Continuing Healthcare Operating Procedure

1st April 2019

The current versions of all policies can be accessed at:

Information for Health and Social Care Staff

Contents

Section One – Eligibility.....3
1. Introduction.....4
2. Purpose.....4
3. Key used in this operating procedure:.....5
4. Key Legislation & Responsibilities.....5
5. Core Values & Principles.....6
6. Continuing Healthcare.....7
7. Transitions Cases.....9
8. Primary Health Need.....10
9. CHC Process.....14
10. Consent.....16
11. Mental Capacity.....16
12. Best Interest Decisions.....17
13. DoLs.....17
14. IMCA.....17
15. Advocate.....17
16. Fast track.....18
17. Checklist.....20
18. Decision Support Tool (DST).....24
19. Ratification.....34
20. Disagreements.....38
21. Sheffield Dispute Resolution Policy for NHS Continuing Healthcare & NHS Funded Nursing Care (Revised October 2018).....39
22. Interim Care/Funding Arrangements/Refunds - Annex E.....39
23. Case/Care management.....40
24. Quality Assurance and Audit.....40
25. Glossary.....42

Section Two: Discharge to assess.....44

Section Three: Resource Allocation.....45

Section One – Eligibility

1. Introduction

2. Primary Health Need

3. Fast Track

4. Checklist

5. Decision Support Tool

6. Ratification

7. Disputes

1. Introduction

These jointly agreed operating procedures stipulate how NHS Continuing Healthcare services will be delivered throughout Sheffield. The service will be delivered by Sheffield Clinical Commissioning Group and Sheffield City Council in line with National Framework for NHS Continuing Healthcare.

The 'National Framework for NHS Continuing Healthcare (CHC) and Funded Nurse Care (FNC)' October 2018 (revised) sets out the principles and processes for its implementation and provides a set of national tools to be used to support the assessment of applications for CHC and for Fast Track cases. The operating procedure describes the processes and local policies that Sheffield CCG and Sheffield City Council will adopt in the delivery of working practices with regard to assessment and care management process.

The revised 2018 Framework and associated documentation replace all previous versions and will be implemented on 1st October 2018.

There have been no specific policy changes, the revised framework provides further clarification on the CHC process for individuals and staff and reflects legislative changes since the 2012 Framework was published, primarily the implementation of the Care Act 2014.

Importantly, none of the 2018 amendments and clarifications to the National Framework, Practice Guidance, annexes or National Tools are intended to change the eligibility criteria for NHS Continuing Healthcare.

Below link to all associated documents from the Department of Health:

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

The operating procedure does not apply to Children, for 18 years and under please refer to Section 7 Transitions.

2. Purpose

This procedure has been written to support Continuing Healthcare (CHC) practices in Sheffield for Health & Social Care Staff who are implementing the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care'*. October 2018 (Revised)

The primary purpose of the National Framework is to support practitioners across health and social care to undertake assessments and deliver NHS Continuing Healthcare and NHS-funded Nursing Care. **(NF12)**
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf

The 'CHC Operating Procedure' operationalises the high level process – available here.

IMPORTANT NOTICE

All those involved in the delivery of NHS Continuing Healthcare should become familiar with the whole National Framework, Practice Guidance, Annexes and National Tools and should align their practice accordingly. (NFpg3)

3. Key used in this operating procedure:

NF	CHC National Framework
PG	CHC Practice Guidance
AX	Annexes
NT	National Tools
FT	FastTrack
CL	Checklist
DST	Decision Support Tool
pg	Page
CCFW	National Framework for Children & Young People's Continuing Care

4. Key Legislation & Responsibilities

NHS England, CCGs and Local Authorities must comply with their statutory responsibilities, as set out in the Standing Rules and Care Act legislation, as appropriate, in relation to NHS Continuing Healthcare. **(NF13)**

Sheffield Clinical Commissioning Group (SCCG)

Further information on the Roles & Responsibilities of CCG's NF21

Where individuals receive care, treatment or support from the NHS this is normally under the provisions of the National Health Service Act 2006, referred to from this point onwards as the NHS Act. This support is provided free at the point of delivery to the individual. (**NF35)**

Standing Rules Regulations issued under the National Health Service Act 2006 require CCG's to have regard to the National Framework. **(NF6)**

SCCG is required to discharge its functions in relation to NHS Continuing Healthcare in accordance with relevant standing rules and guidance, including the National Framework.

SCCG cannot delegate its final decision-making function in relation to eligibility decisions, and remains legally responsible for **all** eligibility decisions made.

However, it is the expectation of SCCG & SCC, that the CHC eligibility process is led by the MDT and that SCCG will have due regard for the professionals involved in DST and

the recommendations being made.

Sheffield City Council - (SCC)

Further information on the Roles & Responsibilities of LA's NF25–30

Where adults receive care and support from local authorities they normally do so under the provisions of the Care Act 2014, subject to them meeting national eligibility criteria for care and support and usually subject to means testing, which may require them to make a financial contribution towards the cost or to meet the full cost themselves. **(NF34)**

The Care Act 2014 preserves the boundary and limits of the Local Authority in relation to the provision of nursing and/or healthcare. (**NF7**)

The Care Act 2014 – needs arising from (or relating to) a physical or mental impairment or illness which result in being unable to achieve two or more of the following outcomes which are or are likely to have a 'significant impact' on their 'wellbeing':

http://www.legislation.gov.uk/uksi/2015/313/pdfs/uksi_20150313_en.pdf

NHS England

Further information on the Roles & Responsibilities of NHSE NF22-24NHS England functions include providing strategic leadership and organisational and workforce development and ensuring that local systems operate effectively and deliver improved performance. NHS England holds CCG's accountable and therefore engages with them to ensure that they discharge their functions. NHSE are also responsible for appointing individual's to act as Chairs of the Independent Review Panels. (IRP's)

5. Core Values & Principles

(NF67-71) (PG4)

"Individuals being assessed for NHS Continuing Healthcare are frequently facing significant changes in their life and therefore a positive experience of the assessment process is crucial. The process of assessment of eligibility and decision-making should be person-centred. This means placing the individual at the heart of the assessment and care-planning process".

- Person Centred Process
- Empathy
- No Discrimination
- Rights of the individual
- Fair and consistent
- Transparent decisions and rationales
- Rights of the individual
- Due consideration to PHN and CHC Eligibility
- Collaborative

- Partnership
- Professional Respect

SCCG and SCC are committed to working to an agreed core set of CHC values and behaviours. We will work with the staff to ensure that these core values and principals are embedded into CHC across CCG and SCC.

6. Continuing Healthcare

What is NHS Continuing Healthcare?

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a 'primary health need'.

Such care is provided to adults 18 years or older who are registered with a Sheffield General Practice or who are resident within the area covered by NHS Sheffield's Continuing Healthcare Service and are not registered with a General practitioner elsewhere.

This includes all care groups:

- Physically Disabled
- Older People
- Learning Disabilities
- People with an organic mental health condition
- Young people in transition

Eligibility for NHS Continuing Healthcare is not determined by the setting in which the package of support can be offered or by the type of service delivery. **(NFpg7)**
An individual has a primary health need if, having taken account of all their needs (following completion of the Decision Support Tool), it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs. Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality.

Continuing Healthcare Video – NHS England

https://www.youtube.com/watch?v=9xE2oGVRqvY

chc-prcss-prompt-card.pdf

Key Points:

- Care for adults aged 18 or over, arranged and funded solely by NHS (free at the point of delivery)
- Nationally very few people are eligible for NHS CHC
- Only those assessed as having a 'primary health need' are eligible for NHS Fully Funded CHC.
- A primary health need depends on the type and level of their care needs and is **not** dependent on diagnosis or disability.

Both Sheffield CCG and Sheffield City Council have a responsibility to ensure that the assessment of eligibility for continuing care and its provision, takes place in a timely and consistent manner.
Each individual case has to be considered on its own facts in accordance with the principles outlined in this National Framework. (**NF56**)

What does the individual need to know?

The individual being assessed and their representative understand the process and receive advice and information that will maximise their ability to participate in the process in an informed way. Decisions and rationales that relate to eligibility should be transparent from the outset. (**NF70**)

At the start of the CHC Process staff should ensure that the individual and/or their representatives are provided with a copy of the DH Pubic Information Leaflet.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770684/National_framework_for_CHC_and_FNC_-_public_information_leaflet.pdf

An 'Easy Read' version is also available.

At the SCCG and SCC we are committed to continually improving the quality of the information *provided*, to enable individuals and representatives to have a greater understanding of the CHC process.

7. Transitions Cases

The National Framework should be used to determine what ongoing care services individuals aged 18 years or over should receive from the NHS.

Legislation and the respective responsibilities of the NHS, social care and other services for are different in child and adult services. For children and young people, from birth to their 18th birthday, needs are assessed against the children's national framework. **(NF331-349)**

Thereafter, the *National Framework for NHS Continuing Healthcare ad NHS-funded Nursing Care'*. October 2018 (Revised), supporting guidance and tools should be used.

Note: The 28 calendar day timescale between checklist and decision does not apply to young people in transition to adult services **(NF342).**

The National Framework for Children and Young People's Continuing care 2016 (DoH)

A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services. **(CCFWpg5)**

There are significant differences between children and young people's continuing care and NHS Continuing Healthcare for adults. Although a child or young person may be in receipt of a package of continuing care, they may not be eligible for NHS Continuing Healthcare or NHS funded Nursing Care once they turn 18.

Transition sets out the process for assessing a young person who will be assessed under the Adults Framework. Future entitlement to adult Continuing Healthcare should be clarified as early as possible in the transition planning process, especially if the young person's needs are likely to remain at a similar level until adulthood. **(CCFW2016 111-128)**

At 14 years of age:

Children's services should identify those young people for whom it is likely that adult NHS Continuing Healthcare 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. **(NF339)**

At 16-17 years of age:

This should be followed up by a 'formal referral' for screening to the adult NHS Continuing Healthcare team at the relevant CCG, when the child or young person is 16. (**NF 340)**

As soon as practicable after the young person's 17th birthday, eligibility for adult NHS Continuing Healthcare should be determined 'in principle' by the relevant CCG, so that, wherever applicable, effective packages of care can be commissioned in time for the

individual's 18th birthday. In order to do this staff from adult services (who are familiar with the adult NHS Continuing Healthcare National Framework) will need to be involved in both the assessment and care planning to ensure smooth transition to adult services. If needs are likely to change, it may be appropriate to make a provisional decision, and then to recheck it by repeating the process as adulthood approaches. (**NF 341)**

At 18 years of age:

Full transition to adult NHS Continuing Healthcare or to universal and specialist health services should have been made, except in instances where this is not appropriate. **(CCFW117)**

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499611/children_s_continuing_care_Fe_16.pdf

8. Primary Health Need

See further information **NF 55-66**

What is a Primary Health Need?

Primary health need' is a concept developed by the Secretary of State to assist in deciding when the NHS is responsible for meeting a person's assessed health and social care needs. (NHS duty to provide under the 2006 Act). To determine whether an individual has a primary health need, there is an assessment of eligibility process that must be undertaken by a multidisciplinary team (MDT), which must use the national Decision Support Tool (DST) to look at the "**totality**" or the overall picture of a person's needs in deciding whether a person has a primary health need. **(NFpg7)**

An individual has a primary health need, if having taken account of all their needs, it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs. Having a primary health need is not about the reason why an individual requires care or support, nor is it about their **diagnosis**; it is about the level and type of their overall actual day-to-day care needs taken in their totality.

Therefore the 'primary health need' test should be applied so that a decision about 'ineligibility' for NHS Continuing Healthcare is only possible where, taken as a whole, the nursing or other health services required by the individual:

a) are no more than **incidental** or **ancillary** to the provision of accommodation which local authority social services are, or would be but for a person's means, under a duty to provide;

AND

b) are not of a nature beyond which a local authority whose primary responsibility it is to provide social services could be expected to provide.
(**NF58**)

In applying the primary health need test, as set out above SCCG should take into account that section 22(1) of the Care Act 2014, sets out the **limits of Local Authorities** and this includes care being provided in a person's own home or in a care home.

Certain characteristics of need and their impact on the care required to manage them, may help determine whether the **quality** or **quantity** of care required is more than the limits of a Local Authorities responsibility.

The multidisciplinary team (MDT) works together to collate and review the relevant information on the individual's health and social care needs. The MDT uses this information to help clarify individual needs through the completion of the Decision Support Tool (DST), and then works collectively to make a professional judgement about eligibility for NHS Continuing Healthcare, which will be reflected in its recommendation. This process is known as a multidisciplinary assessment of eligibility for NHS Continuing Healthcare. (NFpg39-P123)

In all cases, the DST domain 'levels' are just one aspect for the multi-disciplinary team to consider and to evidence the overall picture, the MDT need to consider the **four key characteristics** of Nature, Intensity, Complexity and Unpredictability of the individual's needs. (**NFp41-P137**)

Nature:
This describes the particular characteristics of an individual's needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.

Intensity:
This describes the particular characteristics of an individual's needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them - the quantity and severity of care.

Complexity:
This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.

Unpredictability:

This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. An individual with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual's needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered when completing the DST (refer to paragraphs 131-141).

Well Managed Needs:

The decision-making rationale should not marginalise a need just because it is successfully managed; well-managed needs are still **needs (NF142-146).** Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on NHS Continuing Healthcare eligibility.

"well managed needs are still needs… an example of this might occur in the context of behaviour domain where an individual's support plan includes support/interventions to manage challenging behaviour, which is successful in that there are no recorded incidents which may indicate a risk to themselves, others or property. In this situation, the individual may have needs that are well managed and if so, these should be recorded and taken into account in the eligibility decision". **(NF143)**

"In applying the principle of well-managed need, consideration should be given to the fact that care-providers may not routinely produced detailed recording of the extent to which a need is managed. It may be necessary to ask the provider to complete a detailed 24/48 hour diary to demonstrate the nature and frequency of the needs and interventions and their effectiveness". **(NF144)**

MDT's are required to make a 'recommendation' as to whether the individual has a primary health need, and is therefore eligible for NHS Continuing Healthcare. The MDT recommendation should take into account the range and levels of needs, consideration of the four key characteristics and how these characteristics in combination or alone, demonstrate a primary health need based on the quality and/or quantity of care required to meet the individual's needs. **(NF pg44, pg147)**

Primary Health Need Recommendation:
(DSTpg8)

At the end of the DST, there is a summary sheet to provide an overview of the levels chosen and a summary of the individual's needs, along with the MDT's recommendation about eligibility or ineligibility. A clear recommendation (and decision) of eligibility for NHS Continuing Healthcare would be expected in each of the following cases:

A level of **priority** needs in any one of the four domains that carry this level.
A total of two or more incidences of identified **severe** needs across all care domains.

Where there is either

A severe level need combined with needs in a number of other domains or
A number of domains with high and/or moderate needs

This may also, depending on the combination of needs, indicate a primary health need and therefore careful consideration needs to be given to the eligibility decision and clear reasons recorded if the decision is that the person does not have a primary health need.

In all cases, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments should be taken into account in determining whether a recommendation of eligibility for NHS Continuing Healthcare should be made. It is not possible to equate a number of incidences of one level with a number of incidences of another level, as in, for example 'two moderates equals one high'. The judgement whether an individual has a primary health need must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of the individual's needs.

The recommendation should:

provide a summary of the individual's needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs.

provide statements about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these characteristics provided in paragraphs (refer to paragraphs 58-66 of the National Framework) of the National Framework.

give an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability.

in the light of the above, give a recommendation as to whether or not the individual has a primary health need (with reference to paragraphs (refer to paragraphs 58-66 of the National Framework) of the National Framework). It should be remembered that, whilst the recommendation should make reference to all four characteristics of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

What does the individual need to know?

A person only becomes eligible for NHS continuing healthcare once a decision on eligibility has been made by the CCG, informed by a completed Decision Support Tool or Fast Track Pathway Tool.
A DST is completed by an MDT comprising of; one professional who is from a healthcare profession (SCCG) and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014 (SCC).

Eligibility for NHS Continuing Healthcare is not indefinite, as needs could change.

Key Points:

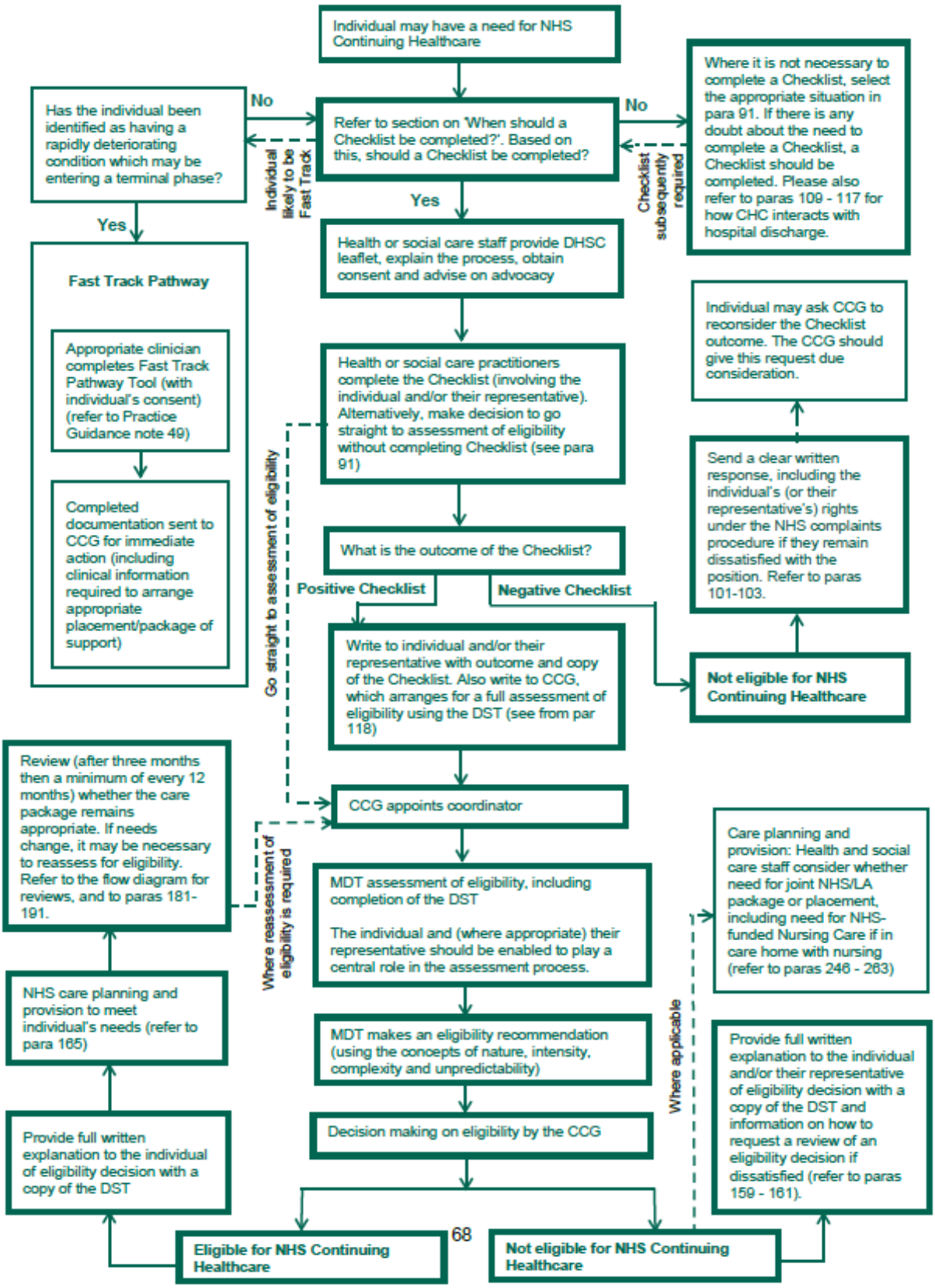
- Only those individuals assessed as having a ‘primary health need’ are eligible for NHS Fully Funded CHC.

- There should be no gap in the provision of care. Therefore organisations should work together to ensure funding is not ceased or cancelled depending on changes in eligibility.

- Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, will this have a bearing on NHS Continuing Healthcare eligibility.

  Both Sheffield CCG and Sheffield City Council have a responsibility to ensure that the assessment of eligibility for continuing care and its provision, takes place in a timely and consistent manner.

9. CHC Process


Individual may have a need for NHS Continuing Healthcare
Has the individual been identified as having a rapidly deteriorating condition which may be entering a terminal phase?
No
Yes
Individual likely to be Fast Track
Refer to section on 'When should a Checklist be completed?'. Based on this, should a Checklist be completed?
No
Yes
Checklist subsequently required
Where it is not necessary to complete a Checklist, select the appropriate situation in para 91. If there is any doubt about the need to complete a Checklist, a Checklist should be completed. Please also refer to paras 109 - 117 for how CHC interacts with hospital discharge.
Fast Track Pathway
Appropriate clinician completes Fast Track Pathway Tool (with individual's consent) (refer to Practice Guidance note 49)
Completed documentation sent to CCG for immediate action (including clinical information required to arrange appropriate placement/package of support)
Health or social care staff provide DHSC leaflet, explain the process, obtain consent and advise on advocacy
Health or social care practitioners complete the Checklist (involving the individual and/or their representative). Alternatively, make decision to go straight to assessment of eligibility without completing Checklist (see para 91)
Go straight to assessment of eligibility
What is the outcome of the Checklist?
Positive Checklist
Negative Checklist
Write to individual and/or their representative with outcome and copy of the Checklist. Also write to CCG, which arranges for a full assessment of eligibility using the DST (see from par 118)
Not eligible for NHS Continuing Healthcare
Individual may ask CCG to reconsider the Checklist outcome. The CCG should give this request due consideration.
Send a clear written response, including the individual's (or their representative's) rights under the NHS complaints procedure if they remain dissatisfied with the position. Refer to paras 101-103.
CCG appoints coordinator
MDT assessment of eligibility, including completion of the DST
The individual and (where appropriate) their representative should be enabled to play a central role in the assessment process.
Where reassessment of eligibility is required
Review (after three months then a minimum of every 12 months) whether the care package remains appropriate. If needs change, it may be necessary to reassess for eligibility. Refer to the flow diagram for reviews, and to paras 181-191.
NHS care planning and provision to meet individual's needs (refer to para 165)
Provide full written explanation to the individual of eligibility decision with a copy of the DST
MDT makes an eligibility recommendation (using the concepts of nature, intensity, complexity and unpredictability)
Decision making on eligibility by the CCG
Where applicable
Care planning and provision: Health and social care staff consider whether need for joint NHS/LA package or placement, including need for NHS-funded Nursing Care if in care home with nursing (refer to paras 246 - 263)
Provide full written explanation to the individual and/or their representative of eligibility decision with a copy of the DST and information on how to request a review of an eligibility decision if dissatisfied (refer to paras 159 - 161).
Eligible for NHS Continuing Healthcare
Not eligible for NHS Continuing Healthcare
68

10. Consent

See further info See further information **NF72-73 and PG5&6.**

Referrals cannot be processed without the individuals consent.

Where the individual concerned has capacity, their informed consent should be obtained before the start of the process to determine eligibility for NHS Continuing Healthcare. This consent will need to encompass permission to undertake the NHS Continuing Healthcare assessment process and also to the 'sharing and processing of data' (i.e. sharing relevant personal information between professionals in order to undertake the eligibility assessment for NHS Continuing Healthcare and, where appropriate, for audit and monitoring of decisions).

Key principles: Explicit, Specific, Informed, Freely Given, Can be withdrawn.

If an individual with capacity does not consent to being assessed for NHS Continuing Healthcare or to sharing information which is essential for carrying out this assessment, the potential consequences of this should be carefully explained. This might affect the ability of the NHS and the local authority to provide appropriate services to them. The fact that an individual declines to be assessed for NHS Continuing Healthcare does not, in itself, mean that a local authority has an additional responsibility to meet their needs, over and above the responsibility it would have had if they had been assessed for NHS Continuing Healthcare.

11. Mental Capacity

See further information **NF74-76 and PG6, 7&8**

If there is a concern that the individual may not have capacity to give consent to the assessment process or the sharing of information, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice12. CCGs should be particularly aware of the five principles of the Act:

http://www.legislation.gov.uk/ukpga/2005/9/contents

A person must be assumed to have capacity unless it is established that he lacks capacity.

- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved

12. Best Interest Decisions

See further information **NF77-81 and PG7**

If the person lacks the mental capacity to either give or refuse consent to the assessment process or the sharing of information, a decision must be made in the person's 'best interests' as to whether to proceed with the assessment and sharing of information. The best interests decision should be recorded. The person leading the assessment is responsible for making this decision and should bear in mind the expectation that everyone who is potentially eligible for NHS Continuing Healthcare should have the opportunity to be considered for eligibility. A third party cannot give or refuse consent for an assessment of eligibility for NHS Continuing Healthcare, or for sharing information, on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (Health and Welfare)15 or they have been appointed as a Deputy (Health and Welfare) by the Court of Protection.

13. DoLs

The Mental Capacity Act 2005 contains provisions that apply to a person who lacks capacity and who, in their own best interests, needs to be deprived of their liberty in a care home or a hospital, in order for them to receive the necessary care or treatment. The fact that a person needs to be deprived of his/her liberty in these circumstances does not affect the consideration of whether that person is eligible for NHS Continuing Healthcare.

14. IMCA

An IMCA does not routinely need to be appointed in the context of an NHS Continuing Healthcare assessment. However, NHS bodies and LA's have a duty under the MCA 2005 to instruct and consult an IMCA if an individual lacks capacity in relation to, serious medical treatment or a change of accommodation for a certain period, in a hospital or care home and has no family/representatives available or appropriate to consult on their behalf.

15. Advocate

Individuals involved in Checklists, DSTs or Independent Review Panels are entitled to nominate a representative or advocate to support them to fully participate in the process. This could be a family member, friend or someone independent who has an advocacy role. Individuals do not need to have legal representation through the eligibility process but on occasion an individual may choose to have a legally qualified person to act as their advocate.

Advocates represent the views and/or speak on behalf of the individual and should be given access to relevant documentation with the individual's consent (or if it is in the person's best interests if they lack capacity to consent). Advocates are not assessors or decision makers however representing the person's views and wishes may include raising questions or providing information relevant to the MDT's decisions on domain weightings and identifying a primary health need. Advocates' representations should be considered in the same way as those of the individual being assessed.

The framework's Core Values and Principles 4.3 states: "The provision of advocacy, where appropriate, is an important means of achieving meaningful participation... All reasonable efforts should be made to involve the individual and/or their representative in the assessment process."

It is the responsibility of the NHS CHC Coordinator to instruct an advocate if the person requests one or if it is in the person's best interests if they lack capacity to do so. Sheffield Advocacy Hub – referrals@sheffieldadvocacyhub.org.uk 0800 035 0396

SCCG are committed to ongoing improvement to strengthen the process and working practices relating to advocacy services with the aim of improving the service experience

16. Fast track

This tool should be used in conjunction with **NF 216-245**.

The Fast Track Pathway Tool for NHS Continuing Healthcare October 2018 (Revised) should be used when an individual has been identified as having a *"rapidly deteriorating condition, which may be entering a terminal phase".*

NHS continuing healthcare fast-track pathway tool - GOV.UK

The intention of the Fast Track Pathway is that it should identify individuals who need access to NHS Continuing Healthcare quickly, with minimum delay and with no requirement to complete a Checklist (CL) or the Decision Support Tool (DST).

A completed Fast Track Tool that evidences that an individual is "**rapidly deteriorating"** and **"entering a terminal phase" is in itself 'sufficient'** to establish eligibility.

In Fast Track cases, Standing Rules state that it is the 'appropriate clinician' who determines that the individual has a primary health need.
The 'appropriate clinician' will be a person who is knowledgeable about the individual's health needs and responsible for the diagnosis, treatment or care for the individual **and** is a registered nurse or medical practitioner.

SCCG will require a completed care plan to be provided with the Fast Track Tool, which describes the immediate needs and preferences, in order to commission the appropriate care.

Whilst SCC will not be involved in a Fast Track, the clinicians involved in completing the tool should make the individual aware that their needs may be subject to review and accordingly the eligibility may change, subject to the outcome of the review. This could have an impact on ongoing care provision and charging for care under the Care Act.

When should a Fast Track be considered?

If a health or social care practitioner identifies an individual as having a *"rapidly deteriorating condition, which may be entering a terminal phase".*

Even if an individual is already receiving a social care or joint funded package of support. This is important, as the individual or SCC may be funding their care and the NHS may be responsible to fund their care in full if a Fast Track is approved.
It is important to bear in mind that this is not the only way that an individual can qualify for NHS Continuing Healthcare towards the end of their life. The DST asks practitioners to document deterioration (including observed and likely deterioration) in an individual's condition, so that they can take this into account in determining eligibility using the DST. However, this should not be used as a means of circumventing use of the Fast Track Pathway Tool when individuals satisfy the criteria for its use.

Note: A DST should not be used to circumvent the use of the Fast Track Pathway Tool.

What does the individual need to know?

- The Fast Track Pathway Tool should only be used in those situations that it was intended.

- Fast Track does not imply 'permanent' NHS funding and sensitivity is required by the clinician to explain this to the individual and careful decision making is essential to mitigate undue distress that may result from changes in eligibility within a short period of time. The referrer should also document that they have had the appropriate discussion with the individual in relation to the terminal phase of their illness.

- No individual identified as eligible via Fast Track should have this funding removed without their eligibility being reconsidered through the completion of a DST by an MDT. **(NF244)**

Key Points:

- SCCG will monitor care packages to consider when and whether a reassessment of eligibility is appropriate. Where it is apparent that the individual is nearing the end of their life and the original eligibility decision was appropriate it is unlikely that a review of eligibility will be necessary. (If an individual continues to be in receipt of end of life service after 6 months the CCG will undertake a DST)

- A Fast Track Tool can be completed in any setting (e.g. own home, care home, hospice)

- A review of an individual's care needs and the effectiveness of the care arrangements, in certain situations needs may indicate that it is appropriate to review eligibility for NHS Continuing Healthcare

- CCG's are responsible for commissioning, funding and case/care management in full.

- The MDT will ensure that the individual and their representatives being assessed are fully engaged and understand the process, and receive advice and information that will maximise their ability to participate in the process in an informed way.

TIMESCALE

Process	Sheffield CCG has a responsibility to respond within the following timeframes	Timescale
Fast Track	Fast-track application received and decision ratified / commission support.	Same Day: The recommendation of appropriate clinician should automatically be accepted and commissioned support should not exceed 48 hours. (in some cases referrals have to be returned for more information to support the FT Tool) Applications received after 2pm on Friday will be processed on Monday.

17. Checklist

This tool should be used in conjunction with **NF82-107 & PG11**

The NHS Continuing Healthcare Checklist Tool October 2018 (Revised) should be used to help practitioners identify individuals who may need a referral for a full assessment of whether their healthcare needs **may qualify** for NHS Continuing healthcare funding. All

staff who complete the Checklist should be familiar with the principles of the National Framework and associated tools.

NHS continuing healthcare checklist - GOV.UK

Note: The Checklist is the only screening tool that can be used.

The Care Act 2014 states that "where it appears that a person may be eligible for NHS Continuing healthcare, local authorities must notify the relevant clinical commissioning group". Social care assessors should consider completing a checklist when they complete a 'conversation' with an individual following seeking appropriate consent.

The completion of a checklist is intended to be a relatively quick process. It is not necessary to provide additional 'detailed' evidence alongside the checklist **(CL13)** Assessors/Practitioners should compare the domain descriptors to the needs of the individual and select the level (A, B, C), domains that most accurately reflect the person's presenting needs. If the needs of the individual are the same or greater than the 'A' descriptor, then 'A' should be selected. Practitioners are required to give a brief summary of the individuals needs to support the chosen level, ensuring that they record any references to supporting evidence.

The assessor must complete the MCA forms, the equal opportunity questions.

A full assessment for NHS Continuing Healthcare would be expected where the checklist tool indicates:

a) Two or more domains selected in column A;

b) Five or more domains selected in column B, **or**

c) One domain selected in A and four in B; **or**

d) One domain selected in column A, which has an asterisked* domain, with any number of selections in the other two columns.

The principle in relation to 'well-managed need' apply equally to the completion of the Checklist as they do the Decision Support Tool.

Once completed the checklist needs to be sent to SCCG to progress.

There are two potential outcomes following the completion of the Checklist:

- A **Negative** Checklist, meaning the individual doesn't require a full assessment of eligibility, and they are not eligible for NHS Continuing Healthcare; or
- A **Positive** Checklist, meaning an individual now requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean the individual is eligible for NHS Continuing Healthcare. **(NF87)**

If an individual has been screened out following completion of the Checklist, they may ask the CCG to reconsider the Checklist outcome. The CCG should give this request due consideration, taking account of all the information available, and/or including additional information from the individual or carer, though there is no obligation for the CCG to undertake a further Checklist

Where the Checklist is positive, SCCG will allocate a CHC Nurse Coordinator to arrange an MDT for completion of a DST.

However, there may very occasionally be **exceptional circumstances** where a full assessment of eligibility is appropriate even though the individual does not apparently meet the indicated threshold. **(NF85)**

Following a positive Checklist, an individual should not be left without appropriate support while they await the outcome of the assessment and decision making process. Prior to that decision being made, any existing arrangements for support/funding of care should continue, unless there is an **'urgent**' need for adjustment. In considering such adjustments SCCG & SCC should have regard to the limitations of their statutory powers. **(NF105)**

Annex E will be used to ensure refunds when a decision on eligibility has been ratified. **(NFpg159-163)**

It is important that all completed checklists, both **negative** and **positive** are sent to SCCG to ensure that due consideration has been demonstrated and the outcome must be communicated clearly and in writing to the individual or their representative and a copy of the completed checklist provided.

When should a Checklist not be completed?

The situations where it is not necessary to complete the Checklist include: **(CLpg7) (NF91)**

- It is clear to practitioners working in the health and care system that there is no need for NHS Continuing Healthcare at this point in time. Where appropriate/relevant this decision and its reasons should be recorded. If there is doubt between practitioners the Checklist should be undertaken.
- The individual has short-term health care needs or is recovering from a temporary condition and has not yet reached their optimum potential (although if there is doubt between practitioners about the short-term nature of the needs it may be necessary to complete the Checklist).
- It has been agreed by the CCG that the individual should be referred directly for full assessment of eligibility for NHS Continuing Healthcare.

- The individual has a rapidly deteriorating condition and may be entering a terminal phase – in these situations the Fast Track Pathway Tool should be used instead of the Checklist.
- An individual is receiving services under Section 117 of the Mental Health Act that are meeting all of their assessed needs.
- It has previously been decided that the individual is not eligible for NHS Continuing Healthcare and it is clear that there has been no change in needs.
- Sheffield Hospital discharges via the Discharge to Assess Procedure (further information can be found in Part 3 of this guidance)

Note: If upon review of these statements, it is deemed that it is not necessary to screen for NHS Continuing Healthcare at this time, the decision not to complete the Checklist and its reasons should be clearly recorded in the individual's notes.

What does the individual need to know?

- Screening and assessment of eligibility for NHS Continuing Healthcare should be at the right time and location for the individual and when the individual's ongoing needs are known. This may be in a variety of settings, although the full assessment of eligibility should normally take place when the individual is in a community setting, preferably their own home. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and ongoing needs. This will help practitioners to correctly identify individuals who require a full assessment of eligibility for NHS Continuing Healthcare.

- The checklist threshold is intentionally set low to ensure that all those who require a full assessment of eligibility, have this opportunity.

- A positive checklist does not indicate that an individual will be found eligible for NHS Continuing Healthcare.

- A copy of the completed checklist will be provided to the individual and/or representative when the outcome is confirmed.

Key Points:

- Checklist is a nationally prescribed tool to determine **IF** an individual needs a full assessment for NHS Continuing Healthcare.

- The Checklist can be completed by a variety of health and social care practitioners, having received the appropriate training

- Weightings or Levels NOT Scores

- Threshold is set “intentionally” low to ensure that all those who require a full assessment of eligibility for NHC Continuing Healthcare have this to **maximise opportunity**

- If an individual has been screened out following completion of the Checklist, they may ask the CCG to reconsider the Checklist outcome. The CCG should give this request due consideration, taking account all of the information available, and/or including additional information from the individual or carer, though there is no obligation for the CCG to undertake a further Checklist.

  The CCG may refer the individual back to the original referrer.

- The referrer will ensure that the individual and their representatives being assessed are fully engaged and understand the process, and receive advice and information that will maximise their ability to participate in the process in an informed way, using the NHS England leaflet.

Timescale

Process	Sheffield CCG has a responsibility to respond to referrals within the following timeframes	Timescale
Checklist	Checklist decision – positive or negative outcome	2 working days

18. Decision Support Tool (DST)

This tool should be used in conjunction with **NF118-152** and decision making on eligibility **NF153-164**.

Following the referral for a full assessment of eligibility, an MDT needs to be convened to assess whether the individual has a primary health, using the Decision Support Tool (more commonly known as the DST).

The multidisciplinary team (MDT) works together to collate and review the relevant information on the individual’s health and social care needs. The MDT uses this information to help clarify individual needs through the completion of the Decision Support Tool (DST), and then works collectively to make a professional judgement about eligibility for NHS Continuing Healthcare, which will be reflected in its recommendation. This process is known as a multidisciplinary assessment of eligibility for NHS Continuing Healthcare. **(NF39-123)**

The NHS Continuing Healthcare Decision Support Tool October 2018 (Revised) should be used as a way of bringing together information from the assessment of needs and applying evidence in a single practical format to facilitate consistent evidence-based recommendations and decision making regarding eligibility for NHS Continuing Healthcare (CHC).

https://www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool

The DST has been developed to aid consistent decision making. The DST supports practitioners in identifying the individual's needs. This combined with the practitioners'' skills, knowledge and professional judgement, should enable them to apply the primary health need test in practice. **(NF 40-131)**

The DST is not an assessment of needs in itself. Rather, it is a way of bringing together and applying evidence in a single practical format, to facilitate consistent, evidence-based assessment regarding recommendations for NHS Continuing Healthcare eligibility. The evidence and rationale for the recommendation should be accurately and fully recorded. **(NF 40-132)**

SCCG and SCC agree in principle that their MDT's will comprise of one professional who is from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014. **(NFpg38)(PG pg114)(DST pg4)** and only in exceptional circumstances and for clearly articulated reasons would a DST be completed without a social care practitioner in attendance.

It is expected that the MDT should usually include practitioners who are knowledgeable about the individual's health and social care needs and where possible have recently been involved in the assessment, treatment or care of the individual. Standing Rules require that, as reasonably practicable, the SCCG must consult with the SCC before making any decision about eligibility. **(NF121)**

The health or social care professional responsible for completing the initial Checklist given their knowledge of the individual should be a representative of the MDT. When social workers are planning to complete Checklists there is a need to take into account their holidays as typically the DST will be scheduled within 14 calendar days of the Checklist being processed taking into account the 28 day process.

The CCG will appoint a co-ordinator who will email details of the DST meeting to the SCC Business Support team at the relevant work site, who will then schedule a social care practitioner to attend the DST. The individual should be given every opportunity to participate in the meeting, with support where necessary, and their views and preferences should be documented at every stage. The MDT in relation to NHS CHC have a specific role and purpose. The social care practitioner will be expected to fully participate in the MDT utilising relevant social care assessments i.e. support plan, social care assessment. At the conclusion of the DST the MDT will work collectively to make a recommendation about eligibility for CHC funding.

The reasons given for a decision on eligibility should not be based on the:

- the person's diagnosis;
- the input currently being provided rather than the care needs;
- the setting of the care;
- the ability of the care provider to manage care;
- the use (or not) of NHS-employed staff to provide care;
- the need for/presence of 'specialist staff' in care delivery;
- the existence of other NHS-funded care; or
- any other input-related (rather than needs-related) rationale.

The rationale for the CHC eligibility decision should also include consideration of the **four key characteristics** of the nature, intensity, complexity, and unpredictability (either alone or in combination) of the individual's needs and whether they are more than merely **incidental** and **ancillary** to needs which could be met by the local authority under the Care Act 2014.

It is important that the individual's own view of their needs, including any supporting evidence, is given appropriate weight alongside professional views. Many people will find it easier to explain their needs and preferred outcomes if the assessment is carried out as a 'conversation', dealing with key issues as the discussion naturally progresses, rather than using the DST tool in a linear fashion. **(NF125)**

Where a Care Act 2014 assessment has already been carried out and is still relevant to the current needs, it is expected that SCC shall provide advice and assistance to SCCG over individual cases **as far as reasonably practicable**. Once a case has been brought to the attention of SCC, in addition to giving advice, providing relevant social care assessments, and assistance it should, having regard to the facts of the case, also consider whether a Care Act assessment is required.

SCC is responsible for having systems that respond promptly to requests for information when SCCG has received a referral for CHC, which will include undertaking assessments and jointly completing the DST, including where the individual is a self-funder.

Completing the DST:

The DST is designed to ensure that a full range of factors that have a bearing on eligibility are taken into account. The tool comprises of '12' care domains or generic areas of need. Each domain is broken down into a number of levels and the level represent a hierarchy from low to high needs and there are sets of statements reflecting different levels of need that are then attached to a scoring system, from 'no-needs' up to 'severe' and 'priority' in some domains. (Further details about the 12 care domains (**DST6)(DST pages15-39)(NF136)**

At the DST meeting the MDT (coordinator/assessors) will go through each domain and discuss the individual needs relating to each, with the person and the representatives, this may also include the care & support provider.

The DST domains are distinct from the Care Act 2014 assessment domains. The Care and Support (Eligibility Criteria) Regulations 2015 clearly demonstrates the difference between welfare/social care and health needs.

https://www.legislation.gov.uk/uksi/2015/313/introduction/made

In all cases, the DST domain 'levels' is just one aspect for the multi-disciplinary team to consider and to evidence the overall picture, the MDT need to consider the **four key characteristics** of Nature, Intensity, Complexity and Unpredictability of the individual's needs are such that they have a primary health need **(NF141pg35).**

Nature:

This is about the characteristics of the individual's needs.

Nature

Ask yourself questions such as:

- How would you describe the needs?
  (Rather than the medical condition leading to them)
- What adjectives would you use?
- What is the impact of the need on overall health and wellbeing?
- What types of interventions are required to meet the need?
- Is there particular knowledge/skill required to anticipate and address the need?
- Could anyone do it without specific training
- Is the individual's condition deteriorating / improving?

e.g. *"John's needs arise out of his cognitive impairment as a result of severe dementia. He needs two carers to assist with all personal care activities". Nature also describes the quality of care/skill needed to support someone. E.g. When John becomes agitated, he requires carers look at de-escalation techniques as a least restrictive option, or if required, to make a judgement as to when to administer PRN lorazepam and, if and when to deliver 'safe holds' to ensure key interventions can be completed"*.

Intensity:

This is about quantity, severity and continuity of needs/care.

Intensity

Ask yourself questions such as:

- How severe is this need?
- How often is intervention required?
- How much care?
- How many carers are required?
- For how long is the care needed for each time?
- Does the care relate to needs over several domains?

i.e. how many carers/ skilled staff are needed, how often each day, for how long to complete tasks. E.g. One carer doing 15 minute checks over 24 hrs to ensure a person's

safety, or "John needs 1-2-1 support every day to maintain his and others' safety" or "4 carers are needed four times a day to assist with essential moving and handling tasks due to risk of pain from an unstable fracture.

Complexity:

This is about the level of skill/knowledge required to address an individual's need or the range of needs.

Complexity
Ask yourself things like:

- How difficult is it to manage the need(s)?
- Are the needs interrelated?
- Do they impact on each other making the needs even more difficult to address?
- How much knowledge is required to address the need(s)?
- How much skill is required to address the need(s)?
- How does the individual's response to their condition make it more difficult to provide appropriate support?

E.g. "John has end stage dementia and is unable to communicate his needs. He's bed-bound with contractures and can't remember how to swallow. He's lost lots of weight and this has led to breakdown in his skin".

Unpredictability:

This is about the degree to which needs fluctuate and thereby create challenges in managing them.

Unpredictability
Ask yourself questions such as:

- Are you able to anticipate when the need(s) might arise?
- Does the level of need often change?
- Is the condition unstable?
- What happens if you don't address the need when it arises?
- How significant are the consequences?
- To what extent is professional knowledge/skill required to respond spontaneously and appropriately?
- What level of monitoring/review is required?

e.g. unstable diabetes; rapid deterioration, e.g. end stage cancer, or the level of risk to health if adequate or timely care is not provided.

Well Managed Needs:

Within the four key characteristic, it is important to consider a **'well-managed need'** if appropriate:

"well managed needs are still needs… an example of this might occur in the context of behaviour domain where an individual's support plan includes support/interventions to manage challenging behaviour, which is successful in that there are no recorded incidents which may indicate a risk to themselves, others or property. In this situation, the individual may have needs that are well managed and if so, these should be recorded and taken into account in the eligibility decision". **(NF143)**

"In applying the principle of well-managed need, consideration should be given to the fact that care-providers may not routinely produce detailed recording of the extent to which a need is managed. It may be necessary to ask the provider to complete a detailed 24/48 hour diary to demonstrate the nature and frequency of the needs and interventions and their effectiveness". **(NF144)**

When considering what evidence is needed to support the completion of the DST, a 'proportionate' approach should always be taken **(NF140) (PG35)**

At the DST meeting, the MDT is required to make a recommendation as to whether or not the individual has a primary health need. In coming to this recommendation the MDT should work collectively using professional judgement. The written recommendation needs to be clear and concise, whilst providing sufficient detail demonstrate the rationale for the recommendation **(NF147-148)**

If the MDT do not believe that the individual has a primary health need, they need to consider if they are eligible for a joint package of care, funded nursing care or a social care package. SCCG uses the 'Eligibility Panel' represented by colleagues from SCCG and the SCC to ensure quality and consistency in decision-making and this panel should ratify the MDT recommendation, unless there is an exception identified.

The SCCG notifies the individual of the DST outcome in writing. If they, or their family, acting with their agreement or on their behalf, are not happy with the outcome, they can appeal in writing to the CCG within 6 months of receiving the outcome letter.

What happens if the MDT is unable to agree with the DST recommendation being proposed?

If an MDT is unable to reach an agreement on the recommendation the reasons should be clearly documented with the **relevant** evidence to support an alternative recommendation.

The DST (paragraph 21 of the user notes) advises practitioners to move to the higher level of a domain where agreement cannot be reached but there should be clear reasoned evidence to support this. If practitioners find themselves in this situation they should review the evidence provided around that specific area of need and carefully

examine the wording of the relevant domain levels to cross-match the information and see if this provides further clarity. Additional evidence may be sought, although this should not prolong the process unduly. If this does not resolve the situation, the disagreement about the level should be recorded on the relevant domain along with the reasons for choosing each level and by which practitioner. This information should also be summarised within the recommendation so that the CCG can note this when verifying recommendations. **(PG33)**

If practitioners are unable to reach agreement, the higher level should be accepted and a note outlining the position included within the recommendation on eligibility. **(PG33)**

In these circumstances the social care assessor will be invited to write and submit an Alternative Recommendation within 3 working days following receipt of the signed DST from the nurse coordinator. Where the signed DST is received after 2pm on Friday the notice period will commence from Monday.

The only exception to a recommendation not being reached at the DST meeting is if there is a specific piece of evidence missing. In these situations, a recommendation should be agreed **'in principle'** pending that piece of evidence being provided in a timely manner.

A copy of the DST will only be signed by the MDT, when the nurse coordinator has completed fully and provided a signed copy to the social care assessor. All MDT professionals must have had sight of the DST content and the recommendation being submitted before submission to the CCG for ratification.

Note: Changes should not be made to the DST after the MDT have signed and agreed the content (with the exception of grammatical errors).

When will a DST be completed?

- Following a positive checklist being screened in/New
- Following a planned review (of an existing patient in receipt of any NHS funding)
- If there has been a change of needs to an existing individual, a DST assessment will be required.
- Following a hospital discharge via the NHS led routes two and three

When will a DST Review be completed?

- 3 months – Where an individual has been found eligible for NHS Continuing Healthcare, a review should be undertaken within three months of the initial eligibility decision being made. **(NF181)**

  The SCCG 'New' Team are responsible for the completion of DSTs as well as the majority of the 3 month reviews. This ensures a positive service experience for the individual as a result of continuity of care and the knowledge that the nurse

coordinator has gained from completing the original DST.

- 12 months – After this, further reviews should be undertaken on at least an annual basis for CHC, Joint Packages of Care, Funded Nursing Care. Some individuals will require more frequent review in line with clinical judgement and changing needs. **(NF18)**

  SCCG have introduced a shortened review process in conjunction with SCC for; CHC, joint packages of care and funded nursing care having recognised that in the majority of cases it is rare that someone's eligibility changes at 3 and 12 month reviews. Asking the individual and representatives to participate in a full DST is traumatic and time consuming.

  The revised framework has clarified that the 3 month and 12 month review process is predominantly around reviewing the care received by the individual ensuring that it is least restrictive in meeting their needs.

  The shortened review paperwork refers to the original DST and if no changes are found then the eligibility remains the same.

  If any changes are identified that may change the individuals eligibility the process identifies that a full DST must be completed.

- A guiding principle is that the frequency, format and attendance at reviews should be proportionate to the situation in question in order to ensure that time and resources are used effectively. **(NF182)**

- These reviews should primarily focus on whether the care plan or arrangements remain appropriate to meet the individual's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility. **(NF183)**

- It is expected that the most recently completed Decision Support Tool (DST) will normally be available at the review and should be used as a point of reference to identify any potential change in needs. **(NF184)**

- Where reassessment of eligibility for NHS Continuing Healthcare is required, a new DST must be completed by a properly constituted multidisciplinary team (MDT), as set out in this National Framework. **(NF185)**

What does the individual need to know?

- The individual should be given every opportunity to participate in the meeting, with support where necessary, and their views and preferences should be documented at every stage.
- Whilst the DST document is intended to be as clear and accessible as possible, the nature of the NHS Continuing Healthcare process is such that some words used may not be immediately understandable to someone who is not professionally trained. As far as is possible, professionals completing the DST

should make sure that individuals, and carers or representatives (where consent is given), understand and agree to what has been written. In some situations advocacy support may be needed and the CCG will provide support to sign post individuals to gain appropriate access to services. **(DSTpg3)**

Key Points:

- An individual will be eligible for NHS Continuing Healthcare where it is identified that they have a 'primary health need'.

- The decision as to whether an individual has a primary health need takes into account the legal limits of local authority provision and the rational should refer to ancillary and incidental care and the quality or quantity of care.

- The DST is not an assessment in itself, rather a way of bringing together and applying evidence in a single format.
- Completion of the tool should be carried out in a manner that is compatible with wider legislation and national policies where appropriate.
- By practitioners working in partnership, following the National Framework, it should be possible to resolve many disagreements regarding eligibility recommendations through the normal processes without the need to invoke formal dispute resolution and/or local appeal procedures.

- Throughout the DST process, the MDT are inputting their professional opinion regarding the person and their needs. A social care practitioner is not there to advocate on behalf of the individual, they are present as an 'MDT professional'. If the individual requires representation, this should be someone they know or paid advocacy.

- The social worker responsible for completing the initial Checklist should wherever possible be part of the MDT given their knowledge of the individual and to ensure continuity of care.

- The DST should not be completed without a multidisciplinary assessment of needs (meaning a comprehensive collection and evaluation of an individual's needs, refer to paragraphs 124-130). If any assessments relating to the individual's health and wellbeing (such as a needs assessment under the Care Act 2014) have recently been completed by practitioners, they may be used to inform the evidence to complete the DST. However, care should be taken to ensure that such assessments provide an accurate reflection of current need.

- The MDT will ensure that the individual and their representatives being assessed are fully engaged and understand the process, and receive advice and information that will maximise their ability to participate in the process in an informed way.

Timescales

Process	Sheffield CCG has a responsibility to respond to referrals within the following timeframes	Timescale
DST	Completion of DST and supporting evidence from the point at which a positive Checklist is screened in or the need for a DST is identified	*16 calendar days*
DST	Notice provided to members of the MDT, individuals and their representatives from the point at which the positive Checklist is screened in or the need for a DST is identified	14 calendar days
DST	Where the MDT agrees the DST recommendation from the point at which the signed DST is received from the Nurse Coordinator. Signed approval provided by SCC	1 working day
Alternative Recommendations	Where the LA disagree with DST recommendation from the point at which the signed DST is received from the Nurse Coordinator, they will submit to CCG to inform panel decision making process re ratification.	3 working days Where the signed DST is received after 12noon on Friday the notice period will commence from Monday.(SCC to return within 3 working days or the DST progressed to ratification)
DST – Returned to MDT for further work	If a DST is returned to the MDT for further work, the MDT needs to complete and return the DST. It is the responsibility of all team members to support the process.	3 working days where the DST is received after 2pm on Friday the notice period will commence from Monday. If not returned in 3 days the DST will be progressed.
Ratification	The CHC Framework (156) expects SCCG to normally respond to MDT recommendations within.	2 working days
Communication of	Length of time from SCCG	Within 5 working

Decision	verification to decision to letter sent to individual advising outcome.	days
Final Ratification	The CHC Framework (156) expects the overall Assessment & Eligibility Decision Making Process from the date SCCG receives the 'Positive' checklist. *(N.B Exception does not apply to Children & Young People in Transition)*	28 calendar days *N.B Exception, if a valid & unavoidable reason for 28 day delay*

19. Ratification

Eligibility for CHC is measured against the completed Decision Support Tool following the 28 day process, triggered at the point at which the positive Checklist has been screened in.

"CCGs are responsible for decision making regarding NHS Continuing Healthcare eligibility, based on the recommendation made by the multidisciplinary team in accordance with the process set out in this National Framework. Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed" **(NF 153)**

The National Framework states that a CCG or panel can only reject an MDT's recommendation in **'exceptional circumstances'**.

The NHS CHC Practice guidance PG39 defines '**exceptional circumstances'** as:

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

In such circumstances the CCG or panel may return the assessment "to the MDT for the relevant matters to be addressed". Where there is an urgent need for care/support to be provided, the CCG (and the LA where relevant) should make appropriate **interim** arrangements. **(NF39)**

Whatever arrangements, it must be remembered that the National Framework places a strong emphasis on the MDT recommendation. Sheffield's guiding principle is that the health and social care representatives in an MDT are presumed to have delegated authority to act in that role. Senior managers in SCCG & SCC are expected to support the recommendation made by their members of staff and should not dispute a recommendation made by their member of staff, unless there are **exceptional circumstances**.

SCCG should not refer a case back, or decide not to accept a recommendation, simply because the MDT has made a recommendation that differs from the one that those who are involved in making the final decision would have made, based on the same evidence.

When will a case be presented to a decision making panel?

DECISION MAKING PANELS

CHC Team Leader (TL)	For DST's with an agreed MDT recommendation of CHC, JPOC, FNC and SCO **Agreed:** All representatives of the MDT are notified of the CHC ratified outcome with the 'CHC 05' sent to the MDT. The CHC team will correspond with the individual as to the outcome. **Not Agreed:** If the Team Leader is unable to identify the information in relation to the individuals need to support the MDT's recommendation, they will return the DST to the MDT with clearly articulated rational for the exceptions 1-4 (see DST Information Sheet). It is the nurse co-ordinators responsibility to liaise with the social worker/care manager and/or any other relevant MDT member. Collective responsibility of the MDT to respond to and provide the additional information/evidence to any request in a timely manner or reconvene to discuss/review the information they have and original recommendation. DST should be resubmitted to the Team Leader by the date requested. (New DST should adhere to 28 day process) This may lead to an Alternative Recommendation being resubmitted. A DST must only be presented to the Team Leader twice. (The DST should not be returned to the MDT a 2nd time, for different reasons) If this disagreement cannot be resolved, the DST should be presented to Eligibility Panel.
Eligibility	For DST's with a disagreement in the MDT recommendation following team leader or DST OR DST's where there has been no LA representation. SCCG has established an Eligibility Panel to ensure consistency and

	quality of decision making. Decision Makers at this panel should include 1 x Health - Clinical Team Leader 1 x SCC – Social Care Team Manager It is the expectation of SCCG/SCC that panel member reach an agreed recommendation at this point. For cases that have already been considered by Team Leader, if an agreement is not reached by this panel, the case will be presented at Dispute Panel. With supporting panel information sheet with a clearly articulated rational. **Any escalation to Dispute Panel should be an 'exception'.**
Disputes Panel Stage 1 of Dispute Resolution Policy	All DST's that have NOT been ratified via Team Leader or Eligibility Panel must be presented to Dispute Panel. CHC team will provide list of cases to be presented at panel the day before. CHC Decision Making - Quorate SCC/CCG 1 x CHC Health – Clinical Lead and/or Team Leader (as appropriate) 1 x NHS - GP 1 x SCC - Service Manager and/or Team Manager (as appropriate. Dispute Panel will provide feedback to members of the eligibility panel if it is deemed that early resolution should have been achieved.
Stage 2 of Dispute Resolution Policy Heads of Service	Head of Service SCCG and SCC resolution **Stage 2: Referral of the dispute to the Head of Services of the Partner Organisations** In the event that the Dispute Panel recommendations are not accepted by either Partner Organisation, the dispute may be referred by either Partner Organisation within 5 working days of the Dispute Panel's decision to the Heads of Service at the Sheffield Clinical Commissioning Group and the Sheffield City Council. The respective Heads of Service will meet to discuss the decision of the Disputes Panel and, within 14 working days of referral to them, will make recommendations to the partner organisations as to whether they agree with the decision of the Dispute Panel. An independent CHC advisor should be present to provide advice to the Heads of Service on the framework, with the nominated advisor agreed by both parties. An appointed clinical advisor, agreed by both parties, may also be necessary to provide advice. The partner organisations will accept the recommendation made by the

	Heads of Services. However, in the event that the Heads of Service fail to reach agreement on the Dispute Panel decision, the matter shall be referred for arbitration in accordance with Stage 3 of this Disputes Resolution Policy. Authorisation to Stage 3 approved at Director Level (PH/MP)
Stage 3 of Dispute Resolution Policy Arbitration Independent Panel	Independent Panel **Stage 3: Arbitration - Independent Panel** In the event that the Dispute cannot be resolved through Stage 2 of the Disputes Procedure, either Partner Organisation may serve written notice on the other confirming that they wish to refer the matter for arbitration to an independent panel. Such notice shall be made no later than 14 working days following confirmation by the Heads of Services that they are unable to resolve the dispute. Any dispute referred to Stage 3 of this Disputes Resolution Policy shall be determined by an independent panel through a jointly agreed regional Clinical Commissioning Groups Eligibility Panel within the SYB ICS footprint.

What does the individual need to know?

- CHC Panels in Sheffield will be used to ratify the eligibility decision, based on the recommendation made by the MDT.
- Panels will verify and confirm MDT recommendations.
- Eligibility Panels are kept separate from Resource Panels to ensure the integrity of the process
- Decision making processes will not be used as a means of financial gatekeeping
- DST's will not be completed or altered by the decision making process
- Panel will not be used for overturning recommendations

20. Disagreements

Separate procedures exist for individuals and their representatives to appeal CCG decisions regarding their eligibility for NHS continuing healthcare.

Individual

- Appeal – if an individual is found not to be eligible for NHS CHC and wishes to challenge this decision, they will be advised on the CHC appeals process which is initiated by SCCG.

  Appeals should not be used as a tool for referring practitioners who disagree with the outcome of the DST, in these circumstances the disagreement procedures will be used in **all** cases.

- The individual will be informed of the appeals process which is part of the DH Guidance PG55, in the letter that confirms the eligibility outcome.

- Local Resolution Process – earlier resolution/consistency **(NF194)**

- NHSE – Independent Review Panel

Informal Disputes – before Ratification

This applies to disagreements between members of the MDT that arise whilst an assessment for CHC eligibility is being completed. It also concerns assessments which are sent back to an MDT for further work, and the MDT disagrees with part or all of the reason why the assessment was returned.

This procedure is distinct from the **'Dispute'**, as the escalation process is for use in resolving disagreements regarding recommendations being made during an assessment.

This process only applies when:

- A DST has been returned twice to an MDT for further evidence

- The DST has been resubmitted twice to Sheffield CCG

- SCCG or the SCC considers that insufficient evidence has been provided, despite the DST having been returned to the MDT on two occasions.

Where the above criteria apply, the case will be sent to the 'Dispute Panel', clearly recorded as an Escalation case, to review the evidence provided. There must be a SCC Senior 'Lead' present at this 'Quorate' panel.

21. Sheffield Dispute Resolution Policy for NHS Continuing Healthcare & NHS Funded Nursing Care (Revised October 2018)

The CCG Regulations 2012 and the National Framework 2018 require NHS bodies and local authorities to have in place a local dispute resolution process about eligibility for NHS Continuing Healthcare. **(NF208)**

The Disputes Resolution Policy is a jointly-agreed approach between Sheffield CCG and Sheffield City Council, only for use after a recommendation has been ratified, **after** the completion of an assessment for CHC and accords with the CHC **Practice Guidance** published by the Department of Health

22. Interim Care/Funding Arrangements/Refunds - Annex E

The National Framework provides that disputes should not delay the provision of the care package and the dispute process makes clear how funding will be handled during the dispute.

The National Framework expects that neither the CCG nor the LA should unilaterally withdraw from funding of an existing package until there has been appropriate reassessment and agreement on future funding responsibilities and any alternative funding arrangements have been put into effect.

The parties to this agreement with regard to inter agency disputes, will adopt a **without prejudice approach** to interim funding whereby the final outcome of the dispute will be backdated to cover the whole period of eligibility. This means that any existing funding arrangements will remain in place until the dispute is resolved and will be reimbursed by the responsible organisation. This means that if a dispute commences when an individual is in the community and SCC are meeting their needs, the local authority will continue to meet these needs without prejudice until the dispute is resolved. Conversely if the individual is in hospital or currently receiving CHC or interim health funding in the community, the NHS will continue to fund without prejudice until the dispute is resolved.

Where the LA has funded without prejudice and the individual has been required to make a financial contribution, reimbursement to the LA will be on the basis of the gross cost of the service provision. The LA will then reimburse the individual in accordance with **Annex E** of the National Framework Paragraph 16. CCG will require evidence of reimbursement made to individual.

Costs incurred on a without prejudice basis should be reimbursed within 28 days from the final resolution date, in line with relevant payment schedules.

23. Case/Care management

NF 167-170

Once an individual (New to service) has been found to be eligible for NHS Continuing Health Care, SCCG will be responsible for their case/care management and for service funding from day one **(NF167)**

Once an individual (Existing) has been found to be eligible for NHS Continuing Health Care, SCCG will be responsible for their case/care management from day 29, and for service funding from the point at which eligibility is approved. **(NF167)**

The CCG should ensure arrangements are in place for an ongoing case/care management role for all those eligible for NHS Continuing Health Care, with regards to the NHS elements of joint packages, social services should liaise with the appropriate clinician within generic services.

Where an individual's eligible need no longer qualifies them for NHS Continuing Health Care, SCC will be responsible for their case/care management from day 29, and for service funding from the point at which eligibility is approved.

In cases where there is a Dispute, existing care management responsibilities should continue to apply.

24. Quality Assurance and Audit

SCCG and SCC are committed to *'Learning from Experience'* across all aspects of the CHC process.

Examples of learning will include learning from the decision made by the 'Dispute Panel' with cases communicated to the respective staff groups, with the expectation that workers will take the learning from the panels decisions when participating in future MDTs in the completion of DSTs.

The below table details examples of the key performance indicators to be included in a new CHC Performance Management Dashboard which would need to be digitally enabled. The performance indicators are aimed at informing service and workforce developments to deliver continual service improvement.

1	Number of Positive Checklists received by organisation, team, and individual – identifies good practice
2	Number of Negative Checklists received by organisation, team and individual – potentially identifies training requirements
3	Total Checklists received by organisation, team, and individual
4	Number of DSTs completed by organisation, team and individual
5	Number of DSTs completed in the absence of social workers by organisation and team – with reason code
6	Number of DSTs completed where the social worker who completed the original positive Checklist **did not** participate as part of the MDT - with

	reason code
7	DST outcomes by community and discharge to assess by Care Home - CHC/JPOC/FNC/Social Care Only
8	DST outcomes in relation to Domain weighting
9	Number of weekly cases referred to the 'Eligibility Panel', evaluated by team and individuals who represented the MDT
10	Number of instances where MDTs fail to agree DST recommendation – alternative recommendation by team and individual
11	Response rates to agreeing DST outcomes by organisation, team and individual
12	Number of changes in eligibility moving from Social Care only>JPOC>FNC>CHC
13	Number of changes in eligibility moving from CHC>FNC>JPOC>Social Care only
14	Number of reviews completed by organisation, team and individual along with the outcomes- increased service in relation to the need, service appropriate for the need, service decreased least restrictive, potential change to eligibility identified DST triggered
15	Fast Track: *Number of referrals by organisation, team and individual* *Number of returned referrals as above to identify training needs* *Timeline covering all key elements of the pathway* *Demand, capacity and productivity by team member* *Re-admissions and final outcomes*
16	Productivity monitoring service activities completed by team and individual
17	NHSE Quarterly Returns - Eligibility and Conversion
18	Compliance with the NHSE Performance Targets

SCCG and SCC are committed to ongoing collaboration with Healthwatch with the aim of delivering continual service improvement.

Questionnaires are targeted at individuals and representatives to capture their service experience following assessments and annual service reviews covering both CHC and joint packages of care.

This new approach will ensure that individual's and their representatives will have a significant 'voice' which will help to assess quality at the same time as informing and shaping continual service improvement.

There will be an increasing focus on peer support and review with collaborative bi yearly education and peer support away days.

25. Glossary

SCCG	Sheffield Clinical Commissioning Group
CHC	NHS Continuing Health Care as defined in the National Framework.
CHC / FNC Panel	A panel that has been established by the CCG to ensure consistency and quality of decision making for the purposes of determining a person's eligibility for CHC or Funded Nursing Care.
Checklist	An initial assessment completed by a community based health or social care practitioner when completing a referral for CHC
Coordinator	A person(s) who coordinates the NHS Continuing Healthcare eligibility assessment process.
Eligibility Panel	Replaces QAC for eligibility ratification
Exceptions Panel	Replaced Escalation for 'disagreements'
Directions	NHS Continuing Healthcare (Responsibilities) Directions 2007.
Disputes Panel	Process for SCC Disputes regarding the Primary Health Need eligibility of an individual.
DST	The purpose of the Decision Support Tool (DST) is to support the application of the National Framework and inform consistent decision making.
Eligible	Individual who is or has been deemed eligible to receive NHS Continuing Healthcare funding.
Fast track assessment route	Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require 'fast tracking' for immediate provision of NHS Continuing Healthcare.
Fast Track Tool	The Fast Track Tool should be completed by an appropriate clinician, who should give the reasons why the person meets the criterion required for the fast-tracking acceptance.
Incidental or Ancillary	See Guidance
Joint Funded	A package of care which is part funded by the NHS for the health elements.
Team leader	Team Leader at SCCG
MDT	The multi-disciplinary team.
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 2 of the Mental Capacity Act 2005.
Mental disorder	Mental disorder is defined in section 1(2) of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) as meaning '*any disorder or disability of the mind*'.
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	In the context of assessing eligibility for NHS Continuing Healthcare, a multidisciplinary team (MDT) is a team of at least

	two professionals, usually from both the health and the social care disciplines.
National Framework	National Framework for NHS Continuing Healthcare and NHS Funded
Palliative care	Palliative care is the active holistic care of individuals with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount.
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.
Primary Health Need	Concept developed by the Secretary of State to assist in deciding which treatment and other health services it is appropriate for the NHS to provide. Where a person has been assessed to have a 'primary health need', they are eligible for NHS Continuing Healthcare.
Representative	(**NFpg151**) The term is intended to include any friend, unpaid carer or family member who is supporting the process as well as anyone acting in a more formal capacity. (e.g. welfare deputy, power of attorney or an organisation representing the individual) (PG 22)
Quality	See Guidance
Quantity	See Guidance
SCC	Sheffield City Council
LA	Local Authority
Well Managed Needs	See Guidance

Section Two: Discharge to assess

"Why Not Home, Why Not Today?"

Route Two – Home to Assess (Active Recovery)
Route Three – Somewhere else to Assess

THIS PROCESS IS CURRENTLY BEING DEVELOPED JOINTLY BETWEEN SCCG, SCC and STH

Add Finalised SOP for D2a

https://www.sheffieldccg.nhs.uk/Downloads/Your%20health/CHC%202019/Why%20not%20home%20why%20not%20today%20Standard%20Operating%20Procedure%20%20Ongoing%20Care.pdf

DRAFT COPY ONLY

Section Three: Resource Allocation

THIS PROCESS IS CURRENTLY BEING DEVELOPED JOINTLY BETWEEN SCCG & SCC

1. Sec 117 and Sec 117 50/50 (7 May 2015) - Pathway applies to an individual detained in hospital for treatment under Sections 3, 37, 45A, 47, 48)

2. Joint Packages of Care (JPOC)

3. Resource Allocation – Joint Panel

4. Joint Funding Disputes - Decisions on joint funding will only take place after CHC/PHN eligibility has been ruled out.

5. NHS – funded Nursing Care (FNC) provided to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS-funded Nursing Care has been based on a single band rate.