Sheffield Clinical Commissioning Group

Continuing Healthcare Refunds Guidance

Applying Annex F of the National Framework for Continuing Healthcare

1.0 Purpose and Scope

1.1 This process sets out how Sheffield Clinical Commissioning Group (CCG) will implement the Department of Health's guidance on responsibilities when a decision on NHS Continuing Healthcare (CHC) eligibility is awaited or is disputed. It also applies to service-users assessed as eligible for Funded Nursing Care (FNC) and Joint Packages of Care.

1.2 This paper has been written to inform professionals working with service-users who believe they may be eligible for a refund, in respect of continuing healthcare. It is also provided for service-users and family members, to help them understand when a refund may be provided and how a refund would be made.

1.3 Refunds under this guidance refer to how the LA and CCG refund each other, or how service-users are refunded.

2.0 Background

2.1 The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 set out the responsibilities of Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) when assessing a service-user's eligibility for continuing healthcare. This includes the duty to consult the relevant Local Authority, wherever reasonably practicable, before making a decision on NHS CHC eligibility. The Local Authority is under a similar duty to participate in assessments for CHC.

2.2 The National Framework for Continuing Healthcare (as revised in November 2012) expands on these responsibilities. The Framework states that:

> "The time that elapses between the Checklist (or, where no Checklist is used, other notification of potential eligibility) being received by the CCG and the funding decision being made should, in most cases, not exceed 28 days."

CCGs and Local Authorities have dual responsibilities for meeting these timescales.

2.3 The National Framework also states:

> "Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute."

2.4 Prior to November 2012, the Department of Health published separate Refunds Guidance. This has been superseded by the revised National Framework, specifically annex F. This process is written in accordance with the revised National Framework.

2.5 The CCG has agreed protocols with Sheffield City Council to provide for timely decision-making. By following these protocols, members of MDTs will contribute to ensuring that decisions regarding eligibility for continuing healthcare are not unduly delayed.

3.0 Provision of services whilst a decision on NHS CHC is awaited, in a case that does not involve hospital discharge

3.1 The National Framework (Annex F) specifies that no service-user should be left without required services, whilst a decision regarding eligibility for continuing healthcare is pending. It also specifies that a person only becomes eligible for NHS CHC once a decision on eligibility has been made by a CCG, informed by a completed Decision Support Tool or Fast Track Pathway Tool.

3.2 Whilst a service-user is waiting for a decision regarding eligibility, and the service-user is already receiving a package of care, these arrangements should continue. Where the service-user's needs have changed, urgent adjustments should be made, subject to the limitations of the statutory powers of the funding body. No individual should be left without appropriate support because statutory bodies are unable to agree on respective responsibilities.

3.3 Where a practitioner is assessing a service-user and believes that they need a service which is beyond the legal powers of the Local Authority to meet, they should invite the CCG to participate in the assessment. The CCG will consider and meet its responsibilities under the NHS Act 2006 pending the NHS continuing healthcare eligibility decision, as explained above. Annex F requires both the CCG and the LA to ensure that no individual is left without appropriate support because statutory bodies are unable to agree on respective responsibilities.

4.0 Provision of services whilst a decision on NHS CHC is awaited, in a case that does involve hospital discharge

4.1 The CCG, along with local partners, has agreed protocols for arranging timely discharges from hospital, which apply in most cases. These protocols were developed under the Right First Time Partnership, and key local stakeholders are members of this partnership. These protocols include arrangement

4.2 The above protocols usually apply where a service-user is moving from hospital to have a period of intermediate care. They also apply where a patietn is moving to live in a nursing home, and their needs can be met under the CCG's standard specification, or under the Local Authority's contracts. However, some service-users' needs cannot be met under either of these pathways.

4.3 Some service-users who are ready for discharge from hospital have needs which cannot be met using one of the above pathways. The National Framework for CHC makes it clear that their discharge should not be unduly delayed. Therefore in such circumstances the CCG and LA will agree an interim, 'without prejudice' means for arranging care for the service-user. For example, one such arrangement might be for the CCG to advance payment to the provider, with the LA refunding the CCG the costs (or share of the costs) if the service-user is not eligible for CHC.

5.0 Where a CCG has unjustifiably taken longer than 28 days to reach a decision on eligibility for NHS CHC

5.1 Annex F specifies the circumstances under which the CCG should refund the LA the costs of providing care. These circumstances occur when

i) a CCG makes a decision that a person is eligible for NHS CHC; and
ii) it has taken more than 28 days to reach this decision; and
iii) an LA or the individual has funded services whilst awaiting the decision.

5.2 However, the above circumstances only apply when the delay was unreasonable. Annex F states that no refund would be due when the delay is reasonable "as it is due to circumstances beyond the CCG's control".

5.3 Examples of delays that are beyond the CCG's control are:

i) evidence (such as assessments or care records) essential for reaching a decision on eligibility have been requested from a third party and there has been delay in receiving these records from them;
ii) the individual or their representatives have been asked for essential information or evidence or for participation in the process and there has been a delay in receiving a response from them;
iii) there has been a delay in convening a multidisciplinary team due to the lack of availability of a non-CCG 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 by telephone.

5.4 The CCG and Sheffield City Council have agreed protocols to minimise the time taken to make decisions regarding eligibility for continuing healthcare. These include how assessments will be ratified and an escalation process for resolving disputes.

5.5 Where a decision regarding eligibility for continuing healthcare has been delayed, the CCG will consider refunding to a Local Authority the costs of the care package that it has incurred from the 29th day following receipt of the check list. The CCG will respond to requests from the Local Authority for a refund by considering whether the delay was unreasonable. The CCG will respond to such requests within 20 working days. Such requests will be discussed at the CCG's CHC Resource Panel (or its successor body

5.6 Annex F specifically requires CCGs to make gross refunds to the Local Authority. In many cases, service-users will have been contributing towards the cost

of their care when it was arranged by the Local Authority, as a result of an assessment of their resources. The CCG cannot refund contributions direct to individuals in these circumstances. Where the CCG makes a gross cost refund, the Local Authority should refund any financial contributions made to it by the individual in the light of the fact that it has been refunded on a gross basis. Any individual service-user, who considers that they may be entitled to such a refund, should apply to the Local Authority.

5.7 Where the CCG has unreasonably delayed making a decision regarding eligibility for continuing healthcare, and the service-user was paying for all of the care themselves, the CCG will consider making an ex gratia payment. Such payments would need to be made in accordance with the guidance for ex-gratia payments set out in Managing Public Money.

5.8 No refund will ever be made to any date preceding the 29th calendar following the receipt of a valid Checklist. In order for a Checklist to be valid, it must have been completed in accordance with the CCG's policy on the completion of Checklists. This includes ensuring the patietn has given consent to be assessed, and has capacity to do so, in line with the CCG's policy. It also includes providing sufficient references on the Checklist to the precise location, and nature of the supporting information and how it evidences the need for a full assessment. Practitioners should ensure that they are familiar with the CCG's guidance on completing a Checklist.

6.0 Where the CCG has revised its decision following an appeal or a dispute

6.1 The National Framework states that

> "When the Board or a CCG has made a decision on NHS continuing healthcare eligibility, that decision remains in effect until the Board or the CCG revises the decision."

Therefore all eligibility decisions made by the CCG will stand unless the CCG subsequently revises the decision.

6.2 There are three policies which could lead to a CCG eligibility decision being revised.

- the Disputes Policy, which is used to resolve disagreements regarding eligibility between the CCG and Sheffield City Council; and
- the Appeals Policy, which is used by service-users or their representatives to challenge eligibility decisions.
- The Individual Review Process of the Strategic Health Authority, which would only be activated once the Appeals Policy had been exhausted.

6.3 Where the CCG revises an eligibility decision following the application of one of the above polices, and a Local Authority has been paying for a care package for the service-user concerned, it will refund the Local Authority the costs of the care package.

6.4 Where the CCG refunds a Local Authority the cost of the care package, it will refund the gross costs. The CCG cannot refund contributions direct to individuals in these circumstances. Where the CCG makes a gross cost refund, the Local Authority should refund any financial contributions made to it by the individual in the light of the fact that it has been refunded on a gross basis. Any individual service-user, who considers that they may be entitled to such a refund, should apply to the Local Authority.

6.5 Where the CCG revises an eligibility decision following the application of one of the above polices, and the Local Authority applies for a refund, it will refund the costs from the date the eligibility decision was made. For the avoidance of doubt, 'eligibility decision' in this context means the decision that was subject to the successful challenge. An exceptionality to this arrangement will exist where the CCG can demonstrate that there was an reasonable delay in coming to the eligibility decision, in line with the steps set out in section 5.0 (above).

6.6 Where the Local Authority did not fund any service provision for the service-user, and the service-user paid for care services themselves, the CCG will consider making a refund direct to the service-user. Any such refund will be made in accordance with the guidance for ex-gratia payments set out in Managing Public Money.

6.7 Where the outcome of the assessment for continuing healthcare is subject to the Disputes Process, the CCG will not consider any application for a refund until the dispute is resolved. Both the Local Authority and the service-user have three months from the date that the dispute is resolved to submit a request for a refund.

6.8 Where the outcome of the assessment for continuing healthcare is subject to an appeal, the CCG will not consider any application for a refund until the appeal is resolved. Both the Local Authority and the service-user have three months from the date that the appeal is resolved to submit a request for a refund.

6.9 Where a service-user has arranged and paid for their own care and the CCG agrees to make a refund, the CCG will consider:

- the cost at which the CCG could have secured the care; and
- the services did the service-user reasonably require to meet their assessed health and social care needs; and

in determining the amount to be refunded.

6.10 Where a service-user has been contributing to the cost of their care and a local authority has arranged the care, the service-user (or their family) may have elected to pay for additional services or a 'top-up'. The CCG will not usually refund the cost of additional services or top-ups, unless it can be demonstrated that these were reasonable requirements, to meet the service-users assessed health and social care needs.

7.0 Deciding whether to refund payments

7.1 The CCG becomes liable for the cost of a service-user's care from the date eligibility for continuing healthcare is decided. Eligibility decisions cannot be backdated. However, where a decision is successfully disputed the effect is to revise the previous decision.

7.2 The CCG will consider requests for refunds from Local Authorities, where the Local Authority believes the delay in making the eligibility decision was unreasonable. Such requests should be made in writing and within three months of the date of the eligibility decision.

7.3 The CCG will consider requests for refunds from service-users, where the service-user believes the delay in making the eligibility decision was unreasonable. Such requests should be made within three months of the date of the eligibility decision. Requests should usually be made in writing. The CCG will also accept requests for refunds from family members on behalf of service-users, where they have

- lasting Power of Attorney to deal with the service-user's financial affairs, registered with the Office of the Public Guardian; or
- an Enduring Power of Attorney, registered with the Office of the Public Guardian; or
- a Court order appointing them as Deputy.

7.4 The CCG will consider all requests for refunds at its weekly Commissioning of Care Panel, as set out in the terms of reference. The CCG will respond to requests for refunds within 20 working days of the receipt of the request.

7.5 Where a service-user disagreed with the CCG decision as to whether to make a refund to them, either partially in fully, they should complain using the CCG's Complaints Process.

8.0 Urgent Health Needs

8.1 Annex F of the National Framework also considers the CCG's responsibilities where care needs to be provided whilst a decision on NHS continuing healthcare is awaited. Annex F refers to the CCG's duties under the NHS Act 2006 and states:

> "…CCG should consider whether the individual's health needs are such that it would be appropriate to make services available to help meet them in advance of the NHS continuing healthcare eligibility decision…Where there are urgent healthcare needs to be met, these should be assessed by the relevant healthcare professional."

8.2 The CCG and the wider NHS commissions a range of services under the NHS Act 2006. The Executive Summary of the National Framework states:

> "Those entitled to NHS continuing healthcare continue to be entitled to access the full range of primary, community, secondary and other health services."

Therefore a person awaiting the outcome of an eligibility decision should usually be able to have their health needs by commissioned services.

8.3 The CCG has a process for providing emergency access to funded nursing care. This process can also be used where a service-user is awaiting the outcome of assessment for continuing healthcare.

8.4 Similarly, a service-user who has a primary health need arising from a rapidly deteriorating condition who may be entering the terminal phase would be eligible for continuing healthcare on the fast track. Such a service-user should be referred for continuing healthcare on the fast track, by an appropriate clinician.

8.5 Where a service-user:

- has a need for urgent services, which are beyond the powers of a Local Authority to meet; and
- the NHS has not commissioned a service that would meet the needs of the service-user; and
- their health needs cannot be met through the use of emergency funded nursing care; and
- they are not eligible for continuing healthcare on the fast track;
- and they are awaiting the outcome of an assessment for eligibility for continuing healthcare,

the CCG will consider whether it should arrange an interim service until the outcome of the NHS continuing healthcare decision-making process is known. Such arrangements will be discussed jointly with the Local Authority. No individual should be left without appropriate support because statutory bodies are unable to agree on respective responsibilities.

9.0 Governance

9.1 This guidance is owned by Sheffield's Clinical Commissioning Group.

9.2 This guidance will be due for review in October 2016. Responsibility for the review will lie with the Head of Clinical Services at Sheffield Clinical Commissioning Group.

9.3 The CCG may delegate some of its functions under this policy to a third party to carry out in its behalf, such as a Commissioning Support Unit.

9.4 This policy will take effect once authorised by the CCG's Chief Nurse.

Version Control

Version	Date	Author	Comment
0.1	21 August 2012	E Harrigan	For initial NHSS

			comments
0.2	7 January 2013	E Harrigan	Following CHC SMT discussion and revised national framework.
0.3	7 May 2013	E Harrigan	For PDG (NB: no feedback received from LA)
0.4	11 June 2013	E Harrigan	Following dialogue with LA
0.5	30 September 2013	E Harrigan	Following development of new re-ablement pathway.
0.6	11April, 2014	E Harrigan	Following further comments from LA, for Operational Group April 2014.
0.7	22 April 2014	E Harrigan	Following discussion at Operational Group, and approved by Chief Nurse 9 May 2014.