

Structural Summary of National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)

PART 1 THE NATIONAL FRAMEWORK

Executive Summary

1. The National Framework - reflecting the new NHS structures from April 2013
2. Transfer of Legal Duties - from PCTs to CCGs, except for armed forces (+families) and prisoners where duties transfer to National Commissioning Board (the Board)
3. Definitions - CCG includes those exercising CCG functions but CCG can't delegate final eligibility decision. The Board includes those authorised to carry out its functions
4. Scope - replaces previous Framework and includes Practice Guidance, FAQs etc.
5. Legal Framework - this document sets out duties for NHS and LAs
6. Primary Health Need (PHN) - this is explained
7. Core Values and Principles - these are explained - need for fairness and consistency
8. Eligibility Consideration - decision making process based on MDT assessment
9. Commissioning, care planning and provision - CCGs/Board responsibilities
10. Access to other NHS-funded services - including how joint packages should operate
11. Links to other policies - e.g. MH, children's services, personal health budgets (PHBs)
12. Review - guidance on carrying out 3 monthly and annual reviews
13. Dispute resolution - where individual challenges decision, also interagency disputes
14. Governance - roles of Board and CCGs

The National Framework

Summary

1. This revised guidance sets out the principles and processes of the National Framework for NHS continuing healthcare and NHS-funded nursing care.

Actions

2. **CCGs** and the **Board** assume responsibilities for NHS continuing healthcare (CHC) from 1/4/13
3. **The Board** will assume responsibilities for specified groups (e.g military personnel & prisoners). Also it will be responsible for reviewing decisions where individual challenges
4. **The Board** should avoid conflict of interest if required to review own eligibility decisions
5. Throughout Framework read '**the Board**' for 'CCG' in relation to these specified groups
6. **CCGs** and **The Board** need to align processes with new Framework, including regarding arrangements with providers and consideration of PHBs
7. **Board** to help facilitate above, also Board required to run Independent Review Panels (IRPs)
8. **LAs** should fit their practices with the guidance
9. **Provider Organisations** should consider Framework in relation to discharge procedures
10. **Provider Organisations** should consider contractual and CQC requirements, make CHC referrals, keep good records and share info for assessments
11. **The Board, CCGs, NHS trusts and LAs** should work together
12. **CCGs, NHS trusts, LAs and the Board** must comply with Standing Rules/Directions re CHC

Background

13. definition of '**NHS continuing healthcare**' (CHC): 'a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' (PHN).

14. definition of '**NHS-funded nursing care**' (FNC): 'the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse.
15. ongoing care/support requires timely assessment by NHS and LAs. If not CHC then possibly joint package, which could be in any setting.
16. PHBs (which are not new money) give patients choice and control - more info available.
17. Basis of this guidance - statute, case law, ombudsman, responses to consultation. Framework to be read in conjunction with national tools: Checklist, Decision Support Tool (DST), and Fast Track Pathway Tool, each of which have user notes.

Legal Framework

- 18-23. 'continuing care', 'CHC' and 'PHN' aren't in primary legislation but NHS Act 2006, amended by Health & Social Care Act 2012 (H&SCA 2012), requires **Secretary of State (SOS)** to promote comprehensive health service, designed to secure improvement, having regard to NHS constitution. SOS must have regard to need to reduce inequalities. The **Board** was established by NHS Act 2006 to hold **CCGs** to account etc. Section 3 of 2006 NHS Act requires **CCGs** to provide care/after care for people who are/have suffered from illness, if considered appropriate as part of NHS.
24. LAs have duty to assess anyone who appears to be in need of community care services and notify **CCG** if someone might need NHS Act 2006 provision
25. NHS bodies should notify LA if potential need for community care services
26. Section 21 (8) of National Assistance Act 1948 (NAA) (accommodation) prohibits LAs from making provision that is 'authorised or required' to be provided by the NHS.
27. Section 29 (6) (b) of NAA 1948 (welfare services) only prohibits LAs from providing services 'required' to be provided by the NHS.
28. S.49 of Health & Social Care Act 2001 prohibits LAs from providing registered nursing
29. Balance between LA and **CCG** responsibilities has been subject of key court judgments

Case Law

30. Coughlan indicated limits of LA responsibility in relation to nursing care (in broad sense, not just registered nursing) - 'incidental or ancillary' & 'nature of social services' tests.
31. H&SCA 2001 stopped LAs from providing registered nursing
32. Have to consider CHC before considering FNC - see Grogan judgment
- PG1 *Is there an authoritative definition of "beyond the responsibility of the local authority"*
- PG2 *What is the difference between a healthcare need and a social care need?*

Primary Health Need

33. SOS has developed concept of PHN - if someone has PHN then they're eligible for CHC and then '*the NHS is responsible for providing all of that individual's assessed health and social care needs - including accommodation if that is part of the overall need.*'
34. Should be no gap in the provision of care - thus someone beyond LA limits ('incidental or ancillary' & 'nature of social services' tests) must be found eligible for CHC.
- 35-37. limitations to tests - neither **CCG** nor LA can dictate what other should provide. A practical approach to eligibility is required using concepts of nature, intensity, complexity and unpredictability which in combination or alone may indicate PHN.
38. Important to take account of deterioration when considering eligibility for CHC - if rapidly deteriorating and possibly terminal consider use of Fast Track Pathway Tool.
39. Need to reflect principles of National End of Life Programme in CHC
- 40-41. DST has been developed to inform consistent decision-making. Further details of DST below. Before using it need to have evidence from all necessary assessments.
- PG3 *What is a Primary Health Need?*

Core Values and Principles

42. Process of assessment and decision making should be person centred
43. Access to assessment, decision making and provision should be fair and consistent
44. Process should be explained and transparent for individuals, families, carers and staff
- PG4 ***What are the key elements of person-centred approach in NHS continuing healthcare?***

Consent

45. Should obtain informed consent before embarking on eligibility process
46. Need to be explicit about what individual is consenting to
47. If consent not given have to explain potential consequences of this to the individual
- PG5 ***What specific guidance is there in relation to dealing with confidentiality?***
- PG6 ***What if an individual with mental capacity refuses to give consent to being considered for NHS continuing healthcare eligibility?***

Capacity

48. If there is concern that individual may lack capacity, apply the Mental Capacity Act 2005 (MCA) - be aware of the 5 principles: presumption of capacity; support individuals to make own decisions; unwise decisions don't necessarily indicate lack of capacity; act in individual's best interests; use least restrictive option.
49. Difficulty in expressing views doesn't in itself indicate lack of capacity
50. If person lacks capacity then a best interest decision needs to be made re embarking on CHC process - expectation is that people should have the opportunity to be considered for eligibility.
51. If best interest decision needs to be made, consult first with any relevant 3rd party.
- PG7 ***What if there are concerns that the individual may lack capacity to consent to the completion of a Checklist/DST?***

Advocacy

52. Duty to instruct an IMCA where someone, who lacks capacity and has no friends/family, faces an important decision re serious medical treatment or change of residence.
53. Even where criteria for IMCA not met, people should be made aware of advocacy services and CCGs should consider whether strategic action needed to ensure adequate advocacy services available.
- PG8 ***When is it appropriate to involve an Independent Mental Capacity Advocate (IMCA)?***
- PG9 ***Whose responsibility is it to provide advocacy for individuals going through the eligibility decision-making process?***
- PG10 ***Do individuals need to have legal representation during the NHS continuing healthcare eligibility process?***

Carers

51. Carers have a right to have their needs assessed

Other eligibility issues

55. Eligibility for CHC is based on needs, not diagnosis or condition
56. CHC can be provided in any setting. Eligibility not influenced by setting or who provides care. Also well-managed needs are still needs.
57. Financial considerations have no part in the eligibility decision
58. Eligibility should not be based on diagnosis, setting, ability of provider to manage care, whether NHS staff are employed to provide care, need for specialist staff, the fact that a need is well managed, existence of other NHS funded care, any other input related rationale.

59. CHC is not indefinite as needs can change.
 PG11 *How should the well-managed need principle be applied?*

Assessments

60. Good quality comprehensive assessment is crucial. Importance of right knowledge/skills being brought to assessment.
61. Whether or not assessment leads to CHC eligibility, LAs and CCGs should consider whether the assessment has revealed issues that need addressing
- PG12 *Dealing openly with issues of risk*

Eligibility Consideration

Diagram of process

Hospital Discharge

62. Consider CHC before giving notice under delayed discharge legislation
63. Local protocols should be in place re delayed discharge arrangements and CHC, including who to Checklist
64. Can assess for CHC in or outside hospital, but accurate assessment may be more difficult in acute setting and may not accurately reflect abilities. Consider whether potential for rehab before considering CHC.
- 65-66 Consider whether further NHS-funded services are appropriate to maximise potential before considering CHC - if so responsibilities under Community Care (Delayed Discharges etc) Act 2003 are not triggered.
67. If someone outside hospital is having needs assessed/reviewed by LA or NHS body, consider whether Checklist should be completed

Checklist

68. If not Fast Track then Checklist is first step for most people. In hospital don't use Checklist until discharge needs clear.
69. Standing Rules Regulations (SRR) say that if CCG uses a screening tool then it has to be the Checklist (but can move straight to full CHC consideration without using Checklist).
70. CCG must 'take reasonable steps to ensure that individuals are assessed for NHS continuing healthcare in all cases where it appears there may be a need for such care.'
71. Make sure individual knows +ve Checklist only signifies need for full assessment, not likely eligibility for CHC
72. Checklist threshold is deliberately low
73. Variety of professionals can use Checklist, so long as they understand principles of Framework and DST
74. If +ve Checklist as part of hospital discharge can decide to provide interim NHS services prior to full assessment, which should be in most appropriate setting. NHS funds these interim services.
75. Make sure people have appropriate support whilst awaiting outcome of eligibility process
76. Give outcome of Checklist to individual in writing - including right to request reconsideration if screened out
- PG13 *How does NHS continuing healthcare fit with hospital discharge procedures?*
- PG14 *How does NHS continuing healthcare link with intermediate care?*
- PG15 *What is the NHS continuing healthcare Checklist?*
- PG16 *Does everyone need to have a Checklist completed?*
- PG17 *Who can complete a Checklist?*
- PG18 *When should a Checklist be completed if the individual is in hospital?*

- PG19 *When should a Checklist be completed if the individual is in the community or in a care setting other than hospital?*
- PG20 *Who needs to be present when a Checklist is completed?*
- PG21 *What information needs to be given to the individual when completing a Checklist?*
- PG22 *What should happen once the Checklist has been completed?*
- PG23 *What evidence is required for completion of the Checklist?*
- PG24 *Can registered nurses in care home settings complete a Checklist Tool?*
- PG25 *Can someone self-refer by completing a Checklist themselves?*

Decision Support Tool

77. Once individual referred for full assessment CCG is responsible for co-ordinating the process and should identify a 'co-ordinator' who may, by agreement, be from an external organisation.
78. Even if not eligible for CHC, care planning will be need and maybe FNC
79. DST should be used following up-to-date comprehensive MDT assessment
80. The assessment should be done with consent, involve the individual/carer as much as possible and draw on those with direct knowledge of the individual's needs
81. DST isn't an assessment tool, but it facilitates consistent evidence-based eligibility decisions re CHC.
82. MDT assessment should enable needs to be met irrespective of CHC eligibility
83. LA as well as health professionals should be involved (if poss) and SRRs require CCG to consult with LAs before deciding eligibility as far as is reasonably practical. If consulted LAs should give advice & info and should not allow individual's finances to influence whether they get involved.
84. DST has 12 domains with different levels of need on each
85. Completion of DST gives overall picture of needs and nature, intensity, complexity and unpredictability of these needs. *Diagram showing domains and potential levels.*
86. Use 12th domain if particular needs don't fit into other domains
- 87-88. MDT should use DST to indicate interaction between needs. The tool doesn't directly determine eligibility but indicative guidelines are included. The tool aids decision as to whether person has PHN using the 4 characteristics
89. Once MDT has reached agreement it should make recommendation to CCG re eligibility
- PG26 *What is the role of the Continuing Healthcare Co-ordinator?*
- PG27 *Why isn't the DST an assessment tool?*
- PG28 *What are elements of a good multidisciplinary assessment?*
- PG29 *Potential Sources of Information/Evidence*
- PG30 *What is a Multidisciplinary team in the context of NHS continuing healthcare?*
- PG31 *What happens if the coordinator is unable to engage relevant professionals to attend an MDT meeting?*
- PG32 *Where should an MDT meeting take place?*
- PG33 *What process should be used by MDTs to ensure consistency when completing the DST?*
- PG34 *What is proportionate and reasonable in terms of evidence required to support domain levels and the recommendation in a DST?*
- PG35 *What happens if MDT members cannot agree on the levels within the domains of the DST?*
- PG36 *What happens if the individual concerned or their representative disagrees with any domain level when the DST is completed?*
- PG37 *What does DST recommendation need to cover?*
- PG38 *How does the DST and PHN test apply to people with learning disabilities?*

Decision Making

90. CCGs should be aware of legal/ombudsman cases where eligibility has been decided, but be wary of extrapolating too widely from these.
91. If CCG uses panel it should not fulfil gate-keeping nor financial monitor function. Only in exceptional circumstances should MDT recommendation not be followed.
92. CCG can ask for further work to be done on DST but not just because MDT has made a different recommendation than those involved in the final decision would have made.
93. CCG should not decide on eligibility in absence of MDT recommendation unless urgent. Finance officers should not be part of a decision-making panel
94. CCGs can review patterns of recommendations by MDTs but as a separate exercise to approval of recommendations in individual cases
- 95-96 Time between receipt of Checklist and eligibility decision should mostly not exceed 28 days. If delay, keep individual/representative informed.
- PG39 *If a CCG uses a panel as part of the decision-making process what should its function be and how should it operate?*
- PG40 *What should role of CCG decision-making process be?*
- PG41 *What are the 'exceptional circumstances' under which a CCG or panel might not accept an MDT recommendation regarding eligibility for NHS continuing healthcare?*
- PG42 *How should decisions be communicated to the individual/representative?*
- PG43 *If a person dies whilst awaiting a decision on NHS continuing healthcare eligibility, should a decision still be made in respect of eligibility for the period before their death?*

Fast Track Tool

97. An 'appropriate clinician' (defined) should complete the Fast Track Tool if the individual has 'a rapidly deteriorating condition that may be entering a terminal phase'.
98. 'Appropriate clinicians' can include certain clinicians employed in voluntary and independent sector orgs, but if someone other than this identifies potential need for Fast Track they should refer to an appropriate clinician
99. The Fast Track should be supported by prognosis (if available) but strict time limits regarding life expectancy should not be used to determine whether to use Fast Track.
- 100-101 Completed Fast Tracks should be accepted and actioned immediately by CCGs. However, CCGs should monitor the use of Fast Tracks and deal with any concerns with clinicians, teams or organisations separately from individual cases. Following Fast Track NHS funding can't be removed without using full DST eligibility process.
- 102-103 Purpose of Fast Track is 'to ensure that individuals with a rapidly deteriorating condition that may be entering a terminal phase are supported in their preferred place of care as quickly as possible.' Explain Fast Track Process sensitively and avoid individual moving in and out of CHC within a short period of time. Where person expected to die in near future CCG should consider taking responsibility until death.
104. Remember that DST requires consideration of deterioration so person might receive CHC this way, but use Fast Track when criteria for it are met.
105. Where deterioration expected in near future take this into account.
106. In end-of-life (EOL) situations have regard to paras 169-171 below.
107. EOL assessment, care planning & commissioning should take account of individual preferences and follow EOL strategy
- PG44 *In a Fast Track case is it the CCG or the 'appropriate clinician' who decides that the individual has a primary health need?*
- PG45 *Who can complete the Fast Track Pathway Tool?*
- PG46 *What is the relationship between the Fast Track Pathway Tool and the Checklist/Decision Support Tool?*

- PG47 *Do individuals need to consent to a Fast Track Pathway Tool being completed?*
- PG48 *Is the use of the Fast Track Pathway Tool dependent on specific timescales in relation to end of life care?*
- PG49 *What evidence is required when completing the Fast Track Pathway Tool?*
- PG50 *Can a CCG refuse to accept a completed Fast Track Pathway Tool?*
- PG51 *What actions can CCGs take if the Fast Track Tool Pathway Tool is being used inappropriately?*
- PG52 *How quickly could a hospital discharge take place following the completion of the Fast Track Tool?*
- PG53 *What settings can a Fast Track Pathway Tool be used in?*
- PG54 *Does the Fast Track tool need to be completed if the individual is already receiving a care package which appears could still meet their needs?*
- PG55 *Should individuals receiving care via the Fast Track Tool Pathway Tool have their eligibility for NHS continuing healthcare reviewed?*
- PG56 *Can the national tools be changed?*
- PG57 *Why is it important to complete the equality monitoring forms with the tools?*

Commissioning, Care Planning and Case Management

108. The CCG is responsible for all aspects of commissioning for those eligible for CHC, including securing ongoing case management for those in receipt of CHC.
109. CCG responsible for monitoring quality, access and patient experience in context of provider performance.
110. CCGs should take a strategic as well as individual approach to commissioning. Expectation of partnership working between LAs and CCGs
111. Take account of *Supporting People with Long Term Conditions: Commissioning Personalised Care Planning*, also *Valuing People Now*

Other existing commitments to NHS-funded care

112. Apart from CHC and provision under the Mental Health Act 1983 (MHA), there are other circumstances where the CCG may take responsibility for someone's long-term care, e.g. following closure of long-stay hospitals or campuses. This doesn't make it CHC. Need to look at detail of agreements.

Joint packages of health and social care services

113. If not eligible for CHC individual might receive a joint package of health & social care.
114. Though not eligible for CHC, DST might identify needs that are beyond LA powers - CCGs and LAs should work in partnership to agree respective responsibilities
115. Apart from NHS FNC, there is a range of other health services that the NHS might fund - examples listed.
116. LAs will be responsible for providing (social) care within lawful (Coughlan) limits, subject to their eligibility criteria.
117. NHS and LA partners to agree on other types of joint package (note LA can provide some health services, subject to their legal limitations).
- PG58 *What are joint packages of care?*
- PG59 *Practice example - Joint Package of Care.*
- PG60 *Does NHS-funded Nursing Care cover the entire cost of a person's nursing needs?*
- PG61 *In a joint package does the DST define which elements are the responsibility of the NHS and which are the responsibility of social services?*
- PG62 *How does NHS-funded nursing care affect other funding for the care package such as from local authorities?*
- PG63 *Is there a national tool for assessing NHS-funded nursing care?*

Links to Other Policies

Links to mental health legislation

118. CCGs and LAs should be familiar with MHA 1983
119. s117 MHA aftercare is freestanding. LAs & CCGs should have local agreements on s117.
120. Where someone qualifies for services under s117 they should receive these particular services under this not under CHC.
121. There are no powers to charge for s117 - it is not necessary to assess eligibility for CHC where all the services fall under s117.
122. Someone with 117 needs may have/develop separate (physical health) needs and be eligible for CHC because of these.
- PG64 *What is the relationship between NHS continuing healthcare and section 117 after-care under the Mental Health Act?*
- PG65 *Is there any additional guidance on the relationship between NHS continuing healthcare and the Mental Health Act?*
- PG66 *Do we make NHS-funded Nursing Care payments for s.117 patients placed in nursing homes?*

Deprivation of liberty safeguards

123. MCA 2005 contains provisions for DOL - this doesn't affect consideration for CHC

Transition from child to adult services

124. CHC guidance only applies to those 18 or over.
125. Different legislation and responsibilities apply to children. The term 'continuing care' has different meanings for adults and children.
126. Transition planning should take account of *Transition: moving on well* and also *A transition guide for all services*
127. CCGs should be involved in strategic planning of transition services and adult CHC should be represented in individual transition planning meetings where person might be eligible for CHC when they reach adulthood.
128. Clarify future entitlement to CHC early in the transition process.
129. Children's services should first notify CCG re potential CHC eligibility when child is 14.
130. Formal referral for screening at age 16.
131. Determine CHC eligibility in principle at age 17.
132. Use Checklist and DST and usual CCG decision making process to establish eligibility prior to young person reaching 18.
133. If young person not eligible for CHC, notify them and also of their right to request IRP. CCG should still participate in transition planning process.
134. If young person is placed out of area, establish responsible commissioner at an early stage by reference to *Who Pays? Establishing the Responsible Commissioner*.
135. Even if not eligible for CHC young person may have needs that are the responsibility of the NHS.
136. Aim for consistency of provision in transition from child to adult services. No services should be unilaterally withdrawn without full assessment and alternative arrangements.
137. Legal responsibilities sometimes overlap between child and adult services - need to ensure clarity and no gaps. Adult CHC doesn't acquire early responsibility due to gaps.
138. For some young people services are treated as having been made under adult continuing care provisions. CCGs and LAs should monitor and actively participate in reviews

Review

139. Review after 3 months then at least annually. Refer to previously completed DST at review. Focus of review not just on CHC eligibility but also on whether needs being met.
140. Beneficial to do joint LA and CCG reviews - if both involved both need to do reviews.
141. Use Checklist when reviewing FNC to check for potential need for CHC assessment.
142. Review will determine whether needs have changed, whether package needs to be revised and whether funding responsibilities may need to change
143. No unilateral withdrawal of funding by LA or CCG without consultation and joint reassessment. If agencies can't agree, or if individual challenges, use disputes resolution procedures.
144. Carefully consider risks and benefits before change of location or support.
- PG67 *Is it necessary to complete a full Checklist and Decision Support Tool (DST) when carrying out a routine / annual review of NHS-funded Nursing Care?*

Dispute Resolution

Challenges to individual decisions

145. CCG has formal responsibility for informing individuals of decisions about CHC eligibility and right to request a review.
146. CCG should give clear reasons for its eligibility decision and explain the arrangements and timescales for dealing with a review of the eligibility decision.
147. Individual can apply for IRP if not happy with procedure or application of criteria, and local dispute resolution has failed. If Board has made original eligibility decision the IRP arrangements must avoid a conflict of interest.
148. If screened out using Checklist individual can ask CCG to reconsider, and if necessary pursue further through complaints process.
149. CCGs and NCB should deal promptly with request to review decisions.
150. Two stages of review are a) local resolution and b) request to Board.
151. Each CCG should agree and publish local review process, including timescales, and provide details of this in writing to anyone requesting review of eligibility decision.
152. Once local processes exhausted case should be referred to Board - in some cases Board might agree to IRP if local process would cause undue delay
153. Sets out key principles for dispute resolution procedures including: gathering all evidence; compiling identification of needs; audit of attempts to obtain records (if unavailable); full involvement of individual/representative; record of review panel deliberations; clear & evidenced written conclusions on process & outcome.
154. All parties should have access to relevant evidence to be considered under disputes procedure, though exceptionally there may be restrictions in sharing info - this needs discussion with chair or relevant disputes resolution body.
155. Not necessary for any party to be legal represented at IRP.
156. CCG should accept IRP recommendations in all but exceptional circumstances.
157. Next stage is referral to the Parliamentary and Health Service Ombudsman.
158. Rights to use (NHS or LA) complaints processes remain unaltered.
- PG68 *There are two different kinds of dispute that may arise in relation to NHS continuing healthcare.*
- PG69 *What issues should be considered at the Checklist stage of the decision-making process to avoid or resolve disputes?*
- PG70 *What issues should be considered at the DST stage of the decision-making process to avoid or resolve disputes?*
- PG71 *What factors need to be considered in local disputes processes?*

- PG72 *What if dispute crosses CCG/LA borders?*
 PG73 *What if the individual wants to challenge the final eligibility decision made by the CCG?*

Disputes regarding responsible body

159. LAs and CCGs should have dispute resolution processes re CHC and Joint Packages.
 160. *Who Pays?* Sets out how disputes between CCGs should be handled - there should be no gaps in provision whilst disputes resolved. [nb. *Who Pays* updated Dec 2012]
 PG74 *What can key agencies do to improve partnership working in relation to NHS Continuing Healthcare?*

Governance

161. Both CCGs and SHAs have governance responsibilities re CHC
 162. CCGs are responsible for: consistent application of national policy on CHC; promoting awareness of CHC; implementing good practice; ensuring quality standards are met; providing training opportunities; identifying and acting on issues relevant to CHC; making people available to sit on panels; informing commissioning.
 163. CCGs may find it helpful to have a system to record assessments, outcomes and costs
 164. NCB functions include strategic leadership; workforce development; ensuring local systems operate effectively; and holding CCGs accountable.
 165. Board also responsible for appointing IRP chairs and establishing list of IRP members.
 PG75 *What is the role of the CCG in relation to NHS continuing healthcare?*
 PG76 *What is the role of the LA in NHS continuing healthcare?*
 PG77 *What information is available to give to members of the public about NHS continuing healthcare?*

Commissioning, Care Planning and Provision

Provision

166. Care planning helps in deciding how to meet needs irrespective of CHC eligibility.
 167. For those eligible for CHC the package to be provided is decided by the CCG, but the LAs assessment of needs may be important in informing this.
 168. LA is not prevented from also providing services, particularly in community setting.
 169. CCGs and LAs should commission using models that maximise personalisation - particularly important where individual has previously received LA direct payments.
 170. CCGs and LAs should avoid unnecessary changes of provider just because responsible commissioner has changed
 171. Above approaches apply to full CHC and to joint packages

Equipment

172. Various routes explained by which people entitled to CHC might access equipment (from care home provider, joint equipment services, bespoke arrangements)

Access to other NHS-funded services

173. Those eligible for CHC are still entitled to the full range of NHS services
 174. Which CCG is responsible should be determined using *Who Pays?*
 175. CCGs need to ensure no gaps between community nursing and provision by care homes.
 PG78 *How should care planning be approached for a person entitled to NHS continuing healthcare?*
 PG79 *Who is responsible for equipment and adaptations if someone is eligible for NHS continuing healthcare and is in their own home?*
 PG80 *Case management.*

- PG81 *How should commissioning be approached for someone entitled to NHS continuing healthcare?*
- PG82 *Can a CCG use an external agency to carry out the commissioning of NHS continuing healthcare services or for negotiation with providers?*
- PG83 *What limits (if any) can be put on individual choice where, if followed, this would result in the CCG paying for a very expensive care arrangement? Under what circumstances can the CCG decline to provide care in the preferred setting of the individual?*
- PG84 *Gunter Case*
- PG85 *What are the responsibilities of CCGs and LAs when a person is supported in their own home?*
- PG86 *If a person is in receipt of NHS Continuing Healthcare are they entitled to any local authority funding for social care?*
- PG87 *If someone receiving NHS Continuing Healthcare also receives some services from the local authority, will they be means tested and charged for these services?*
- PG88 *If someone has NHS Continuing Healthcare at home, does the CCG have to pay rent/mortgage, food and utility bills?*
- PG89 *What is the CCG role in relation to carers when someone is in receipt of NHS continuing healthcare?*
- PG90 *Can a personal health budget be used for people eligible for NHS continuing healthcare?*
- PG91 *What information and advice is available regarding the development of personalised commissioning and personal health budgets?*
- PG92 *What practical examples are there of how someone with a primary health need can have their needs met through a 'notional health budget'?*
- PG93 *What practical options are there for meeting the needs of someone eligible for NHS continuing healthcare by means of a 'real budget held by a third party'?*
- PG94 *Can the LA be an intermediary for a real personal health budget where the individual has been assessed as having a primary health need? If so, how?*
- PG95 *Can a local authority act as a 3rd party to administer direct payments to someone who has been deemed eligible for NHS continuing healthcare?*
- PG96 *Can an individual pay for additional services themselves in addition to their NHS continuing healthcare package?*
- PG97 *Example*
- PG98 *Example*
- PG99 *Can an individual 'top-up' their package to pay for higher-cost services or accommodation?*

PART 2 PRACTICE GUIDANCE

- PG1 **Is there an authoritative definition of beyond the 'responsibility of the local authority'?** No simple authoritative definition - a complex matter of statute and case law, including the Coughlan judgment. LAs can fund general nursing care provided it is both incidental & ancillary to the individual's accommodation and of a nature that an LA can be expected to provide.
- PG2 **What is the difference between a healthcare need and a social care need?** Provides lay person's explanation of this, pointing out that for CHC the CCG is responsible for both healthcare and social care needs.
- PG3 **What is a primary health need?** Starting point is limits of LA responsibility - as defined in Standing Rules Regulations (SRR). If needs taken in their totality are above LA limits then individual has Primary Health Need (PHN). Non-legal explanation given. *'In simple terms an individual has a primary health need if, having taken account of all their needs (following completion of the DST), 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'. PHN is not about the reason why someone needs care/support. Explanations of concepts of nature, intensity, complexity and unpredictability by way of the sort of questions under each that the MDT needs to be able to answer.

- PG4** **What are the key elements of a 'person-centred' approach in NHS continuing healthcare?**
Expands on the following elements:
- ensuring the individual is fully involved in the process;
 - taking full account of the individual's own views and wishes;
 - addressing communication needs;
- PG5** **What specific guidance is there in relation to dealing with confidentiality?** Quotes from NHS Code of Practice. Also explains need to make best interest decisions regarding sharing information when individual lacks capacity.
- PG6** **What happens if an individual with mental capacity refuses to give consent to being considered for NHS continuing healthcare eligibility?**
- Explain potential consequences to them
 - Deal with concerns (e.g. fear re loss of Direct Payments)
 - Refusal of consent doesn't give LA additional responsibilities. It may have to withdraw services
 - CCGs and LAs should consider developing joint protocol on process to be followed in such situations. Individual should be enabled to make informed decision on options
- PG7** **What if there are concerns that the individual may lack capacity to consent to the completion of a Checklist/DST?**
- Apply MCA principles
 - Presumption of capacity, consider communication needs first
 - Undertake and record 'capacity test'
 - If fluctuating capacity consider whether to delay seeking consent
 - CHC assessment is a welfare decision - need to make 'best interests' decision in consultation with relatives/friends but it is not up to them to decide unless have legal status to do so (personal welfare attorney/welfare deputy)
- PG8** **When is it appropriate to involve an Independent Mental Capacity Advocate (IMCA)?** An IMCA is not routinely required in CHC but appoint as soon as preliminary view taken that statutory criteria for IMCA might be met.
- PG9** **Whose responsibility is it to provide advocacy for individuals going through the eligibility decision-making process?** - Not LA or CCG member of staff. CCG should make individuals aware of advocacy services and consider strategic actions necessary to ensure advocacy is available.
- PG10** **Do individuals need to have equal representation during the NHS continuing healthcare eligibility process?** - Individuals can choose who they want as advocate but if that person is legally qualified he/she only has same status as any other advocate.
- PG11** **How should the well-managed need principle be applied?** Distinguish environmental causes from an effective support plan. Well managed needs are relevant, but not necessarily determinant, in decision-making process.
- PG12** **Dealing openly with issues of risk.** Assessment of risk central to MDT assessment. Evaluate both likelihood and potential impact of adverse occurrence. Individuals with capacity entitled to take risks. Principles of how professionals should approach this are

explained and reference made to '*Independence, choice and risk*' guidance. If individual lacks capacity need to follow principles of MCA.

- PG13** **How does NHS continuing healthcare fit with hospital discharge processes?** LAs, CCGs, NHS bodies and other providers should agree discharge policies and protocols. Distinction between involvement of LA in MDT process for CHC and referral to LA using Section 2 or 5 notices under Delayed Discharges legislation. Must rule out CHC before giving notice of delayed discharge, but LA should respond positively to referral for involvement in CHC. 5 potential scenarios for use of Checklist on discharge given.
- PG14** **How does NHS continuing healthcare link with intermediate care?** - CCGs should follow latest guidance on intermediate care. Emphasis on using intermediate care where people might be facing admission to long-term residential care, or may have inappropriate and/or extended admissions to acute care.
- PG15** **What is the NHS continuing healthcare Checklist?** Screening tool to identify who may need full consideration of eligibility for CHC
- PG16** **Does everyone need to have a Checklist completed?** No, but take reasonable steps to assess for CHC if it appears it may be necessary. Can't use any other screening tool.
- PG17** **Who can complete a Checklist?** - variety of health and social care practitioners - each LA and CCG needs to identify who can complete locally but these people should be trained in its use.
- PG18** **When should a Checklist be completed if the individual is in hospital?** When needs on discharge clear, though general caution against completing in hospital unless longer term needs are clear. Consider other NHS funded care to maximise abilities first.
- PG19** **When should the Checklist be completed if the individual is in the community or in a care setting other than hospital?** As part of community care assessment, or at a review, or when there has been a change in needs, or any other circumstances suggesting potential eligibility for CHC.
- PG20** **Who needs to be present when a Checklist is completed?** - allow time for individual (who should normally be present) and/or rep to be involved where possible. Tell individual they can have an advocate or other rep present.
- PG21** **What information needs to be given to the individual when completing a Checklist?** Give DH leaflet, explain process and be clear on what Checklist signifies, give completed Checklist to individual, advise of right to complain/seek review.
- PG22** **What should happen once the Checklist has been completed?** Send Checklist to CCG by fastest secure way. Inform individual of outcome of Checklist and give copy to them. Good practice to send negative and positive Checklists to CCG.
- PG23** **What evidence is required for completion of the Checklist?** Not necessary to submit detailed evidence but record references to evidence and give rationale.
- PG24** **Can registered nurses in care homes complete a Checklist Tool?** Home should ask CCG to complete Checklist unless protocol in place for a different arrangement.
- PG25** **Can someone self-refer by completing a Checklist themselves?** No
- PG26** **What is the role of the NHS continuing healthcare coordinator?**
- Receive and action referral
 - Identify and secure involvement of MDT members
 - Help MDT members understand their role and decide what assessments are needed.
 - Support individual to play full role in process
 - Manage timetable (28 days - calendar not working days)
 - Ensure compliance with framework, including proper eligibility recommendation etc.

- PG27 • Be impartial resource to MDT and ensure recommendation sent to CCG in good time
Why isn't the DST an assessment tool? Different purposes involved - DST not designed as assessment tool. It is a national tool that should not be altered.
- PG28 **What are the elements of a good multidisciplinary assessment?** Preceded by consent, proportionate, person-centred, drawing on info from those directly involved, holistic, taking account of different views and impact on others, focused on outcomes, evidence based, clear about risks etc. cf Single Assessment Process and Common Assessment Framework.
- PG29 **Potential Sources of Information/Evidence (not an exhaustive list):**List of potential sources of information provided.
- PG30 **What is a multidisciplinary team in the context of NHS continuing healthcare?** Minimum 2 professionals from different healthcare professions or one from health and one from social care. Strong push on involvement of social care alongside health professional(s) - staff involved should be knowledgeable about individual's needs. List of potential MDT members provided. Individual and/or rep should be fully involved.
- PG31 **What happens if the coordinator is unable to engage relevant professionals to attend an MDT meeting?** Must have MDT recommendation, normally based on face-to-face meeting. If face-to-face not possible find other ways of involving key professional(s) e.g. through teleconference, written info etc. Meaningful MDT discussion about correct recommendation is crucial.
- PG32 **Where should an MDT meeting take place?** Anywhere appropriate but as close to individual as possible to allow them and those caring for them to participate.
- PG33 **What process should be used by MDTs to ensure consistency when completing the DST?** Following elements cited:

 - Gather info in advance
 - Explain role of MDT to individual and encourage participation
 - Discuss evidence at face-to-face MDT mtg (wherever poss.)
 - Complete text boxes first then choose domain level
 - Discuss findings in terms of nature, intensity, complexity, unpredictability
 - Agree recommendation (can do this bit without individual concerned present)
 - Present recommendation to CCG
 - If recommendation (exceptionally) isn't accepted by CCG can refer back to MDT
 - Decision communicated in writing to individual asap
- PG34 **What is proportionate and reasonable in terms of evidence required to support domain levels and the recommendation in a DST?** Depends on case but remember purpose is to ensure accurate picture not convince court of law of veracity. It's quality of evidence not volume that counts. Borderline cases may need more evidence. Consider using 24/48 hour care diary. Don't disregard oral evidence if pertinent.
- PG35 **What happens if MDT members can't agree on the levels within the domains of the DST?** Clarifies 'move to higher level' rule in terms of evidence needed for this - shouldn't be used to artificially steer towards decision of eligibility where this is not justified. Record any disagreements. CCG should monitor patterns around this.
- PG36 **What happens if the individual concerned or their representative disagrees with any domain level when the DST is completed?** Discuss, record, take full account of individual's view etc, but individual is not member of MDT and it is up to MDT to agree on domain levels.

- PG37** **What does DST recommendation need to cover?** Summary of needs including individual's views. Provide statements about the 4 aspects (nature, intensity, complexity, unpredictability) and how needs interact across domains. Make recommendation with reference to the 4 aspects (but note any one could indicate PHN). Rationale for recommendation must be clear. Possibly also indicate factors to consider when arranging care for the individual. Take account of deterioration in making eligibility recommendation - if necessary recommend early review. Remember that individual will receive a copy of DST.
- PG38** **How does the DST and primary health need eligibility test apply to people with learning disabilities?** Framework & DST for all adults; PHN based on balance of need once all needs assessed; eligibility based on needs not based on diagnosis or inputs; important to involve people with expertise in LD in assessment process; check whether existing commitment of NHS funding applies (e.g. following campus closure); apply *Valuing People* principles to commissioning (whoever funds); consider where best to secure skilled case management.
- PG39** **If the CCG uses a panel as part of the decision-making process what should its function be and how should it operate?** Don't have to have panel but if do then it can verify recommendation on eligibility made by the MDT, examine whether DST correctly completed, consider whether evidence supports recommendation and refer back if not (or if no recommendation), ensure consistency and quality of decision making. It can't gatekeep money, complete or change DSTs, or overturn recommendations. If have panels best to use selectively e.g. for: auditing 'no' recommendations; considering cases where LA and CCG disagree; considering cases where individual disagrees; examining sample of 'yes' cases for auditing etc.
- PG40** **What should role of CCG decision-making process be?** Verify & confirm MDT recommendations, agree actions where concerns arise, but not gatekeeping, completing/altering DSTs, overturning recommendations. Can refer back to MDT in exceptional circumstances.
- PG41** **What are the 'exceptional circumstances' under which a panel might overturn an MDT recommendation regarding eligibility for NHS continuing healthcare?** - If DST not complete, no recommendation made, significant gaps in evidence, obvious mismatch between evidence & recommendation, or where recommendation would result in either LA or CCG acting unlawfully.
- PG42** **How should decisions be communicated to the individual/representative?**
In writing asap, including reasons and details of how to request review of decision. Best to send DST with covering letter
- PG43** **If a person dies whilst awaiting a decision on CHC eligibility, should a decision still be made in respect of eligibility for the period before their death?** Only if this might affect who pays for care prior to death.
- PG44** **In a Fast Track case is it the CCG or the 'appropriate clinician' who decides that the individual has a primary health need?** If rapid deterioration + possible terminal phase then PHN criteria met if appropriate clinician says so. No other test required.
- PG45** **Who can complete the Fast Track Pathway Tool?** - 'appropriate clinicians' as defined Regulations.
- PG46** **What is the relationship between the Fast Track Pathway Tool and the Checklist/DST?** - If using Fast Track no need for Checklist or DST, but use DST if considering taking 'fast tracked' individual off CHC.

- PG47** Do individuals need to consent to a Fast Track Pathway Tool being completed? - Yes, but if unable to provide consent apply MCA and make best interest decision.
- PG48** Is the use of the Fast Track Pathway Tool dependent on specific timescales in relation to end of life care? - No, and don't interpret 'rapidly deteriorating' too narrowly.
- PG49** What evidence is required when completing the Fast Track Pathway Tool? - Don't have to provide evidence, completed tool is sufficient evidence, but it can be helpful to provide information to inform package etc.
- PG50** Can a CCG refuse to accept a completed Fast Track Pathway Tool? - Basically, no.
- PG51** What actions can CCGs take if the Fast Track Pathway Tool is being used inappropriately? - Deal separately with clinicians in question - possibly offer training, or use management action, or address through contracting/performance routes.
- PG52** How quickly could a hospital discharge take place following the completion of the Fast Track Tool? Action should be taken urgently to agree and implement care package - normally within 48 hours.
- PG53** What settings can a Fast Track Pathway Tool be used in? Normally hospital but could be anywhere, including person's own home, a care home or hospice. Point is to get necessary support in place asap.
- PG54** Does the Fast Track tool need to be completed if the individual is already receiving a care package which appears could still meet their needs? Yes.
- PG55** Should individuals receiving care via the Fast Track Pathway Tool have their eligibility for NHS continuing healthcare reviewed? Important to review care arrangements, but only review CHC eligibility in particular cases, and sensitively.
- PG56** Can the national tools be changed? No.
- PG57** Why is it important to complete the equality monitoring forms with the tools? To help CCGs identify whether individuals from different groups are accessing CHC on an equitable basis.
- PG58** What are Joint Packages of care? - If individual doesn't have PHN then might need joint package where they have healthcare needs which LA can't meet. Could take form of additional direct health services, the CCG commissioning care/services to support the package, or transferring funding to the LA. Joint packages can be in any setting. In a care home NHS contribution may need to go beyond NHS-funded nursing care level.
- PG59** Practice example - Joint Package of Care
- PG60** Does NHS-funded Nursing Care cover the entire cost of a person's nursing needs? No, it's a contribution towards the cost of services provided by a registered nurse.
- PG61** In a joint package does the DST define which elements are the responsibility of the NHS and which are the responsibility of social services? No. LA and CCG need to decide how they are going to apportion costs and should agree protocols for this.
- PG62** How does NHS-funded nursing care affect other funding for the care package such as from local authorities? Depends on how care home fee is shared between NHS, the resident and/or the LA.
- PG63** Is there a national tool for assessing NHS-funded nursing care? See Annex of NHS-funded Nursing Care Practice Guide.
- PG64** What is the relationship between NHS continuing healthcare and section 117 after-care under the Mental Health Act? s117 needs are dealt with under s117 not CHC. CCG and LA should have local agreement in place. Preferable to separate CHC and s117 budgets.

- PG65** **Is there any additional guidance on the relationship between NHS continuing healthcare and the Mental Health Act 1983?** Arrangements under the MHA are separate and different from CHC and the two should not be confused. The above particularly deals with s117, but the same principles apply where an individual is subject to s17 leave or to a s17a Supervised Community Treatment Order.
- PG66** **Do we make NHS-funded Nursing Care payments for s117 patients placed in nursing homes?** Yes.
- PG67** **Is it necessary to complete a full Checklist and DST when carrying out a routine/annual review of NHS-funded Nursing Care?** Not necessary to redo full DST if previously done and needs haven't changed.
- PG68** **There are two different kinds of dispute that may arise in relation to NHS continuing healthcare:** a) Disputes between CCG & LA b) Challenges by individual/representative. Note that challenge from someone who doesn't have LPA or deputy status might still need to be acted on depending on the individual's views (if they have capacity) or best interest decision (if individual lacks capacity).
- PG69** **What issues should be considered at the Checklist stage of the decision-making process to avoid or resolve disputes?** Checklist has deliberately low threshold, should be actioned by CCG. If individual challenges CCG should give this prompt consideration and a response given in writing - if individual still dissatisfied can use complaints process. CCG can at any stage do another Checklist or go straight to full DST.
- PG70** **What issues should be considered at DST stage of the decision-making process to avoid or resolve disputes?** Follow DST user notes and this Guidance, work in partnership, but ultimately organisations can use formal disputes process (as required by SRR). Where individual/rep has concerns take time to discuss with them and record any remaining disagreements.
- PG71** **What factors need to be considered in local disputes processes?** Clear levels of escalation and ultimately a level at which the matter has to be resolved - could choose to refer to another CCG as final arbiter. CCG should monitor disputes.
- PG72** **What if dispute crosses CCG/LA borders?** If between LA and CCG apply local dispute process which applies to the CCG. If between two CCGs apply dispute process of CCG where individual residing at outset of decision-making process.
- PG73** **What if the individual wants to challenge the final eligibility decision made by the CCG?** Individual can go to Independent Review Panel (IRP) but CCG should work with individual and exhaust local resolution processes first. May need agreed processes to resolve disputes which are outside the remit of IRPs.
- PG74** **What can key agencies do to improve partnership working in relation to NHS Continuing Healthcare?** Lists key actions including: adopting similar approaches to commissioning; similar approaches to risk and enablement; supporting staff in best practice and in being open/honest with each other; practitioners respecting each other's professional judgement, dealing correctly with disagreements and being clear on what can be commissioned by their respective organisations; joint training etc.
- PG75** **What is the role of the CCG re NHS continuing healthcare?**
- CCG lead (but also role for LA)
 - Expands key responsibilities of CCGs re: Ensuring consistency; Promoting awareness; Maintaining good practice; Quality standards; Training and development opportunities; Identifying and acting on issues; Informing commissioning arrangements
- PG76** **What is the role of the LA in NHS continuing healthcare?**

SRRs require CCG to consult with LA (where practicable) before deciding CHC eligibility, and LAs must provide advice & assistance to the CCG. The roles that a LA should undertake as part of this duty include:

- Fielding staff for MDTs (including where the individual is a self-funder).
- Contributing to eligibility panels (where these exist) and participating in the decision-making process on eligibility.
- Making staff available to undertake joint reviews
- Having systems for responding promptly to requests for information when the CCG has received a referral for CHC
- Working jointly with CCGs in the planning and commissioning of care for individuals deemed eligible for CHC where appropriate, sharing expertise and local knowledge.
- Make staff available to be members of SHA Independent Review Panels

PG77 **What information is available to members of the public about NHS continuing healthcare?** DH Public Information Leaflet which CCGs are responsible for making available to public. Some areas also have local leaflets.

PG78 **How should care planning be approached for a person entitled to NHS continuing healthcare?** Link commissioning to intended outcomes in (regularly reviewed) individual care plan. Follow guidance in '*Supporting People with Long-Term Conditions; Commissioning Personalised Care Planning. A Guide for Commissioners*'. Amongst other things care planning should put individual at heart of process, maximise choice and control, and be focused on outcomes.

PG79 **Who is responsible for equipment and adaptations if someone is eligible for NHS continuing healthcare and is in their own home?** Individuals eligible for CHC should have access to joint equipment services, and funding agreements between LA and CCG for this should reflect that NHS is responsible for meeting support needs of these individuals. Disabled Facilities Grants (DFGs) (means tested grants) may be available for housing adaptations. There are overlapping powers/responsibilities that housing authorities, CCGs and LAs have to provide additional support where needed. Local protocols should be in place to deal with situations where someone subject to CHC has a need for housing adaptation, although '*CCGs should first consider whether the responsibility to meet a specific need lies with them as part of the NHS continuing healthcare responsibilities.*'

PG80 **Case management.** This is a CCG responsibility for people in receipt of CHC. Core elements include: ensuring suitable care plan in place; ensuring care/support meets needs and delivers intended outcomes; ensure any non-NHS services which are part of the package are working effectively; monitoring quality of care and responding to concerns; acting as link person to co-ordinate services; ensuring changes in needs are addressed; reviewing regularly (and when needed);

PG81 **How should commissioning be approached for someone entitled to NHS continuing healthcare?** CCGs have responsibilities both at strategic and individual level. General encouragement to work closely with LA. Need clarity on roles of commissioners and providers, and bear in mind those in receipt of CHC should still have access to the full range of other statutory and locally provided services. Emphasis on maximising personalisation.

PG82 **Can a CCG use an external agency to carry out the commissioning of NHS continuing healthcare services or for negotiation with providers?** Yes, but only under proper and clear agreements, and in any event the CCG retains ultimate responsibility.

- PG83** What limits (if any) can be put on individual choice where, if followed, this would result in the CCG paying for a very expensive care arrangement? Under what circumstances can the CCG decline to provide care in the preferred setting of the individual? CCG can consider best use of resources. Start with preferences, if more expensive cost comparison has to be fair in terms of cost-effectiveness etc. Should maximise choice etc. and CCG should be clear and careful in their reasoning if refusing the person's preferred place/model of care. Factors to consider are listed. Gunter case cited re relevance of Article 8 of European Convention on Human Rights.
- PG84** **Gunter Case**
- PG85** What are the responsibilities of CCGs and LAs when a person is supported in their own home? CCG remains financially responsible for all health, personal care services and associated social care services to support assessed health and social care needs. However, there may be 'additional community care needs' which LA may need to address e.g. support with essential parenting activities, support to access other community facilities, carer support services etc. CCGs and LAs have some overlapping powers in such situations so rigid rules are not appropriate and a partnership approach, underpinned by local protocols, is required. Key questions to inform decision making in individual circumstances include:
- a) is this service part of the support plan necessary to meet the individual's assessed health personal care and associated social care needs?
 - b) what support is it necessary for the CCG to fund/provide in order for the individual to access essential services?
 - c) what responsibilities do other organisations/agencies have to enable the person to access the service?
 - d) what would happen if the CCG did not fund/provide the service in question - what would the outcome be?
- PG86** If a person is in receipt of NHS Continuing Healthcare are they entitled to any local authority funding for social care? LA can't provide community care services to anyone funded by CHC in a care home (but may have wider role around safeguarding etc). If individual in home see PG85 above.
- PG87** If someone receiving NHS Continuing Healthcare also receives some services from the local authority, will they be means tested and charged for these services? Yes, the LA may use its powers to charge.
- PG88** If someone has NHS Continuing Healthcare at home, does the CCG have to pay rent/mortgage, food and utility bills? No.
- PG89** What is the CCG role in relation to carers when someone is in receipt of NHS continuing healthcare? CCG should consider any training needs of carers and may need to provide care for the individual so that the carer can have a break. Possibly refer to LA for separate carer assessment.
- PG90** Can a personal health budget be used for people eligible for NHS continuing healthcare? Yes. Could be a notional budget held by the CCG, a budget managed on the individual's behalf by a 3rd party or, in those CCGs which are pilot sites, a 'healthcare direct payment'.
- PG91** What information and advice is available regarding the development of personalised commissioning and personal health budgets? Advice & info is available via the personal health budgets learning network website.

- PG92** What practical examples are there of how someone with a primary health need can have their needs met through a 'notional health budget'? Case example given.
- PG93** What practical options are there for meeting the needs of someone eligible for NHS continuing healthcare by means of a 'real personal budget held by a third party'? Case example given.
- PG94** Can the LA be intermediary for real personal health budget if individual is in receipt of CHC? LAs and CCGs should work closely together and make proper use of pooled budget and joint funding arrangements. However, health and social care legislation currently prevents CCGs from passing health money over to LAs to use as an LA direct payment to purchase healthcare.
- PG95** Can a local authority act as a 3rd party to administer direct payments to someone who has been deemed eligible for NHS Continuing Healthcare? Only if the CCG has been authorised to make direct payments for healthcare and if a formal agreement between the CCG and LA is in place.
- PG96** Can an individual pay for additional services themselves in addition to their NHS-funded care package? Summarises 2009 'additional private care' guidance which says tops ups are OK in some situations where there is genuine 'separation' but NHS must fully meet its obligations as a free universal service. Case examples are given as **PG97** and **PG98**
- PG99** Can an individual 'top-up' their care package to pay for higher-cost services or accommodation? Funding provided by CCGs should be sufficient to meet identified needs. *'Unless it is possible to separately identify and deliver the NHS-funded elements of the service, it will not usually be permissible for individuals to pay for higher-cost services and/or accommodation (as distinct from purchasing additional services).'* Topping up by 3rd party is legally permissible where LA is funding but not under NHS legislation. CCG should think carefully before moving someone on cost grounds - e.g. consider risks to health involved in moving them.

Annex A: Glossary

Annex B: The Coughlan Judgment

Annex C: The Grogan Judgment

Annex D: Determining the Need for NHS-funded Nursing Care

Annex E: Independent review Panel Procedures

Annex F: Guidance on responsibilities when a decision on NHS Continuing Healthcare eligibility is awaited or is disputed.

Annex G: Local NHS Continuing Healthcare Protocols

Annex H: Guidance on Time Limits for Reviews of Eligibility Decisions