NHS
Strategic Health Authorities

NHS Continuing Healthcare

Dealing with requests for assessments of previously un-assessed periods of care

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Owner:	**SHA Continuing Healthcare Leads**
Author:	**Karen Scarsbrook**
Further copies from:	**Karen Scarsbrook** **NHS London** **Southside** **105, Victoria Street** **London SW1E 6QT** **Tel: 0207 932 3786** **Email: Karen.scarsbrook@london.nhs.uk**
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NHS Continuing Healthcare Review Process

To be adopted when dealing with requests for assessment of past periods of care between 1st April 2004 and 31st March 2012

1.0 Introduction

1.1 NHS Continuing Healthcare (NHS CHC) is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing healthcare needs. To qualify for NHS CHC, an individual must have a 'primary health need' which is assessed using the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care published 1 October 2007 (revised 2009). Prior to 1st October 2007 eligibility for NHS CHC was established using the relevant Strategic Health Authority (SHA) criteria in place at the time.

1.2 Primary Care Trusts (PCTs) are responsible for the assessment and funding of NHS CHC and receive regular referrals for assessment from a number of different sources including NHS community teams, hospitals, social services, care homes and hospices. This document aims to set out how a PCT should approach a request for an assessment of a past period of care.

2.0 Responsibilities of PCTs

2.1 The responsibilities for PCTs are set out in the NHS Continuing Healthcare (Responsibilities) Directions 2007 and 2009 and previously in the Continuing Care Directions 2004. The Directions stipulate that PCTs have a duty to take reasonable steps to ensure that an assessment of eligibility for NHS CHC is carried out in all cases where it appears to the NHS that there may be a need for such care.

3.0 Closing dates for requesting an assessment of a previously un-assessed episode of care

3.1 In November 2007 the opportunity to request a review where the majority of care was prior to 1st April 2004 was closed (it was recognised that there may have been exceptional circumstances which would mean some cases may need to have been accepted after the deadline). Therefore this policy applies only to requests for assessments for previously un-assessed episodes of care starting 1st April 2004 to 31st March 2012.

3.2 On 15th March 2012, the Department of Health announced its intention to introduce a close down for any new cases to the system which require assessment of eligibility for NHS CHC. More information about the closing dates can be found in the 'Dear Colleagues' letter[1] from

[1] Eligibility for NHS Continuing Healthcare for cases during the period 1st April 2004 –

Sir David Nicholson KCB CBE, Chief Executive of the NHS in England, published 15th March 2012.

The closing dates which apply to each specific period are set out in the table below:

Time Period	Deadline
1st April 2004 – 30th September 2007	30th September 2012
1st October 2007 – 31st March 2011	30th September 2012
1st April 2011 – 31st March 2012	31st March 2013

Again, it is recognised that there may be exceptional circumstances that mean some cases may need to be accepted after these deadlines.

4.0 Considering requests for assessments of past periods of care (Appendix 1)

4.1 On receipt of a request for an assessment of eligibility for NHS CHC for a past period of care, the PCT will have to complete a number of preliminary checks to establish if it should be done, as set out below:

4.1.1 The PCT will first have to establish whether or not it is the correct body to deal with the request by making sure it is the responsible commissioner[2] for the individual. If it is not the responsible commissioner the PCT should inform the applicant and the relevant PCT of the request.

4.1.2 Has the request been made within the deadline as set out above?
Requests that are made after the deadline should only be accepted in exceptional circumstances to be determined by the PCT.

4.1.3 Claims made by solicitors or claims companies should only be accepted where the company can show they have authority to act on behalf of the individual. Therefore any request that is not accompanied by the individual's instruction to the company to act on their behalf should be logged but no further action taken if the company cannot produce its authority to act within a reasonable timeframe of three months. A template letter is attached at Appendix 2d, to be used to acknowledge the request, which explains that the PCT will be writing to advise the company of the next stage of the process once the authority to act has been received. However, if the PCT does

31st March 2012

[2] Who Pays establishing the responsible commissioner – April 2010

not receive the authority within three months of the date of receipt of the letter, the PCT should consider the request has been withdrawn.

4.1.4 If the patient lacks capacity, and the claim has been made by a relative, friend or carer, the PCT should make sure that the person making the claim is authorised to do so. The PCT should check whether the applicant (or the client of the solicitor making the claim) is one of the following:

- A person holding Lasting Power of Attorney registered with the office of the Public Guardian.
- The holder of Enduring Power or Attorney registered with the Court of Protection.
- A deputy / receiver appointed by the Public Guardianship Office of the Court of Protection.

If the applicant cannot satisfy any of the above-mentioned criteria, the PCT should refer to the Mental Capacity Act[3] and decide if a best interests decision should made.

4.1.5 If the individual is deceased, the PCT should be satisfied that there is sufficient proof that the representative is an executor or administrator to the estate. If proof of this is not returned with the consent and application forms, the PCT should write to the applicant allowing a period of 3 months for its return (a template letter Appendix 2e is provided for this purpose) . Whilst it is reasonable to allow three months, after such time the application could be considered withdrawn, it is however recognised there may be exceptional circumstances which should be taken into account and an extension of time considered, for example, in the event that there is a delay in obtaining a grant of probate or letters of administration.

4.1.6 The PCT should make sure that the request relates to a previously 'un-assessed' period of care as set out in paragraph 3.0 above. The closing date does not apply to reviews of decisions that have already been made. The PCT should check its records to consider the following:

(i) Has the person been considered for continuing healthcare previously for the period for care being requested? This may be either by the use of the Checklist process (or equivalent if before October 2007), or a full continuing healthcare assessment. If a Checklist was carried out, it should:

- have been completed appropriately;

[3] Mental Capacity Act 2005

- be clinically sound;
- reflect the patient information known at the time;
- relate to the relevant period(s).

(ii) Was the individual in receipt of either Registered Nursing Care Contributions (RNCC) (pre October 2007) or NHS Funded Nursing Care (FNC) (post October 2007)? An RNCC / FNC assessment should have only taken place once it had been established that the individual was not eligible for NHS CHC. Providing a proper consideration of the need for NHS CHC was made prior to the RNCC / FNC assessment or annual review, then a further assessment of the past period of care is not necessary.

(iii) If there is evidence that the individual or their representative refused consent for assessment of a past period of care at the time, the NHS should not accept a new request for an assessment of the same period.

5.0 Completing an assessment of eligibility for a previously un-assessed period of care (Appendix 3)

5.1 Core values and principles

5.1.1 Prior to 1st October 2007 when the National Framework was published, PCTs assessed individuals using local eligibility criteria. The National Framework was welcomed and has improved the consistency of decision making and provided detailed guidance on the roles and responsibilities of PCTs. The core principles and values within the National Framework and NHS CHC Practice Guidance[4] are now fully embedded into the NHS CHC assessment process and should be regarded when completing retrospective reviews regardless of which set of criteria is used.

5.1.2 PCTs have to use the eligibility criteria in place relevant to the time period being considered and as established by former Strategic Health Authorities, prior to introduction of the National Framework. Whichever criteria were in place at the time, the main test was, and remains, whether the nature, intensity, complexity or unpredictability of the individual's needs were such that they had a primary health need. Having a primary health need would make an individual eligible for NHS CHC funding. PCTs historically, developed Decisions Support Tools (DSTs) to consider the totality of the individual's needs, to decide whether or not they had a primary health

[4] NHS Continuing Healthcare Practice Guidance March 2010

need, and there are varying tools in the different sets of criteria that were in use nationally, prior to the publication of the National Framework.

In order to make the process less complicated for patients or their representatives, it is acceptable for PCTs to use the DST published by the Department of Health in June 2009 to support their decision making against the individual SHA eligibility criteria applicable to the period under consideration.

5.2 Consent

5.2.1 Like any assessment, the PCT must obtain the individual's informed consent (Appendix 2b). If the individual does not have capacity or the application is from the estate of a deceased person, then the PCT should obtain consent from the appropriate party with authority to act. The consent should include the gathering, scrutiny and sharing of records and information with all persons involved in the review process.

5.3 The Checklist

5.3.1. The first step in the assessment process for most people will be the NHS CHC Checklist[5]. The Checklist is a screening tool, which will help the PCT work out whether a full assessment of the past period of care is required. The threshold of the Checklist is set intentionally low, to ensure that all those who may be entitled to NHS CHC have a full assessment.

5.3.2. The Checklist is intended to be a relatively quick and straightforward process. PCTs should use the information supplied by the applicant in Appendix 2a, gathering and referencing additional evidence if necessary. If the claim spans a few years, then the Checklist should be applied periodically, either where there is significant change or annually, to ensure it picks up deterioration e.g. if a person has Dementia, it may be that applying the Checklist at the beginning of the claim period will indicate a full CHC assessment is not necessary, however later on in the claim period, due to the progression of Dementia, the Checklist may indicate a full assessment is necessary. Therefore the PCT should write to the family to explain the decision, and inform them what period of the claim will be considered.

5.3.3. If a Checklist indicates a full assessment is not necessary, for all or part of a claim period, the applicant should be advised in writing and reasons given, including a copy

[5] The NHS Continuing Healthcare Checklist

of the completed Checklist. The letter should explain the next steps – i.e. If dissatisfied with the decision, the applicant can complain via the NHS Complaints process.

5.4 Gathering and scrutinising the evidence

5.4.1 To complete a robust retrospective assessment the PCT will have to collect a great deal of contemporaneous evidence from all relevant sources (Appendix 4). If the individual was in a care home, then all care home records relevant to the claim period should be collected, along with GP records, hospital records if applicable, social care assessments, any notes from other NHS services such as Community Mental Health or Speech and Language Therapists.

5.4.2 The PCT should appoint a nurse assessor who has the appropriate skills and is trained in continuing healthcare. The assessor should scrutinise the evidence and compile a needs portrayal document. The needs portrayal should pull together all the relevant information from the different sources of evidence to build up a comprehensive picture of the individual's needs across the whole time period. The evidence should be compiled in chronological order, ideally broken down into the different care domains within the eligibility criteria. PCTs may choose to use the national template attached (Appendix 5).

5.4.3 The needs portrayal document is the starting point after collecting all of the evidence. Usually a nurse assessor will complete a first draft of the document on her own or with a colleague. Once completed the assessor should share the needs portrayal document with the applicant and offer to meet with them, to go through it. The purpose of the meeting is to ensure the document is accurate and to obtain the applicant's views, gathering any additional evidence the applicant may have to get a full picture of the individuals needs.

5.4.4. Once the needs portrayal is complete the information should be used to apply the criteria. The criteria should be applied by a team or panel of multi-disciplinary professionals. If a claim period spans a number of years, then the eligibility criteria may need to be applied several times. The claim period should be broken down into manageable chunks with the criteria applied to each separate timeframe. A good guide is to split the claim into periods of 12 months; however there may be a significant event or clear deterioration that will determine the split. For example, if after the initial 13 months the individual has a stroke, or a serious pressure sore, then this may be a good point to split the periods under consideration.

5.4.5 The National Framework requires that a Multi Disciplinary Team (MDT) completes the Decision Support Tool (DST) and makes a recommendation to the PCT which

should be accepted unless in exceptional circumstances. This principle still applies to retrospective assessments using the National Framework. For retrospective cases using the National Framework, PCTs may use their multi-disciplinary panels to act as the MDT to complete the DST, apply the criteria and make a recommendation. The PCT should then ratify the MDT's decision.

5.4.6 If the claim pre-dates October 2007, the old criteria in use at the time will not require a MDT recommendation. PCTs may choose to use their panels to substitute the MDT in this instance. Panels should be multi-disciplinary with the appropriate skills to review the case. All panel members should have access to all the contemporaneous evidence and the needs portrayal prior to applying the eligibility criteria across the different timeframes. Whether the PCT is using a PCT retrospective panel or a MDT to apply the relevant criteria, the applicant should be invited to contribute to this part of the review process.

5.4.7 Whichever set of eligibility criteria are being used to make the decision, the Primary Health Need Test must be applied. To ensure that the quality and quantity of care required is not more than the limits of local authority responsibilities, the PCT must consider whether the nature, complexity, intensity or unpredictability of the individual's needs indicate a 'primary health need'.

6.0 The Decision

6.1 Once the MDT or multi-disciplinary panel has reviewed the evidence, applied the criteria and made a recommendation, the PCT should ratify the decision and write to the applicant with a detailed rationale for its decision. A copy of the needs portrayal and DST(s) should be sent with the decision letter.

6.2 If the PCT decide that the individual was eligible for all or part of the period under consideration, the PCT should make arrangements to make a restitution payment in line with the Department of Health Redress Guidance[6].

6.3 If the PCT decide the individual was not eligible for NHS CHC funding 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.

[6] NHS Continuing Healthcare: Continuing Care Redress Guidance March 2007

7.0 Dispute resolution

7.1 If the applicant disagrees with the decision made by the PCT, the PCT should make it clear in the decision letter how to request a review. The PCT should have a locally agreed review process.

There are two stages involved in dealing with requests for a review.

i) A local review process at PCT level; and
ii) A review by an Independent Review Panel (IRP) arranged by the SHA.

7.2 All reasonable attempts should be made to resolve a dispute at local level by the PCT before referring the case to the SHA for independent review. This may include:

- A face to face meeting or telephone conversion (if preferred) with the applicant to discuss the concerns
- Review of the decision if key evidence has been overlooked – the PCT may decide to send to a second panel with different members
- A referral to a neighbouring PCT to review the decision

8.0 Independent Review Process

8.1 If the PCT has exhausted attempts at local resolution, the applicant should be advised that they can request a review by an IRP by contacting their SHA.

8.2 The requirement for SHAs to establish independent review procedures is laid down in the NHS Continuing Healthcare (Responsibilities) Directions 2009. The procedures are in place so that individual patients and/or their nominated representatives can challenge a PCT's decision about their eligibility for NHS Continuing Healthcare.

8.3 The independent review procedure can only be used where the individual is dissatisfied with:

a) The procedure followed by the Primary Care Trust or NHS Trust, in reaching a decision about their eligibility; or

b) The 'primary health need' decision by a Primary Care Trust or NHS Trust.

8.4 SHAs all adhere to a national Independent Review Process[7] which contains much more detail about the procedure followed when a request for IRP is received, including the remit of the IRP.

8.5 The IRP will make a recommendation to the SHA. The IRP will provide a detailed report of its recommendation which is sent to the applicant by the SHA with the decision letter. If the SHA accepts the IRP's recommendation that the decision of the PCT was wrong, the SHA will recommend to the PCT that they make a restitution payment, for any care fees paid by the applicant, that should have been funded by the PCT.

8.6 Should the IRP recommend to uphold the decision of the PCT and the applicant remains dissatisfied, the applicant can make a complaint to the Parliamentary and Health Service Ombudsman. The decision letter will contain details of how to do this.

[7] Operational Policy for Independent Review Panels – November 2009