contributing their views on their needs.

If the MDT is to reach its final recommendation privately it is best practice to give the individual/representative an opportunity before they leave the meeting to state their views.

7.3 Documentation

Assessment documentation should be clear, relevant, well recorded, factually accurate, up to date, signed and dated.

At the end of the DST, the MDT completes the DST summary sheet to provide an overview of the levels chosen and a summary of the person's needs, along with the application of the Primary Health Needs Test and the MDTs recommendation of eligibility or ineligibility.

It should be remembered that, whilst the recommendation should make reference to all four concepts of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

The Lead Coordinator should then send the completed MDT DST and associated assessments/documents to the respective Continuing Healthcare team in the fastest and most appropriate secure way.

A copy of the completed DST should be given to the individual and / or representative advising that they consider the contents of the DST and discuss any concerns with the lead coordinator.

On receipt of the completed DST and supporting evidence the CHC team administrator will check responsible commissioner guidance and that all supporting evidence is included to enable an informed decision to be made and validated regarding eligibility.

All completed DSTs are date stamped and logged onto respective recording systems.

The Continuing Healthcare team may ask a MDT to carry out further work on a DST if it is not completed fully or if there is a significant lack or missing evidence to support the levels within the DST and the MDT recommendation. The application will be returned to the Lead Coordinator with a full explanation.

7.4 Decisions

There is no requirement for CCGs to use a panel as part of their decision making processes. Panels may be used in a selective way to support decision making. For example this could include panels considering:

- Cases where the individual or his or her representative is disputing the recommendation of the MDT
- Cases where there is a disagreement between the CCG and the LA over the recommendation.

The CHC team have delegated authority from the CCG to make eligibility decisions on their behalf, including cases where a decision can be made without the need to go through a formal panel process. A decision not to accept the MDT recommendation should never be made by one person acting unilaterally.

Where an individual dies whilst awaiting a decision on NHS CHC eligibility and has received services prior to their death that could have been funded through NHS Continuing Healthcare then the eligibility decision-making process should be completed. Where no such services were provided it is not necessary to continue with the eligibility decision-making process.

Where a decision is made that the individual would have been eligible for NHS Continuing Healthcare funding then payments should be made in accordance with the guidance on refunds in Annex F of the National Framework.

The Continuing Healthcare team will communicate the decision, either verified or made through the full Multidisciplinary Panel process, to the individual (or their representative and relevant professional agencies) in writing within 10 working days of the decision. A copy of the panel minutes and the DST will be sent to the individual, and information with regards to the local resolution process and time scales (within 6 months) should they wish to appeal the decision.

8 Panel.

The CCG may choose to use a Panel to ensure consistency and quality of decision making. However a Panel should not fulfill a gatekeeping function and nor should it be a financial monitor. Only for exceptional circumstance, and for clearly articulated reasons, should a MDT recommendation not be upheld. A decision not to accept the MDT recommendation should not be made unilaterally.

The Panel may ask the MDT to carry out further work on a DST if it is not completed fully or there is a significant lack of consistency between the evidence provided on the DST and the recommendation for eligibility, or where no recommendation has been made by the MDT. However the panel cannot refer a case back, or decide not to accept a recommendation, simply because the MDT has made a recommendation that differs from the one that those who are making the final decision would have made.

Panels are currently held independently and there is a separate Retrospective Panel. The panels across the CECSU currently utilise a mix of independent internal chair person.

Panels may be used in a selective way to support consistent decision making:

- Cases which are not recommended as not being eligible for NHS CHC (for audit purposes or for consideration of possible joint funding)
- For cases where there is disagreement between the CCG and the LA – this could form part of the disputes process
- Cases where the individuals do not agree with the MDT recommendation or are appealing the decision
- For audit purposes

8.1 Role of Panel

The role of the panel is to:

- Verify and confirm the recommendation made by the MDT
- Apply the Primary Health Needs test as part of the verification process.
- Agree required actions where issues or concerns arise

They do not have the role of:

- Financial gatekeeping

- Completing or altering DSTs
- Overturning recommendations (although they can refer back to the MDT in exceptional circumstances).

8.2 Exceptional Circumstances

Exceptional Circumstances and referral back to the MDT:

- When the DST is not fully completed and/or no recommendation is made
- When there are significant gaps in evidence to support the DST
- When there is an obvious mismatch between the evidence provided and the recommendation made.
- Where the recommendation would result in either authority acting unlawfully

8.3 Out of Panel

The main principles of the decision making process applies to the out of panel verification process, but this process would not be applied to:

- Cases where there is disagreement between the CCG and the LA – this could form part of the disputes process
- Cases where the individuals do not agree with the MDT recommendation or are appealing the decision
- Cases where individuals who were previously eligible; and on review, no longer meet the eligibility criteria.

9 Fast Track Pathway

There may be circumstances where an individual, not previously awarded NHS Continuing Healthcare, on the basis of need does have a rapidly deteriorating condition and the condition may be entering a terminal phase. The person may need NHS Continuing Healthcare funding to enable their needs to be urgently met (e.g. to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in a care setting). The Fast Track Pathway Tool should be used by an appropriate clinician to outline the reasons for the fast-track decision.

The process for Fast track applications ensures that decisions about eligibility for NHS Continuing Healthcare can be made, where appropriate, to support the preferred priorities of the individual for their end of life care as soon as is reasonably practicable.

The Fast Track tool should not be used instead of a full assessment because of service pressures for example the need to discharge a patient from hospital, shortage of staff. The CHC teams will monitor use of the tool and raise any concerns with specific teams and the CCG.


NHS-CHC-Fast-Track
-Pathway-tool.pdf

9.1 Who can complete it?

The Fast track tool bypasses the Checklist and DST. The National Framework is clear that it can only be completed by an appropriate clinician. The Fast Track pathway tool for NHS Continuing Healthcare November 2012 defines appropriate clinician as follows:

"*Those who are, pursuant to the National Health Service Act 2006, responsible for an individual's diagnosis, treatment or care and are registered medical practitioners (such as consultants, registrars, GPs) or registered nurses. These can include senior clinicians employed in voluntary and independent sector organisations that have a specialist role in end of life needs (for example hospices)where the organisations services are commissioned by the NHS."*

9.2 Fast Track Application

The CHC team, upon receipt of a completed Fast Track Pathway Tool **must** decide whether the individual is eligible for NHS Continuing Healthcare. Therefore, where a recommendation is made for an urgent package of care via the fast-track process, this should be accepted and actioned immediately. It is not appropriate for individuals to experience delay in the delivery of their care package while disputes over recommendations from completed Fast Track Tools are resolved.

For Fast Track applications, the following information should be submitted:

- A completed consent form or evidence of appropriate consent*
- When care is not already in place, a holistic care plan will be required which describes the immediate needs to be met, other agencies involved in the care and the patient's preferences.

**Clinicians completing the Fast Track pathway tool should explain the process to the individual (and/or their representative) and make them aware that their needs may be subject to a review and that the funding stream may change subject to the review.*

9.3 Decision Making Process

Standing Rules state that the CCG must, upon receipt of a completed Fast Track Pathway Tool, decide that the individual is eligible for NHS Continuing Healthcare. Action should be taken urgently to agree and implement the care package. CCGs should have processes in place to enable such care packages to be implemented quickly. Given the nature of the needs, this time period should preferably not exceed 48 hours from receipt of the completed Fast Track Pathway Tool.

If the individual meets the Fast Track eligibility criteria and all relevant information is available to the clinical verifier, the Clinical verifier can make a decision about eligibility for NHS Fast track funding.

The referrer will be informed verbally at the time of decision to minimise the delay in arranging and commissioning care by the clinical verifier. This will be followed up in writing within 48 hours to the referrer and the patient.

9.4 Exceptions

Exceptionally, there may be circumstances where the completed Fast track tool appears to show that the individual's condition is not related to a rapidly deteriorating condition, which may be entering the terminal phase. In these circumstances the CHC team should urgently ask the relevant clinician to clarify the nature of the individual's needs and the reason for the use of the Fast Track Pathway tool. Where it then becomes clear that the use of the Fast Track tool was not appropriate, the clinician should be asked to submit a completed Checklist for consideration through the wider eligibility process.

The CHC teams will monitor and audit the use of the Fast track Tool quarterly and share outcomes with CCGs

9.5 Review of Fast track

The National Framework outlines that no one who has been identified through the Fast Track Pathway as eligible for NHS CHC should have this funding removed without their eligibility being reviewed. Eligibility for NHS Continuing Healthcare can only be ended by a review through the use of the full MDT-led DST process.

10 Appeals

Where a full assessment has been undertaken of potential eligibility using the Decision Support Tool (or by use of the Fast Track Pathway Tool), and a decision has been reached, if the individual is challenging that decision, this should be addressed through the local resolution procedure within 6 months of the original eligibility decision being communicated.

When an appeal is received this is acknowledged in writing within 10 working days.

10.1 Appeals Process

Stage 1: Informal Resolution Meeting

- The first stage of the appeal process is to consider an informal resolution meeting with the individual and/or their representative to discuss the decision with a senior member of the CHC team. The purpose of this meeting is to allow the individual to review the information that is held in the NHS Continuing Healthcare file regarding their application, and discuss the rationale for the panel's decision. This meeting will be documented and a copy sent to the appellant.
- At the meeting the appellant, or their representative have the right to view and receive copies of all records held on file pertaining to the CHC Application, subject to Data Protection Act 1998 considerations.

- If new evidence is submitted in support of the application, a decision may be made to resubmit the application together with the additional information to the local CHC panel.
- If the appellant is satisfied with the original decision following the local resolution meeting, the appellant is required to respond in writing of their agreement to close the case.

Stage 2: Local Appeal/Resolution Panel

- If the appellant is not satisfied with the outcome following an informal meeting the case will progress onto a local appeal / resolution panel.

11 Commissioning and Funding

To enable the CHC team to commission safe and appropriate packages of care, the following principles need to be identified;

- A holistic care plan identifying all need and how these needs can be best met including who will be meeting these needs i.e. family members, community nurses.
- Unmet needs within the holistic care plan which need to be commissioned by the CHC team on behalf of the CCG need to be clearly identified within the care plan, including relevant risk assessments, such as manual handing and behaviour risk assessments.

The CHC team needs to be assured that the following information has been sourced for all care providers:

- CQC registration and latest inspection report
- Insurance certificate (liability)
- Statement of purpose
- Contingency plans

The CHC team will commission the provision of NHS CHC in a manner that reflects the choice and preference of individuals based on their assessed needs and balances the need for the CCG to commission care that is safe and effective and makes best use of resources. Quality tools are in place to escalate risks to the CCG's and Local Authorities via CCG quality forums.

The CHC team have delegated authority to commission care provision on behalf of the CCGs with an escalation process in place for individual CCGs regarding the sign off of high cost packages of care. Local agreement of escalation processes are in place with each of the CCG's.

Each provider receives a funding agreement setting out the terms and conditions of the care provision, including agreed costs and invoicing procedures.

11.1 When does funding commence?

CHC funding will commence on the 29th day of receipt of the checklist except in cases where the delay is considered reasonable as it is due to circumstances beyond the CCG's control which will include:

- Evidence (such as assessments or care records) essential for reaching a decision on eligibility has been requested from a third party and there has been a delay in receiving these records from them.
- The individual or their representatives have been asked for specific information or evidence of participation in the process, and there has been a delay in receiving a response from them.
- There has been a delay in convening an MDT due to the lack of availability of a non CHC practitioner whose attendance is key to determining eligibility and it is not practicable for them to give their input by alternative means such as written communication or via telephone.

(NHS CHC refunds guidance Department of Health March 2010)

If the above circumstances are applied then funding will be agreed from the date the decision is made to accept the MDT recommendation.

11.2 When does funding cease?

- After death for a patient within a nursing / residential home – 2 days post death
- No longer eligible following full MDT led DST – 28 days.
- No longer eligible following appeal – Once the local resolution process is complete the appellant retains the right to appeal to NHS England IRP, but funding will cease 28 days following the local resolution decision.

12 Funded Nursing Care (FNC)

NHS-funded_Nursing_Care_Best_Practice_

NHS – funded nursing care is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS – funded Nursing Care (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 needs for NHS FNC.

The registered nurse input is defined in the following terms:

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

A checklist should be carried out as part of a routine review of NHS funded nursing care, where the checklist indicates that a full DST should be completed then an MDT should complete a full DST with the following exception. A DST will not be required where:

- The person has previously had a positive checklist and full DST completed by an MDT

  and

- There has been no material changes in their needs that might lead to a different eligibility decision regarding NHS Continuing Healthcare and (by implication) NHS Funded Nursing Care.

In order to determine this the previous DST needs to be available at the NHS funded nursing care review and each of the domains and previously assessed needs levels considered as part of the review by the reviewer, in consultation with the person being reviewed and any other relevant people.

Where there has not been a previous DST completed by an MDT, or when the NHS funded care review indicates a possible change in eligibility, a positive checklist should always be followed by an MDT completed DST and a recommendation of eligibility of NHS Continuing Healthcare.

A care plan should be developed clearly setting out how the individuals identified needs should be met including the provision of care by a the registered nurse using the same comprehensive care domains as used within the DST.

12.1 Funding

FNC will stop 5 days post admission to hospital, but will resume once the patient is re admitted to the nursing home.

FNC payments stop at the date of death.

Where an individual is receiving services under 117 of the mental health act 1983, they will nonetheless be eligible for FNC as a universal service discreet from any 117 provision if they meet the relevant criteria

13 Reviews

A case review should be undertaken no later than 3 months after the initial eligibility decision, and then as a minimum standard on an annual basis. This will ensure the individual patients are receiving the care they need. The care review will also review the continuing eligibility of the individual patient for NHS CHC.

A full MDT led DST will not be required where there has been no material changes in the individuals needs that might lead to a different eligibility decision regarding NHS Continuing Healthcare.

In order to determine this, the previous DST needs to be available at the NHS CHC review and each of the domains and previously assessed needs levels considered as part of the review by the reviewer in consultation with the person being reviewed and any other relevant people.

Where there has not been a previous DST completed by an MDT or when the NHS funded care review indicates a possible change in eligibility, a positive checklist should always be followed by an MDT completed DST, and a recommendation of eligibility of NHS Continuing Healthcare.

Eligibility for NHS Continuing Healthcare can only be ended by a review through the use of the full MDT-led DST process.

The outcome of the review will be communicated to the individual in writing within 10 working days, including time scales for appeal (should this be necessary).

The review should also consider if needs are being met and whether the care package remains appropriate.

The outcome of the case review will determine if the individual needs have changed and that will determine whether the package of care may have to be revised, or the funding responsibility altered.

Some individuals will require more frequent review in line with clinical judgement and changing needs.

14 Contact details

The main contacts for the Continuing Healthcare teams are:

Mid and West Essex
8 Collingwood Road
Witham
Essex
CM8 2TT
Tel: 0300 123 8095
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15 Distribution & Implementation

15.1 Distribution Plan

15.1.1 This document will be made available to all CECSU staff internet site (COLIN).

15.1.2 A global notice will be sent to all Officers notifying them of the release of this document.

15.2 Training Plan

15.2.1 A training needs analysis will be undertaken with Officers affected by this document.

15.2.2 Based on the findings of that analysis appropriate training will be provided to Officers as necessary.

15.2.3 Guidance will be provided on the intranet site (COLIN).

16 Monitoring

16.1 Compliance

16.1.1 Compliance with the policies and procedures laid down in this document will be monitored via Essex and Herts Working Groups and Team Leaders meetings.

16.1.2 The Associate Director of Clinical Services in conjunction with the Team Leaders for CHC, are responsible for the monitoring, revision and updating of this document.

16.2 Equality Impact Assessment

16.2.1 This document forms part of NHS England's commitment to create a positive culture of respect for all staff and service users. The intention is to identify, remove or minimise discriminatory practice in relation to the protected characteristics (race, disability, gender, sexual orientation, age, religious or other belief, marriage and civil partnership, gender reassignment and pregnancy and maternity), as well as to promote positive practice and value the diversity of all individuals and communities.

16.2.2 As part of its development this document and its impact on equality has been analysed and no detriment identified.

17 References

17.1 National Framework

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

17.2 Department of Health Decision support tool

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213139/Decision-Support-Tool-for-NHS-Continuing-Healthcare.pdf

17.3 Department of Health Checklist

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213138/NHS-CHC-Checklist-FINAL.pdf

17.4 Department of Health Fast Track Tool

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213140/NHS-CHC-Fast-Track-Pathway-tool.pdf

17.5 Department of Health NHS Funded Nursing Care Best Practice Guidance

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211256/NHS-funded_Nursing_Care_Best_Practice_Guidance.pdf

Appendix 1 Version Control Tracker

Version Number	Date	Author Title	Status	Comment/Reason for Issue/Approving Body
1.0	May 2014	Gail Partridge	Draft	Initial draft for IGC & SLT approval
	21st May 2014	Gail Partridge	Approved	Approved by SLT

Appendix 2 Draft Document Approval

Version Number	Approval Date	Approver Title	Directorate
			Medical
			Nursing
			Patients & Information
			Finance
			Operations
			Commissioning Development
			Policy
			Human Resources

Version Number	Approval Date	Approver Title	Other Areas
			IT
			Legal
			Information Governance
			Counter Fraud

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