Kernow
Clinical Commissioning Group

NHS CHC (CHC) operational guidelines

Date approved: 17 December 2019

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NHS
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Clinical Commissioning Group

Document control sheet

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V2.3	18/11/2019	C Green	Review of final document

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1. Introduction

1.1. NHS CHC (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding individuals have to be assessed according to a legally prescribed process to determine whether the individual has a 'primary health need'. The final eligibility decision is the responsibility of the clinical commissioning group (CCG).

1.2. Both NHS bodies and local authorities have responsibilities to ensure that assessment for eligibility for and provision of CHC takes place in a timely and consistent way (DH 2018). NHS Kernow Clinical Commissioning Group (NHS Kernow) and Cornwall Council are committed to working in partnership to achieve this, together with local NHS trusts.

1.3. The responsibility of CCGs to provide CHC derives from statutory duties as set out in Section 3 of the National Health Service Act (2006). CCGs are under a statutory duty to manage their finances responsibly and to maintain financial balance and this is an absolute duty imposed on them by Section 229 of the National Health Service Act (2006).

1.4. NHS Kernow will work within the framework set out in 'Who Pays? Determining responsibility for payments to providers' (2013). This process establishes the CCG responsible for the commissioning of an individual's care within the NHS and ensures that there are no gaps in responsibility. This principle is included within the national framework.

1.5. These guidelines have been written in accordance with and should be read in conjunction with the following documents:

- National Framework for NHS CHC and NHS-funded Nursing Care October, Department of Health (DH, revised 2018) – hereafter referred to as The National Framework.
- NHS CHC Practice Guidance (part of the National Framework) (DH, revised 2018)
- Who Pays? Establishing the Responsible Commissioner (DH, 2013)
- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations (DH 2012)
- Mental Capacity Act (DH, 2005)
- Care Act (2014)

This paragraph also constitutes referencing.

2. Purpose

2.1 These guidelines set out the roles and responsibilities for health and social care staff for the implementation of the national framework. It describes the process for determining eligibility for NHS CHC and includes the procedures for this in the relevant appendices. Therefore this document is to be read in conjunction with the National Framework for NHS Continuing Healthcare and Funded Nursing Care (revised 2018) and is not intended to replace it.

2.2 These guidelines also set out the responsibilities of the CCG in those situations where eligibility for NHS CHC has not been agreed, and for the management of situations that may arise as a result of NHS CHC decisions.

2.3 These guidelines support the way in which NHS Kernow will commission and provide care in a manner that reflects the choice and preferences of the individual whilst balancing the requirement to commission care that is safe, effective and makes the best use of available resources.

2.4 This policy does not include children's NHS CHC apart from transition from children's to adult services. There is a separate national framework for children and young people.

3. Definitions

All definitions are taken from the national framework unless otherwise stated.

Care: Support provided to individuals to enable them to live as independently as possible, including anything done to help a person live with ill health, disability, physical frailty or a learning difficulty and to participate as fully as possible in social activities. This encompasses health and social care.

Care package: A combination of care and support and other services designed to meet an individual's 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.

Care planning: A process based on an assessment of an individual's needs that involves working with the individual to identify the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Carer: A carer is anyone who, usually unpaid, looks after a friend or family member in need of extra help or support with daily living, for example, because of illness, disability or frailty.

Clinical commissioning group: CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. References to CCG include any person or body authorised by the CCG to exercise any of its functions on its behalf in relation to NHS CHC. Where a CCG delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the national framework. The CCG cannot delegate its final decision-making function in relation to eligibility decisions, and remains legally responsible for all eligibility decisions made (in accordance with standing rules[1] issued under the National Health Service Act 2006).

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.
- Achieve this with the best use of available resources and best value for the local population.

Co-ordinator: A person(s) who co-ordinates the NHS CHC eligibility assessment process. Refer to Practice Guidance note 20 within the National Framework for NHS CHC and Funded Nursing Care (2018).

End of life care: Care that helps those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms, and provision of psychological, social, spiritual and practical support.

Local authority: Local authorities are statutory bodies responsible for a wide range of public services in specified geographic area, including social services. Individually and in partnership with other agencies, local authority social services departments provide a wide range of care and support for people who are in need and meet nationally specified eligibility criteria for care and support.

Mental capacity: The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is set out in section two of the Mental Capacity Act 2005: 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.

Multidisciplinary: Multidisciplinary refers to when professionals 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.

Multidisciplinary team (MDT): In the context of assessing eligibility for NHS CHC, a multidisciplinary team (MDT) is a team of at least two professionals, usually from both the health and the social care disciplines. It does not refer only to an existing multidisciplinary team, such as an ongoing team based in a hospital ward. It should include those who have an up-to-date knowledge of the individual's needs, potential and aspirations.

NHS CHC: A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual has a 'primary health need'. It can be provided in any setting. Where a person lives in their own home, it means that the NHS funds all the care and support that is required to meet their assessed health and care needs. Such care may be provided either within or outside the person's home, as appropriate to their assessment and care plan. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the person's accommodation, board and care.

NHS England: NHS England is the name given to what is legally known as the National Health Service commissioning board. References to NHS England include any person or body authorised by NHS England to exercise any of its functions on its behalf in relation to NHS CHC. Where NHS England delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the national framework.

NHS-funded nursing care (FNC): Funding provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible. It exists because Section 22 of the Care Act 2014 prohibits local authorities from providing, or arranging for the provision of nursing care by a registered nurse, save in the very limited circumstances set out in Section 22 (4). 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 CHC before a decision is reached about the need for NHS-funded nursing care.

Personal health budget: A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local NHS. It isn't new money, but a different way of spending health funding to meet the needs of an individual. Personal health budgets are one way to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs.

Personalised/personalisation: The term used to describe care and services received by a person that are individualised and tailored to their needs and preferences. Wherever possible, it involves the individual having choice and control over the care and support they receive.

Registered nurse: A nurse registered with the Nursing and Midwifery Council.

Representative: Any friend, carer or family member who is supporting the individual in the process as well as anyone acting in a more formal capacity (e.g. welfare deputy or power of attorney, or an organisation representing the individual).

4. Responsibilities

4.1 The head of continuing healthcare is the lead for CHC within NHS Kernow and is responsible for reporting compliance with the national framework.

4.2 Directors and line managers are responsible for ensuring that staff are made aware of, and are working to, all relevant new and revised policies and similar documentation; and for monitoring compliance with the national framework.

4.3 The CHC programme board is responsible for reviewing the policy reports on regular basis and providing challenge and feedback to policy area owners.

4.4 All NHS Kernow staff working within the CHC teams are responsible for compliance with the national framework with regards to standards and quality, decision making and actions.

5. Screening

5.1 When an individual may have a need for NHS CHC, a checklist should normally be completed. The checklist is the screening tool to help practitioners identify

individuals who need a full assessment. Screening and assessment of eligibility for NHS CHC (CHC) should be at the right time and location for the individual, and when their ongoing needs are known.

5.2 Individuals have the right to decline to be assessed for NHS CHC and therefore the process should only start if consent has been obtained (see Appendix two: consent form and guidance).

5.3 If the individual may not have the mental capacity to give consent, this should be assessed and determined in accordance with the Mental Capacity Act (2005) and the associated code of practice.

5.4 The checklist can be completed by a variety of health and social care practitioners who have been trained in its use e.g. registered nurses employed by the NHS, GPs, other clinicians or local authority staff such as social workers, care managers or social care assistants.

5.5 It is expected, as far as possible, that staff involved in assessing or reviewing individuals' needs as part of their day-to-day work would complete the checklist. The person completing the checklist should have the relevant knowledge and skills as set out in the national framework. This will then ensure the consistency and quality of completed checklists.

5.6 Once a checklist is completed it is submitted to the CHC team electronically. A positive checklist will begin the full assessment process and should be completed within 28 days as per the national framework. A negative checklist indicates that a full eligibility assessment is not required (see Appendix 1: statutory process to determine and review eligibility). The individual and/or their representative will be informed of the outcome of the checklist in writing by the CCG.

5.7 The framework makes it clear that there are many situations where it is not necessary to complete a CHC checklist, including:

- When it is clear to practitioners working in the health and care system that there is no need for NHS CHC at this point in time. Where appropriate/relevant, this decision and its reasons should be recorded. If there is doubt between practitioners a checklist should be undertaken.
- The individual has short-term health care needs or is recovering from a temporary condition and has not yet reached their optimum potential (if there is doubt between practitioners about the short-term nature of the needs it may be necessary to complete a checklist).
- When the individual has been admitted to hospital from a package or residential placement, which all relevant parties agree can still safely and appropriately meet

their needs without any changes, then the completion of the checklist, if required, should take place within six weeks of the individual returning to the place from which they were admitted to hospital.

- When it has been agreed by the CCG that the individual should be referred directly for full assessment of eligibility for NHS CHC.
- If 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 CHC and it is clear that there has been no change in needs.
- When a checklist has already been completed and the individual screened out i.e. funded nursing care review and the individual's needs have not changed since the last review/checklist.

6. Full assessment

6.1 Full assessments for NHS CHC are carried out by a multidisciplinary team (MDT) made up of a minimum of two healthcare professionals who are from different health care professions or one healthcare professional and one person who is responsible for assessing the person under the Care Act (2014). The MDT should be knowledgeable about the individual's health and social care needs and where possible already involved in their care. The individual and/or their representative should be told who is co-ordinating their assessment and how it will be undertaken.

6.2 The co-ordinator is responsible for the assessment process. This includes being assigned at the point of a positive checklist, assessment of eligibility, including completion of the decision support tool (DST) and reporting the MDT recommendation to the CCG.

6.3 It is a core principle of the national framework that the individual and/or their representative should be fully and directly involved in the assessment process. The individual/representative should always be invited to the MDT meeting (at which the DST is to be completed). If they are unable to attend, they should be given the opportunity to send a written contribution/account, or information in another format.

6.4 The individual/representative should receive information regarding CHC appropriate to their situation. This would normally, as a minimum, include a copy of (or link to) the Department of Health and Social Care public information leaflet and information on the assessment process, in advance of the MDT meeting. They

should be kept fully engaged, involved and informed at all stages of the process. This includes keeping them informed of timescales (bearing in mind the expectation that the process should normally be completed within 28 days).

6.5 The nurse co-ordinator will complete the DST, including a recommendation on the individual's eligibility, using the information provided by the MDT, the individual and/or their representative and other sources. The process for application of NHS CHC is set out in Appendix 1.

6.6 The majority of NHS CHC assessments should take place outside of acute hospital settings. This will support accurate assessments of need and reduce unnecessary stays in hospital and should preferably be undertaken in the individual's own home.

6.7 NHS Kernow has developed, with partners, local protocols for the provision of interim and intermediate care in order to facilitate discharge from hospital.

7. Verification and decision making

7.1 As part of the verification process, the locality teams will send the completed DST to the individual and/or their family/representative and adult social care. The respondents then have five working days to return any feedback/additional comments to be considered alongside the completed DST.

7.2 Once a DST has been completed and additional evidence has been received from the individual and/or their representative, and the MDT, the locality team manager and/or their deputy will consider the evidence in order to verify the recommendation. It is expected that the locality team manager and/or their deputy will normally respond to MDT recommendations within 48 hours (two working days), and that the overall assessment and eligibility decision-making process should, in most cases, not exceed 28 calendar days.

7.3 NHS Kernow may convene a verification panel to consider eligibility; however this will be on a selective basis in order to support consistent decision making, for example:

- Cases which are not recommended as eligible for NHS CHC (for audit purposes or for consideration of possible joint funding).
- Cases where there is a disagreement between the CCG and the local authority over the recommendation.
- Cases where the individual or his/her representative is appealing against the eligibility decision.

- A sample of cases where eligibility has been recommended for auditing/ learning processes to improve practice (National Framework 2018 – Practice Guidance paragraph 38.2)

7.4 The verification panel can make one of the following decisions with regard to a recommendation about eligibility for NHS CHC. Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed (see The National Framework, Practice Guidance 39).

- Accept the recommendation of the multidisciplinary team.
- Defer the decision and request further evidence to support decision making.

7.5 NHS Kernow CHC verification panel aims to ensure consistency and quality of decision making and provides governance to the decision-making for eligibility for NHS CHC. This ensures equity of access to NHS CHC and consistent decision-making for all applications.

7.6 Where individuals are found to be eligible for NHS CHC, funding will commence from the date that NHS Kernow verifies the MDT recommendation, or day 29 if the process exceeds 28 days.

7.7 The terms of reference for NHS Kernow CHC verification panel may be found in Appendix 3.

7.8 Eligibility decisions are communicated in writing to the individual and/or their representative; and to the MDT who convened for completion of the DST.

7.9 When an individual has been found not eligible, they or, where appropriate, their representative may appeal against the decision and have six months from the date of the decision letter to do so. The first stage of the appeals process would be a conversation between the applicant and the CHC team manager, known as local resolution.

7.10 The local resolution process can consist of a pre-arranged telephone conversation and/or face to face meeting to attempt to resolve any concerns between the CCG representative and the individual and/or their representative.

7.11 There should be a written summary of the conversation provided by NHS Kernow for both parties. This should be an opportunity for the individual or their representative to receive clarification of the process and, where required, this should also be an opportunity for the individual or their representative to provide any further information that had not been considered.

7.12 If the local resolution process is exhausted and the individual remains dissatisfied, they may formally appeal against the decision using the appeals process which is set out in section 13 of this Guideline. In all cases, present funding arrangements will remain in place pending the outcome of any appeals process.

7.13 Cornwall Council may 'dispute' a decision that is made by NHS Kernow CHC verification panel. This also applies to any other local authority that is affected by a decision made by the NHS Kernow CHC verification panel. In these circumstances, NHS Kernow dispute resolution policy should be implemented.

7.14 Existing funding arrangements cannot be unilaterally withdrawn. In all cases, the present funding arrangements will remain in place pending the outcome of the dispute. NHS Kernow and Cornwall Council or other local authority will adopt a without prejudice approach to such situations whereby the final outcome of the dispute will be backdated to the time of the original funding request.

8. Funded nursing care (FNC)

8.1 Where eligibility for CHC has not been established, however the individual resides in a care home with nursing and has been assessed as requiring access to a registered nurse over a 24-hour period, FNC would be applied.

8.2 FNC is a set contribution made directly to the nursing home. The FNC component and the current rate (amended each financial year by the Department of Health and Social Care) are set out in the standing rules.

9. Fast track

9.1 Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require 'fast tracking' for immediate provision of NHS CHC.

9.2 The intention of the fast track pis that it should identify individuals who need to access NHS CHC quickly, with minimum delay, and with no requirement to complete a DST. Therefore, the completed fast track pathway tool, with clear reasons why the individual fulfils the criteria and which clearly evidences that an individual is both rapidly deteriorating and may be entering terminal phase, is in itself sufficient to establish eligibility.

9.3 NHS Kernow supports the direct involvement of hospital staff in the fast track process to ensure the timely and appropriate discharge planning, the supporting of

end of life care decisions and the provision of clear accountability regarding decision making.

9.4 As with all funded care, the care plan for individuals in receipt of care funded via the fast track pathway will be reviewed after three months. This care plan review may result in a change to the way the care is funded.

10. Care planning and delivery

10.1 The NHS Kernow choice policy describes the way in which NHS Kernow will commission the care of people who have been assessed as requiring NHS funded care, including CHC. The commissioning of such care should be underpinned by the principles of personalisation and of individualised care planning.

10.2 While NHS Kernow will consider choice when working with individuals and their representatives, the CCG is also entitled, and indeed obliged, to take into account the cost of services as well as clinical risks when making an offer of a CHC package of services (care prescription).

10.3 NHS Kernow is responsible for identifying, commissioning and contracting all services required to meet the needs of individuals who have met eligibility.

10.4 NHS Kernow will only commission services from domiciliary care providers, care homes and care homes with nursing that are registered with the Care Quality Commission.

10.5 NHS Kernow has a procurement procedure hosted by the health buyer team for the provision of services required to meet an individual's care plan. This procurement procedure includes set authorisation limits in line with the scheme of delegation.

10.6 NHS Kernow will actively promote equity of access, parity, quality and personalisation.

10.7 NHS Kernow will request from providers such information as may be reasonably required in order to monitor the equity of access to care and to fulfil its own legal and legislative obligations.

10.8 The care planning process is central to the commissioning and provision of care to meet an individual's needs. Responsibility for care planning lies with the care co-ordinator and MDT within commissioner core community services.

11. Case management

11.1 Where an individual is eligible for NHS CHC, NHS Kernow is responsible for care planning, commissioning services, and for case management.

11.2 It is the responsibility of NHS Kernow to plan strategically, to specify outcomes and procure services, and to manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare.

11.3 It is the expectation of NHS Kernow that any services commissioned, including those commissioned from core community services, must include ongoing case management for all those eligible for NHS CHC, including review and/or reassessment of the individual's needs.

11.4 In the context of NHS CHC case management necessarily entails management of the whole package, not only the healthcare aspects of the package.

12. Personal health budgets (PHBs)

12.1 A personal health budget (PHB) is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. It is not new money, but it is money that would normally have been spent by the NHS on a person's care, being spent more flexibly to meet their identified needs. PHBs enable people to have greater choice, flexibility and control over the healthcare and support they receive.

12.2 PHBs can be managed in one of three ways, or a combination of these:

- **Notional budget:** The NHS holds the money on behalf of the individual. The person knows how much their budget is and discusses with the NHS the care and support they require to meet their needs. The NHS purchases the agreed care and support.
- **A third party budget:** An organisation independent of the individual and the NHS holds the budget and makes the arrangements for the agreed care and support. If the budget is used to employ personal assistants, it is the organisation holding the budget who is their registered employer.
- **A direct payment:** Money is paid directly into the individual's (or their representative's) bank account and they can directly purchase the care and support required in line with the agreed personalised care and support plan.

12.3 The provision of CHC through a PHB is subject to the same considerations in relation to clinical and financial risks.

12.4 NHS Kernow has set out the processes for PHB's including organisational responsibilities within the application, development, review and monitoring of the PHB within its PHB policy (see Appendix 4)

13. Transition

13.1 The national framework, supporting guidance and tools only apply to individuals aged 18 years or over. It is important that both the adult and the children's frameworks consider transition.

13.2 Children's services should identify those young people for whom it is likely that adult NHS CHC will be necessary, and should notify whichever CCG will have responsibility for them as adults. This should occur when a young person reaches the age of 14. This should be followed up by a formal referral for screening to the adult NHS CHC team at the relevant CCG, when the child or young person is 16 years of age. If the outcome of the checklist screen is positive, the DST is undertaken in a timely manner and as soon as reasonably practicable after the young person's 17th birthday.

13.3 NHS Kernow will ensure that it is actively involved in the strategic development and oversight of local transition planning processes with their partners. NHS Kernow will ensure that adult NHS CHC is appropriately represented in all transition planning meetings regarding individual young people whenever the identified needs suggest that there may be potential.

14. Review

14.1 If it is decided that an individual is eligible for any care funded in part or in whole by the NHS, their needs and care plan will normally be reviewed within three months and then annually or if there is any change in clinical condition or concerns related to the care plan.

14.2 Routine care plan reviews do not require a full DST to be completed. The focus of these reviews is to ensure that the care plan and care package meet the required needs of the individual.

14.3 Where it is evident that there has been a material change in needs a full review of eligibility will be undertaken using the DST.

15. Inter-agency disputes

15.1 There is a disputes process to cover those occasions where NHS Kernow and the local authority do not agree on the patient's primary need for Healthcare and eligibility for CHC funding. This process is currently under formal review.

16. Appeals (including previously unassessed periods of care)

16.1 The eligibility decisions of NHS Kernow are communicated in writing to the individual patients and/or their representative, and to the lead health and social care professionals making the application, giving a brief rationale for the decision. If the individual is found to be no longer eligible for CHC, 28 days' notice (from the date of decision) will be given for funding to cease. This includes when an individual or their representative appeals.

16.2 When an individual has been found not eligible, they or, where appropriate, their representative may appeal against the decision and have six months from the date of the decision letter to do so.

16.3 NHS Kernow has an established local resolution process. Local resolution is the first stage of NHS Kernow's CHC appeals process.

16.4 NHS Kernow requires applicants to complete a review request and consent form before the basis for the appeal can be investigated.

16.5 Appeal requests will be submitted to NHS Kernow's CHC appeals team. The appeals process will be explained and every effort will be made to ensure that the individual and/or their representative has a clear understanding of NHS CHC eligibility criteria and how it relates to their own situation. The appeals process will come to one of the following decisions:

- Original decision upheld.
- Request for further information gathering with potential for further DST.
- Original decision overturned.

16.6 If the applicant remains dissatisfied with the decision of the review panel, they can request an independent review by writing to NHS England (NHSE) at the following address:

Independent review panel
NHS England
3 Piccadilly Place
Manchester
M1 3BN

16.7 If the applicant remains dissatisfied with the independent review panel decisions they may approach the Parliamentary Health Service Ombudsman.

16.8 There may be circumstances where an individual should have been assessed for funding and therefore may have been found eligible. The DH has given such requests the title of previously unassessed periods of care (PUPoc) and agreed timeframes for individuals to appeal for these previously un-assessed periods of care. In these circumstances, the individual can request a retrospective review of their care needs and eligibility for NHS CHC from NHS Kernow.

17. Complaints

17.1 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 CHC, they may make a complaint to NHS Kernow. NHS Kernow has a compliments and complaints policy. Members of the public can contact the complaints manager using the following contact details:

NHS Kernow Clinical Commissioning Group
Complaints manager
Sedgemoor Centre
Priory Road
St Austell
PL25 5AS
Telephone: 01726 627800
Email: kccg.complaints@nhs.net

18. Implementation plans and monitoring

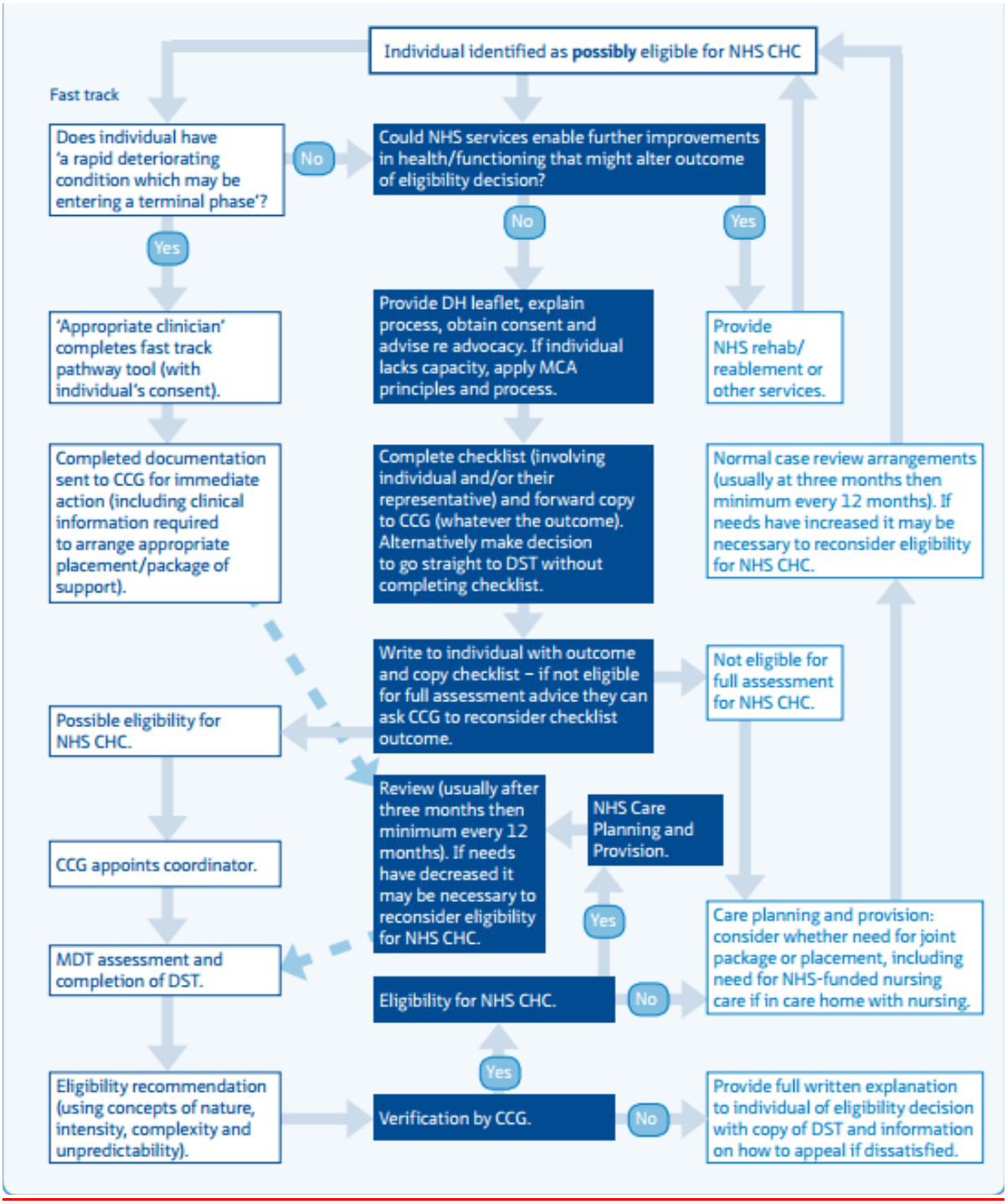
There are no specific training implications identified in order for this guideline to be implemented.

19. Update and review

This guideline will be reviewed in three years from ratification unless there is an indication to the contrary. It is the responsibility of the authors (or nominated officer) to

be aware of influencing factors and to initiate reviews promptly within the three years if appropriate.

Appendix 1: Statutory process to determine and review eligibility



Appendix 2: Consent form and guidance

Service User:		**Date of birth:**	
Address:		**Postcode:**	

Please complete the following:

In signing this form below, I confirm that I am the service user/or their representative (delete as appropriate) named above.

I also give my consent for NHS Kernow Clinical Commissioning Group (NHS Kernow) to carry out the relevant assessments to determine CHC eligibility. These may include reviewing any relevant documentation; such as medical documents from GP practice, adult social care assessments, hospitals, specialist teams, care home and other health organisations in order to establish my healthcare need. I confirm that in order to support the assessment, information will be stored on a database which will be regularly reviewed and validated.

Signature:		**Date:**	

I confirm that I have read and understand the patient consent form notes and I give consent to my information to be shared with the NHS Kernow's internal auditors.

Signature:		**Date:**	

*If the service user has capacity but has a physical limitation restricting their ability to sign, please request them to mark due to a physical health limitation.

Data Protection Act

This form is intended for the individual and/or organisation to which it is addressed and contains information that is privileged and confidential. If you are not the intended recipient, you are hereby notified that any dissemination or copying of this communication and its attachments is strictly prohibited.

Please return this form to the NHS Kernow continuing healthcare co-ordinator at the appropriate office:

CHC team west
Praze-an-Beeble Surgery
School Road
Praze-an-Beeble
Camborne TR14 0LB
kccg.westchcteam@nhs.net

Complex care team
Sedgemoor Centre
Priory Road
St Austell PL25 5AS
kccg.chcnon-core@nhs.net

CHC team north and east
Daromaba House
Clemo Road
Liskeard PL14 3XA
kccg.chcnorth@nhs.net

NHS continuing healthcare patient consent form notes

Please read these notes before signing the patient consent form.

Before we assess a person for NHS continuing healthcare, including reviewing personal information from files and records, we need the consent of the client or patient involved, or the consent of someone with lasting Power of Attorney who is acting on his/her behalf.

It is the responsibility of the person signing the consent form to ensure that any person that they have invited to be present at the completion of the decision support tool has the requisite permission to attend. Any information disclosed during the assessment is subject to data protection and confidentially and remains the property of the client.

In signing the consent form, you are authorising NHS Kernow to carry out such an assessment. If the consent form is not signed, the assessment will not take place. Information provided for the purpose of patient care will be entered into a database which will be restricted and controlled with authorised access. In order to provide the highest quality of care, this data will be reviewed, audited and validated on a periodic basis.

Please note that, in line with the Data Protection Act, the information will be handled in strict confidence and will be used only by those agencies involved in the care of the person named on the consent form. However, in the process of commissioning it is necessary to validate the information we hold and there may be a need to share your information as part of this process with our internal auditors.

Appendix 3: Verification panel terms of reference

1. Purpose

1.1 The purpose of the NHS Kernow CCG Clinical Commissioning Group (NHS Kernow) continuing healthcare (CHC) and NHS-funded nursing care verification panel is to make a decision on whether a person has a primary health need. If so, NHS Kernow will determine that that person is eligible for NHS CHC.

1.2 The verification panel will reach their decisions by examining evidence contained in the decision support tool (DST), considering recommendations made by the multidisciplinary team (MDT) and taking account of views expressed by the individual and/or their representative, family and other professionals in accordance with the National Framework for Continuing Healthcare and NHS-Funded Nursing Care (Revised 2018) and associated practice guidance.

1.3 NHS Kernow may choose to use a verification panel to ensure consistency and quality of decision making. However, a verification panel should not fulfil a gate-keeping function, and nor should it be used as a financial monitor. Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed. A decision not to accept the recommendation should never be made by one person acting unilaterally.

2. Duties and responsibilities

2.1 The principal duty is to agree whether a person has a primary health need, based on information contained with the DST, and recommendations of the MDT using National Framework for NHS CHC and local operational guidance.

2.2 Each verification panel will keep accurate records of decisions and ensure the communication of outcomes within four working days to relevant parties.

2.3 As part of the verification panels responsibility to ensure consistent application of the national framework, they may review the quality of DSTs and the pattern of recommendations made by practitioners in order to improve practice. However, this will be carried out separately from the approval of recommendations in individual cases.

3. Accountability, authority and span

3.1 The verification panels are accountable to the NHS Kernow senior management team and focus on the following areas:

- Review the MDT assessment presented by the CHC co-ordinator for CHC determination.
- Consider whether sufficient information is presented to support the recommendation of the MDT regarding whether the person has a primary heath need for.
- Refer the CHC co-ordinator to acquire additional information to support the eligibility recommendation if required.
- Ratify the CHC recommendation of the MDT.

3.2 The verification panel can make two decisions:

- Uphold the recommendation of the MDT
- Defer the case for further information

3.3 The verification panel will not:

- Consider people requiring funding under Mental Health Act Section 117 or rehabilitation.
- Make decisions regarding the details of joint packages of care funding. However it may be appropriate for the verification panel to recommend for joint package of care funding to be considered.

4. Composition, membership and roles of verification panel members

4.1 In line with the National Health Service Commissioning Board and Clinical Commissioning Panel (Responsibilities and Standing Rules) Regulations 2018, NHS Kernow cannot delegate the decision whether someone is entitled to CHC funding. For this reason, a NHS Kernow commissioner must be in attendance to chair each verification panel to confirm entitlement – this can be any member of the CHC service at Band 6 or above.

4.2 The verification panels will consist of the following members:

Chairmanship: Verification panels will be chaired by an accredited person nominated by the CCG who can act in an authoritative capacity. The chair does not have the voting rights of a verification panel member and therefore does not have the ability to make decision in relation to eligibility but is there to facilitate an equitable decision making process.

Core membership will include: A commissioner from NHS Kernow, generally a Band 7/6 CHC locality team member or more senior member of staff.

And at least one of the following:

Additional representation: For all verification panels, representation will be sought from some or all following partner agencies:

- Adult social care at team manager or equivalent level
- Cornwall Partnership NHS Foundation Trust (CFT) – Band 6/7 team leader or deputy

For complex cases, representation can be sought (on a case by case bases) from the following partner agencies:

- Mental health cases: CFT team manager or deputy
- Learning disability cases – CFT team manager or deputy

We note that representation from partner agencies ensures a multidisciplinary approach to decision making. However, whilst every opportunity will be taken to engage partner agencies in the decision making process, decision making cannot be halted by non-attendance from our partner agencies.

5. Quorum and frequency of meetings

5.1 A minimum of three people (including the chair) must be present in order to ratify whether someone has a primary health need. Quorum must include all of the core membership, the chairperson and at least one person from the additional representative list. In addition a member of the CHC administration staff must always be present at the meetings to take notes.

5.2 Verification panels will be held weekly in both locality CHC teams. Complex cases needing more specialist attendance will be held at the closest locality verification panels, as soon as this can possibly be arranged.

6. In attendance:

- A member of the CHC administration staff.

6.1 Observers from the MDT may be welcomed to attend the verification panel at any time to ensure their professional development.

6.2 Nurse co-ordinators will be in attendance to present their cases where applicable

7. Information provided to the verification panel

7.1 The patient file will be available to enable reference to other supporting information and evidence.

7.2 Supporting information/evidence from the individual and/or representative will be made available.

8. Responsibility, scope and conduct of the verification panel

8.1 Preparation for verification panels

8.1.1 Verification panels will take place on a different day in each area and should normally last no more than half a day.

8.1.2 A meeting room in each area will be booked in advance which can comfortably hold the numbers of attendees.

8.1.3 Verification panels representatives are to be agreed in advance with partner organisations and a rota produced to ensure that people are aware of when they are needed to attend.

8.1.4 Administrative staff are to be present at all verification panel meetings with access to a laptop.

8.2 The day of verification panel

8.2.1 All fast track cases reviewed since the previous verification panel will be agreed on the day of meeting. This is due to fast tracks having to be agreed with immediate effect

8.3 Process for verification panel

8.3.1 The chair will introduce the verification panel members and state the process for decision making.

8.3.2 Verification panel members will seek further information from the CHC co-ordinator/MDT members if needed. The case file should be available to reference any notes that may be needed to assist in the decision making or access to the ‘panel folder’ on the CCG shared drive.

8.3.3 Verification panel members will review the assessed health needs in each of the 12 care domains within the DST and review the level of need with reference to the evidence presented.

8.3.4 Notes of each discussion will be taken and recorded on the CHC eligibility decision form.

8.3.5 Verification panel members will consider whether there is evidence of nature, complexity, intensity and unpredictability of the health care needs within the DST and whether this information therefore indicates a primary health need.

8.3.6 The chair will ask the verification panel members to consider whether the sum total of the needs presented indicates a primary need for health or for social care, and whether the evidence supplied supports the recommendations in the DST.

8.3.7 The chair will ask the verification panel to consider if the health needs are ancillary to social care needs/ accommodation such that the local authority could reasonably be expected to provide.

8.3.8 On the basis of evidence presented to the verification panel and the process of discussion and analysis, the chair will ask the members to identify if the care needs of the case meet the threshold of a primary health need.

8.3.9 The chair of the verification panel will seek consensus on the decision on eligibility between the local authority representative and NHS Kernow commissioners.

8.4 Summary of decision

8.4.1 Once the verification panel has made its decision the chair will summarise the findings on the CHC eligibility decision form. This will include recommendations regarding ongoing care planning needs.

8.4.2 Where the verification panel is unable to reach a decision about a primary health need and therefore eligibility for NHS funded CHC, the verification panel will request further information in respect of the application. This may include referral for further specialist assessment, or further detail in relation to the multi-disciplinary assessment, or evidence from care provided such as diary sheets.

8.4.3 The CHC co-ordinator is responsible for ensuring that these actions are undertaken in a timely way and that the application is brought back to the NHS Kernow CHC verification panel with the requested further information at the earliest opportunity.

8.4.4 There is a disputes process to cover those occasions where the CCG and the local authority do not agree on the patient's primary need for healthcare and eligibility for CHC funding.

8.5 Communication of decision

8.5.1 A letter including the decision making process will be checked and approved by CCG commissioner prior to being sent to the family members within four working days of the verification panel meeting and will include:

- The decision on eligibility for NHS funded CHC.
- The rationale for the decision based on the evidence presented.
- Information on how to appeal against the decision.

8.6 Additional requirements

At each verification panel, the chair will ask to see a sample of up to four cases where eligibility was met but the case did not require full verification panel discussion. These can include cases that are changing funding stream or eligibility status and/or when individuals and/or their representatives are contesting recommendation and have provided additional information for verification panel to consider. An audit tool will be completed for each of these cases to ensure the quality of decision making outside of the verification panel process is robust and that the quality of DSTs is of the required standard.

Appendix 4: Personal health budget policy

Currently in draft – policy or hyperlink to be included once ratified.

Appendix 5: Equality impact assessment

An equality impact assessment is used to establish how a policy or similar document may impact on individuals, communities or equality groups to identify and minimise or remove any disproportionate impact. A full impact assessment should be undertaken for policies, strategies, procedures or projects which are anticipated to have an impact on members of the public.

Guidance to complete this document, and the full impact assessment template, is available on the Document Library.

Name of policy/ service to be assessed	NHS CHC (CHC) Operational Guidelines		
Department/ Section	CHC Team	**Date of assessment**	13/11/2019
Person/s responsible for the assessment	Click here to enter text.	**Is this a new or existing policy?**	Choose an item.
1. Describe the aims, objectives and purpose of the policy.		Clinical commissioning groups are mandated to offer Continuing healthcare over an extended period of time to a person aged 18 or over to meet physical or mental health needs which have arisen as the result of disability, accident or illness. NHS CHC means a package of continuing care arranged and funded solely by the NHS (DH 2007 revised November 2012 and October 2018) In order to ensure NHS Kernow's systems and processes for delivering CHC are robust, the existing guideline has been reviewed. The policy covers adults regardless of ethnicity but it	

	should be noted that the cohorts of patients involved are those with significant/complex health needs and associated disabilities. Some will be semi-independent while others will be wholly dependent on others to provide their care and to communicate their needs. There are clear national guidelines in place for planning and delivering care to those who are eligible for CHC. NHS Kernow's CHC policy has incorporated these in developing its systems and processes and planning the scope of CHC in meeting health and social care needs. This approach will allow NHS Kernow to: • Work in partnership with individual patients/clients and their families throughout the process • Retain robust continuing healthcare choice to health services • Support workforce development to ensure we have the right systems and services in place to deliver dynamic and consistent continuing healthcare services; • Allow us to ensure that we have robust transition arrangements in place for those 16+ who may move to adult NHS CHC funding. • Capture learning to enable the efficient delivery of CHC.
2. Who is intended to benefit from this policy, and in what way?	Adults who require on-going care in a community setting (this could be in a care home) 16+ who may move to adult NHS CHC funding.

	Benefit will be from the utilisation of a consistent process which embeds the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (revised 2018).
3. What outcomes are wanted from this policy? •	Effective management of CHC across Kernow. NHS Kernow aims to ensure that those who require on-going care in the community setting are considered to ensure that safe, effective care is considered with regard to eligibility. Key areas of work are : • Assessments and decision making about eligibility for NHS CHC will be undertaken in a timely manner to ensure that individuals receive the care they require in the appropriate environment, without unreasonable delays • Putting financial systems in place for payments and monitoring packages to ensure efficient use of NHS resources • Ensure robust clinical governance processes around CHC plans and monitoring packages • A dynamic working relationship with individuals and families in ensuring health needs are met in a way that is person-centred and supportive of the patient/carer relationship.
4. What factors/ forces could contribute/ detract from the outcomes?	• Lack of a policy would increase the chances of uncontrolled risk occurring with regard to the NHS Kernow's statutory requirements for CHC. • Managing expectation and ensuring that the correct information is presented to the patient at the initial contact. • Making available information with regard to CHC in a

	format that is readily understood and accessible for all client groups.
5. Who are the main stakeholders in relation to the policy?	NHS Kernow and all staff, Cornwall Partnership NHS Foundation Trust, Cornwall Council
6. Who implements the policy, and who is responsible for the policy?	NHS Kernow's CHC team
7. What is the differential impact on people from the perspective of race, nationality and/ or ethnic origin? Does this have a positive or negative impact on black, Asian and minority ethnic (BAME)? Consider relevance to eliminating unlawful discrimination, promoting equality of opportunity and promoting good race relations between people of different racial groups. Issues to consider include people's race, colour and nationality, Gypsy, Roma, Traveller communities, employment issues relating to refugees, asylum seekers, ethnic minorities, seasonal workers, language barriers, providing translation and interpreting services, cultural issues and customs, access to services, prejudice, discrimination, harassment and abuse, attitudes towards accessing healthcare.	
The ethnic background of the person is not an inhibiting factor affecting eligibility for inclusion, nor is the focus of CHC specifically aimed at this group. The CCG will offer CHC to all those eligible regardless of ethnicity and therefore there is no differential impact.	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
8. What is the differential impact on people from the perspective of sex? Does this have a positive or negative impact on people who identify as male, female or intersex? Consider what issues there are for men and women, e.g. responsibilities for dependants, issues for carers, access to training and employment issues, and attitudes towards accessing healthcare.	
The CCG will offer CHC to all those eligible regardless of sex and/or gender and therefore there is no differential impact.	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
9. What is the positive or negative differential impact on people from the perspective of disability? Consider what issues there are around disabilities, e.g. access to building and services, how we provide services and the	

way we do this, producing information in alternative formats and employment issues. Consider the requirements of the NHS Accessible Information Standard. Consider attitudinal, physical and social barriers. This can include physical disability, learning disability, autism, sensory impairment, mental health conditions, people with long term conditions, communication needs arising from a disability.	
There is none envisaged. Government policy and guidance is available to aid those eligible for CHC in various formats, including for people with a learning disability. The CCG will offer CHC to all those eligible regardless of disability.	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
10. What is the differential impact on people from the perspective of sexual orientation? Does this have a positive or negative impact on people who identify as heterosexual, lesbian, gay, bisexual, pansexual or asexual? Consider what issues there are for the employment process and training and differential health outcomes amongst lesbian and gay people. Also consider provision of services, for example, older and younger people who identify as lesbian, gay, bi-sexual.	
No negative impact identified. The CCG will offer CHC to all those eligible regardless of sexual orientation.	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
11. What is the positive or negative differential impact on people from the perspective of age? Consider what issues there are for the employment process and training. Some of our services impact on our community in relation to age, e.g. how do we engage with older and younger people about access to our services? Consider safeguarding, consent and child welfare, feelings of stigma and discrimination, lack of respect and social isolation.	
No negative impact identified. The CCG will offer CHC to all those eligible regardless of age using the correct framework for adults CHC or children's CHC	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
12. What is the positive or negative differential impact on people from the perspective of religion or belief? Consider what issues there are for the employment process and training. Also consider the likely impact around the way	

services are provided, e.g. dietary considerations, religious holidays, days associated with religious observance, culture and customs, places of worship. Consider what issues there may be for someone who has a religion or belief. Are they likely to be different to those faced by a person who does not hold a religious belief?	
No negative impact identified. The CCG will offer CHC to all those eligible regardless of religion or belief.	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
13. What is the positive or negative differential impact on people from the perspective of marriage and civil partnership? NB: this is particularly relevant for employment policies. This characteristic is relevant in law only to employment; however, NHS Kernow will strive to consider this characteristic in all aspects of its work. Consider what issues there may be for someone who is married or in a civil partnership. Are they likely to be different to those faced by a single person? What, if any are the likely implications for employment and does it differ according to marital status?	
No negative impact. The CCG will offer CHC to all those eligible regardless of impact on marriage or civil partnership	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
14. What is the differential impact on people from the perspective of gender re-assignment? Does this have a positive or negative impact on people who identify as Trans/ transgender, non-binary or gender fluid? Consider what issues there are for people who have been through or a going through transition from one sex to another. How is this going to affect their access to services and their treatment when receiving NHS care? What are the likely implications for employment of a transgender person? This can include issues such as privacy of data and harassment, gender neutral language, dress codes.	
No negative impact. The CCG will offer CHC to all those eligible regardless of gender reassignment of who identify as transgender.	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
15. What is the differential impact on people from the perspective of pregnancy and maternity? Does this have a	

positive or negative impact on people who are pregnant, breast feeding mothers, or those on maternity leave? This characteristic applies to pregnant and breast feeding mothers with babies of up to six months, in employment and when accessing services. When developing a policy or services consider how a nursing mother will be able to nurse her baby in a particular facility and what colleagues may need to do to enable the baby to be nursed. Consider working arrangements, part-time working, infant caring responsibilities.	
No negative impact. The CCG will offer CHC to all those eligible regardless of pregnant or breast feeding mothers.	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
16. Other identified groups: Consider carers, veterans, different socio-economic groups, people living in poverty, area inequality, income, resident status (migrants), people who are homeless or living in unstable accommodation, long-term unemployed, people who are geographically isolated, people who misuse drugs, those who are in stigmatised occupations, people with limited family or social networks, and other groups experiencing disadvantage and barriers to access.	
The CCG gives equity of consideration to all individuals and does not discriminate because of protected characteristics, resident status, lifestyle, income or employment status, housing status, occupation, carer status, peer/social/family support networks or any other factor which could cause disadvantage or barriers to be experienced.	
How will any negative impact be mitigated?	Through consistent use of the principles of the National Framework in addition to compliance with relevant legislation and national/local policies.
17. How have the core Human Rights Values of fairness, respect, equality, dignity and autonomy been considered in the formulation of this policy/ service/ strategy? If they haven't please reconsider the document and amend to incorporate these values. •	
Click here to enter text.	
18. Which of the Human Rights Articles does this document impact?	
The right:	**Yes / No:**
• To life	Yes
• Not to be tortured or treated in an inhuman or degrading way	No

• To liberty and security	No
• To a fair trial	No
• To respect for home and family life, and correspondence	Yes
• To freedom of thought, conscience and religion	Yes
• To freedom of expression	Yes
• To freedom of assembly and association	No
• To marry and found a family	No
• Not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention	No
• To peaceful enjoyment of possessions	No
19. What existing evidence (either presumed or otherwise) do you have for this?	Fairness – The eligibility assessment and evaluation process is managed to reflect the needs of the individual to ensure that appropriate support and advocacy services can be accessed. Respect – we will listen to families and adapt our systems to ensure a robust approach Equality – families will have the same rights to choice and flexibility Dignity – through needs assessment Autonomy – accessible information for individuals to make informed choices. Freedom of expression – ensuring translation e.g. BSL available when needed. Considering the wishes of the individual with regard to assessing eligibility for CHC.
20. How will you ensure that those responsible for implementing the policy are aware of the Human Rights implications and equipped to deal with them?	Through mandatory training expectations, through 1:1 sessions
21. Describe how the policy contributes towards	This contributes to the elimination of these factors through the

eliminating discrimination, harassment and victimisation. Does this make the system fairer? Does it challenge, positively change the culture?	consistent approach in processes, including management of disputes and complaints
22. Describe how the policy contributes towards advancing equality of opportunity. Are you using positive action to increase inclusion? Is this helping groups who may be less often heard?	CHC relates to people with more complex health needs and therefore these individuals could be considered more likely to be socially isolated and/or to be less included
23. Describe how the policy contributes towards promoting good relations between people with protected characteristics. Does it educate, integrate, support?	This policy supports legislation and national/local policies relating to positive outcomes for people with protected characteristics
24. If the differential impacts identified are positive, explain how this policy is legitimate positive action and will improve outcomes, services and/ or the working environment for that group of people.	Differential impacts are neutral
25. Explain what amendments have been made to the policy or mitigating actions have been taken, and when they were made.	None – none identified
26. If the negative impacts identified have been unable to be mitigated through amendment to the policy or other mitigating actions, explain what your next steps are using the following Equality Impact Assessment Action Plan.	N/A If applicable, please complete table below. The following action plan should be completed if the Equality Impact Assessment has identified that additional steps need to be taken to address adverse outcomes for particular protected groups, or to collect additional evidence to inform the analysis. Please list below any recommendations for action that you plan to take as a result of this impact assessment.

Equality impact assessment action plan

Issues to be addressed	Action required	Responsible person	Timescale for completion	Action taken	Comments

Signed (Completing officer): Jenny Pearce

Date: 13/11/2019

Signed (Head of department/section): Helen Childs

Date: 17/12/2019

Please ensure that a signed copy of this form is sent to both the corporate governance team with the policy and the equality and diversity lead.

NHS
Kernow
Clinical Commissioning Group