directors of adass
adult social services

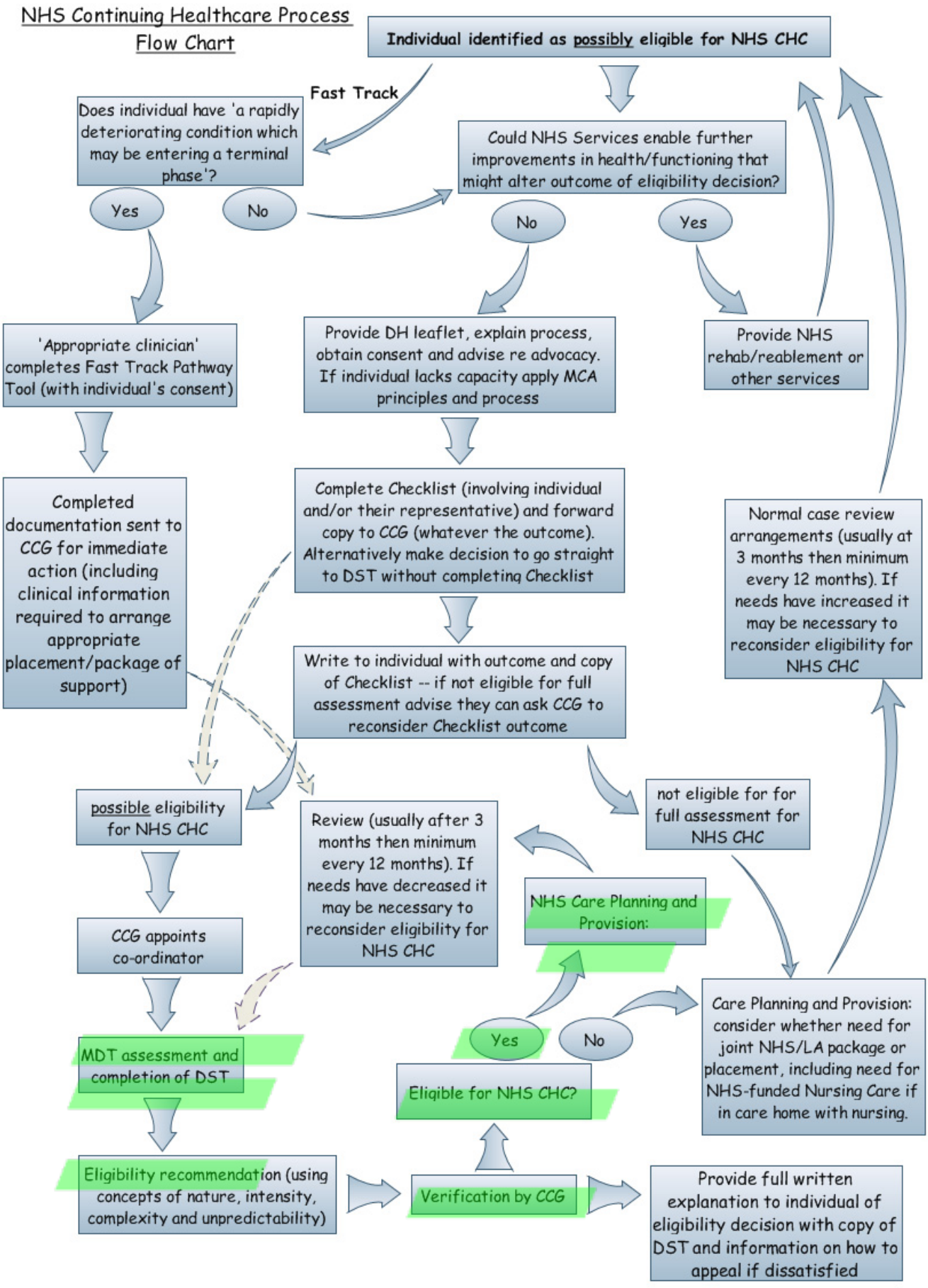
NHS England

NHS Continuing Healthcare

Guide for Health and Social Care practitioners

Ensuring a consistent person-centred assessment

September 2014


NHS Continuing Healthcare Process Flow Chart
Individual identified as possibly eligible for NHS CHC
Fast Track
Does individual have 'a rapidly deteriorating condition which may be entering a terminal phase'?
Could NHS Services enable further improvements in health/functioning that might alter outcome of eligibility decision?
Yes
No
No
Yes
'Appropriate clinician' completes Fast Track Pathway Tool (with individual's consent)
Provide DH leaflet, explain process, obtain consent and advise re advocacy. If individual lacks capacity apply MCA principles and process
Provide NHS rehab/reablement or other services
Completed documentation sent to CCG for immediate action (including clinical information required to arrange appropriate placement/package of support)
Complete Checklist (involving individual and/or their representative) and forward copy to CCG (whatever the outcome). Alternatively make decision to go straight to DST without completing Checklist
Normal case review arrangements (usually at 3 months then minimum every 12 months). If needs have increased it may be necessary to reconsider eligibility for NHS CHC
Write to individual with outcome and copy of Checklist -- if not eligible for full assessment advise they can ask CCG to reconsider Checklist outcome
possible eligibility for NHS CHC
Review (usually after 3 months then minimum every 12 months). If needs have decreased it may be necessary to reconsider eligibility for NHS CHC
not eligible for for full assessment for NHS CHC
NHS Care Planning and Provision:
CCG appoints co-ordinator
MDT assessment and completion of DST
Yes
No
Care Planning and Provision: consider whether need for joint NHS/LA package or placement, including need for NHS-funded Nursing Care if in care home with nursing.
Eligible for NHS CHC?
Eligibility recommendation (using concepts of nature, intensity, complexity and unpredictability)
Verification by CCG
Provide full written explanation to individual of eligibility decision with copy of DST and information on how to appeal if dissatisfied

1 INTRODUCTION

1.1 This document is intended to ensure that staff have the basic operational information they need to carry out their responsibilities in relation to NHS Continuing Healthcare. It is not a substitute for reading the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (revised)* and the user notes contained within the associated tools. A full list of relevant documents with hyperlinks is given in Appendix A of this guide. [Unless otherwise stated references given in this guide are to paragraphs in the National Framework].

1.2 This guide briefly describes the NHS Continuing Healthcare process as relevant to staff employed in health and social care agencies in England. Its purpose is to support a consistent, fair and thorough implementation of the Framework across all local authorities (LAs) and clinical commissioning groups (CCGs).

1.3 CCGs have the lead responsibility for NHS Continuing Healthcare. Many CCGs have entered into contracts with Commissioning Support Units (CSUs), and some have contracted with LAs, to undertake some of the NHS Continuing Healthcare responsibilities on their behalf. In this guide CCG refers to the CCG itself or any other organisation authorised to act on its behalf in relation to NHS Continuing Healthcare functions.

2 THE NATIONAL FRAMEWORK

2.1 The dividing line between care that local authorities can lawfully provide and the care that the NHS should provide is governed by complex statute and case law and can be difficult to define. Many people have ongoing care needs as a result of disability, accident or illness. Individuals requiring ongoing support to meet such needs might receive any or all of the following:-

- Support from friends and family (usually this is unpaid support).
- Care, equipment or help that they choose and buy for themselves.
- Services from their local authority social services department (for example equipment, assistive technology, practical support in their own home, cash payments to allow them to buy their own support, or funding for a care home placement). The individual usually has to pay a charge towards the cost of local authority social services support.
- Help from the NHS, for example medical treatment, therapy, equipment, assistive technology, and nursing services to help them deal with their condition. Apart from a few specific charges (e.g. prescription charges) NHS help is free at the point of delivery.

2.2 For some people in England, however, their need for ongoing nursing and healthcare support is of such a level that they qualify for all their care needs to be met by the NHS, including those personal and social care needs which might otherwise be met by social services. This is **'NHS Continuing Healthcare'** (NHS CHC) and is care for adults aged 18 or over which is arranged and funded solely by the NHS, and is therefore free at point of delivery to the individual concerned. NHS CHC might take the form of a care home placement, or a package of care in the individual's own

home or elsewhere, or a Personal Health Budget (PHB) which might be administered as a 'direct payment for healthcare'.

2.3 Local authorities are not able to provide community care services to anyone in a care home who gets NHS CHC (although they still have a role in relation to their wider responsibilities such as safeguarding vulnerable adults and 'deprivation of liberty safeguards'). Where an individual is in receipt of NHS CHC but is living in their own home the NHS is still responsible for meeting all nursing and personal care needs and associated social care needs but there may be other needs that the local authority can help with e.g. carer support and support with parenting [for fuller information see paragraph PG 85 in the National Framework].

2.4 Over many years eligibility for NHS CHC has been the subject of confusion and controversy. Historically there were different criteria for NHS CHC in each health authority area of the country. In 2007, for the first time, a *National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care* was introduced, which was reviewed and updated in 2009 and again in 2012. The Framework and its associated national 'tools' are underpinned by legally binding Directions and Standing Rules. The Framework provides a single national process for determining eligibility for NHS Continuing Healthcare and has done much to improve fairness and consistency across England. There are three tools associated with the Framework which must be used (unaltered) throughout England:-

a) The *Fast Track Pathway Tool for NHS Continuing Healthcare November 2012 (Revised)* can only be completed by 'an appropriate clinician' where someone is in need of NHS CHC because they have 'a rapidly deteriorating condition, which may be entering a terminal phase.' In these specific circumstances the completion of the Fast Track Tool is sufficient for the individual to be accepted as having a 'primary health need'. The term 'primary health need' is explained below but is a concept developed to help determine whether someone is eligible for full NHS funding for their care needs.

b) The *NHS Continuing Healthcare Checklist November 2012 (Revised)* is a screening tool used to establish whether an individual (who does not meet the criteria for fast tracking) requires full consideration of eligibility for NHS CHC. This is simply referred to as the 'Checklist'. Any member of staff identified by the local authority or the NHS as having a role suitable for completing the Checklist can do so, provided they have received the relevant training [PG 17]. Nurses employed by independent sector nursing homes may complete Checklists only if an agreement is in place to this effect between the home and the CCG. Otherwise a request should be made to the CCG for a Checklist to be completed [PG 24].

c) The *Decision Support Tool for NHS Continuing Healthcare November 2012 (Revised)* – this is known as the 'DST', and must be completed if someone crosses the Checklist threshold for consideration of NHS CHC (unless the Fast Track Pathway Tool is applicable). It is not an assessment in itself but is used to collate assessment information regarding the individual's care needs. It uses 12 care 'domains' to assist in making the decision on eligibility for NHS CHC. The DST is completed by the Multi-Disciplinary Team (MDT), which is defined in the Framework Glossary as '*A team of at least two professionals, usually from both*

the health and the social care disciplines. It does not refer only to an existing multidisciplinary team, such as an ongoing team based in a hospital ward. It should include those who have an up-to-date knowledge of the individual's needs, potential and aspirations.' Strictly speaking a minimum of two professionals who are from different healthcare professions could form the MDT, or it could be a minimum of one healthcare professional and one social care practitioner, but the Framework strongly encourages the involvement of both health and social care colleagues in the MDT.

3 ELIGIBILITY FOR NHS CONTINUING HEALTHCARE

3.1 CCGs have the lead responsibility for NHS CHC in their locality. Although eligibility for NHS CHC is ultimately a CCG decision following an MDT recommendation (see 5.5 below), Directions, Standing Rules and Guidance require the LA to be consulted and closely involved in the decision making process. LAs must work with NHS colleagues to share information and jointly assess the needs of the individual wherever practicable. Good partnership working is essential to ensure that the individual's rights are respected and their needs addressed.

3.2 Where someone is found to have a '**primary health need'** then the CCG must decide that they are eligible for NHS CHC. The concept of 'primary health need' is not straightforward and is not clearly defined in law. The National Framework [PG 3] explains this as follows:-

'*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'*

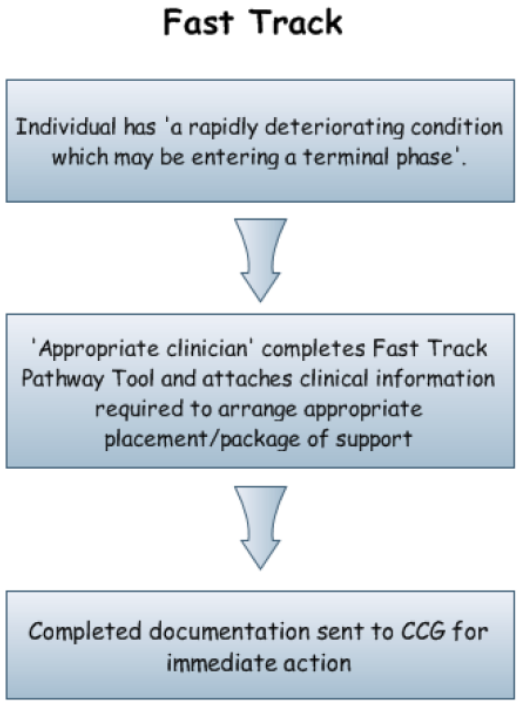
Primary health need is not about the reason why someone requires care or support, nor is it based on their diagnosis; it is about their overall actual day-to-day care needs taken in their totality....'

3.3 However, because there is a legal upper limit to the amount of general nursing/healthcare that local authorities are allowed to provide (and charge for), and because the government has decided that there must not be a gap between what the LA **can** provide and what the NHS **will** provide, decisions on 'primary health need' have to take account of the limits of local authority responsibility. In simple terms the court in the *Coughlan Judgment* said that LAs could provide/purchase some nursing care (in a broad sense, not just registered nursing) or other healthcare services but only in situations where these did not form a major part of the care that the individual required, and so long as the tasks involved were the sorts of things that you would expect a social care organisation (rather than healthcare organisation) to do. Directions and Standing Rules Regulations set out that a person should be considered to have a primary health need if the nursing or other health services they require, when considered **in their totality**, are:-

'*(a) where that person is, or is to be, accommodated in relevant premises, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or*
(b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide'

3.4 In an attempt to make the concept of 'primary health need' clearer the Framework states that four characteristics of need, namely **'nature', 'intensity', 'complexity' and 'unpredictability'** '*may help determine whether the 'quality' or 'quantity' of care required is more than the limits of an LA's responsibilities, as outlined in Coughlan* [para 35 of the Framework]. These characteristics are explained in more detail in para 5.5 below.

Fast Track Pathway



3.5 An individual may also be eligible for NHS CHC because they have *'a rapidly deteriorating condition, which may be entering a terminal phase'*. In such situations the **Fast Track Pathway Tool** should be completed, but this can only be done by 'an appropriate clinician', defined in Standing Rules Regulations as '*a person who is—*
(a) responsible for the diagnosis, treatment or care of the person under the 2006 Act in respect of whom a Fast Track Pathway Tool is being completed, and
(b) a registered nurse or a registered medical practitioner'

3.6 Thus those completing the Fast Track Pathway Tool could include consultants, registrars, GPs or registered nurses. This includes relevant clinicians working in end of life care services within independent and voluntary sector organisations if their organisation is commissioned by the NHS to provide the service. Whoever the practitioner is, they should be knowledgeable about the individual's health needs, diagnosis, treatment or care and be able to provide reasons why the individual meets the conditions required for the fast-tracking decision.

3.7 When the CCG receives a Fast Track tool completed by an appropriate clinician it is obliged to accept that the individual eligible for NHS CHC without delay and without the need for a Checklist or DST to be completed. The CCG will then put in place the necessary support as soon as possible. **It is vital, therefore, that the tool is used correctly and only in those situations for which it was intended.** However, it should be noted that the Framework [PG 48] cautions against adopting a too narrow view of when the Fast Track should be used. There are no specified time limits for life expectancy regarding the use of the tool – 'rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining. The Fast Track Pathway was developed in order to avoid people who may well die soon, and whose needs are changing due to a rapidly deteriorating condition, having to experience delay in getting suitably funded care in place whilst the full assessment process for NHS CHC is carried out.

3.8 The appropriate clinician is not required to provide evidence alongside the completed Fast Track Tool in order for it to be actioned, but it should be supported by a prognosis and/or diagnosis if known. However, when care is not already in place, it is essential that sufficient clinical information is supplied to enable the appropriate placement/package of support to be identified.

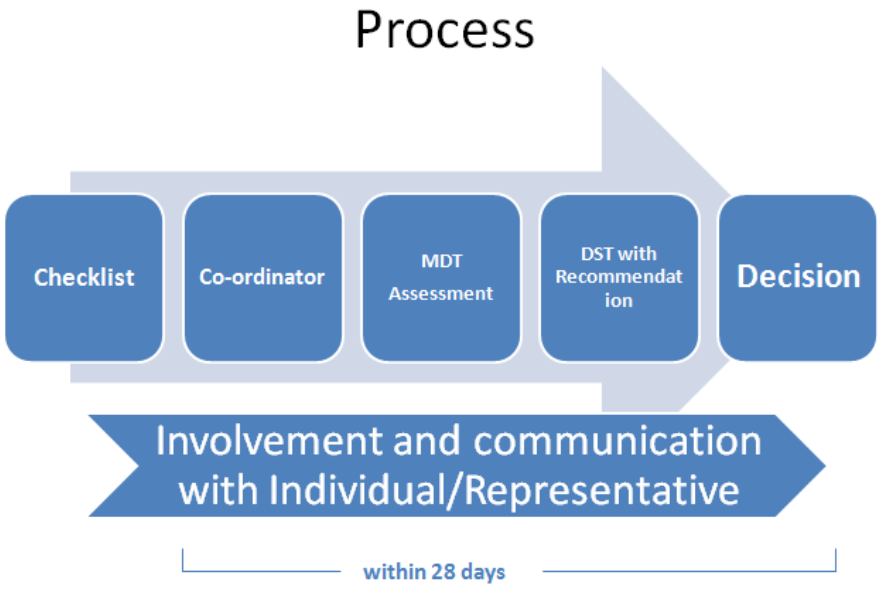
3.9 The appropriate clinician must take into account the practicalities involved in procuring the care package for the patient in Fast Track situations and not raise unrealistic expectations with the patient. This is particularly so where the needs are complex, the home situation is unclear or the request is being made at a weekend or bank holiday. Whilst funding can be agreed quickly it may not be possible to secure appropriate care immediately. It essential to liaise directly with the Continuing Care Team in such situations.

3.10 The Fast Track Tool should not be used instead of a full assessment just because of service pressures e.g. the need to discharge a patient from hospital, shortage of staff etc. It should always and only be used where the individual genuinely has a 'rapidly deteriorating condition which may be entering a terminal phase'.

3.11 Para 101 of the Framework explains that no one who has been identified through the fast-track process as eligible for NHS continuing healthcare should have this funding removed without their eligibility being reviewed in accordance with the correct review processes. This should include completion of a Decision Support Tool by a multidisciplinary team, and that team making a recommendation on future eligibility.

4 THE PROCESS (NON- FAST TRACK) – USE OF CHECKLIST

4.1 The individual (and/or their representative) should be informed and involved as fully as possible throughout the process, and their views sought and recorded at each stage.



Identifying potentially eligible patients/service users

4.2 Whilst there are many situations where it is not necessary to consider eligibility for NHS CHC, Standing Rules require CCGs to take reasonable steps to ensure that individuals are assessed for NHS CHC in all cases where it appears to them that there may be a need for such care. Therefore, unless it is clearly evident that the individual does not have a need for such care, health and social care staff should always consider using the Checklist:-

- At health or social care assessments and/or reviews where the individual has significant health needs
- Before any NHS-funded Nursing Care assessment (FNC), and at each FNC review
- Whenever an individual is placed in a care home
- When an individual is to be discharged from hospital (acute, community or mental health) and requires an ongoing placement or substantial package of care
- Whenever it appears that an individual may potentially be in need of NHS CHC

4.3 There may be occasions when a decision is made (with the individual's permission) to go straight to completing the DST without first undertaking the Checklist screening process. This might be because it is so clearly obvious that a full assessment for NHS CHC is required, or it might be because, for example, a local policy decision has been made to always undertake a full assessment for NHS CHC in certain circumstances, e.g. whenever someone moves directly from an acute hospital bed into long-term nursing home care. However, it is important not to deny someone a full assessment for NHS CHC on the grounds that the worker thinks they would not ultimately be found eligible - the use of the Checklist as a screening tool provides an important record for the organisation and the individual that NHS CHC has been considered.

Exceptions

a) **Section 117**. The main exception to the above is where the individual is subject to Section 117 of the Mental Health Act 1983 and solely requires care and support for his/her mental health aftercare needs. Section 117 applies after an individual has been the subject of a compulsory order under the Mental Health Act 1983 (usually section 3, but it could be a hospital order made under section 37, or a hospital direction made under section 45A or a transfer direction made under section 47 or 48). In such situations the NHS and LA have a statutory joint responsibility to arrange and fund the necessary support under the terms of their local arrangements for this. An individual subject to section 117 should only be considered for NHS CHC where they have significant healthcare needs which are not related to their mental health aftercare needs [see Framework 118-122].

n.b. Where an individual is subject to Section 17 leave or to a Section 17a Supervised Community Treatment Order their mental health after-care needs will normally be addressed under s117 powers and therefore similar approaches to the above should be used to determine the respective s117 and/or NHS continuing healthcare responsibilities. [For more information on s117 responsibilities see circular guidance HSC 2000/003 and the 2008 edition of the Code of Practice to the Mental Health Act 1983].

b) **Children and Young People under 18**. NHS CHC does not apply to children or young people under the age of 18 except as part of the planning process for transition as set out in the Framework paras 124 to 138.

Consent

4.4 Where the person has mental capacity (in relation to the relevant decision(s) and at this point in time) their informed consent should be sought for the NHS CHC process before completion of the Checklist (or, where relevant, before completion of the Fast Track Pathway Tool). It is good practice to seek consent for the whole process (i.e. the full assessment using the DST, should they screen in) at the same time as obtaining consent for the Checklist. The process and its implications should be explained to the individual/their representative and a copy of the DH Public Information Leaflet given to them (if they have not already seen this). When requesting consent to consider an individual's eligibility for NHS CHC, this should also include consent to obtain relevant health and social care records necessary to inform determination of eligibility and also consent for these to be shared appropriately with those involved in the eligibility process. A clear record should be kept to show that consent has been sought and what the outcome of this was [PG 5].

4.5 The **implications of the process** that should be explained before the Checklist is completed, include that:-

- Crossing the Checklist threshold doesn't mean that the individual is eligible for NHS CHC, only that they should be fully considered for this.
- If they do cross the Checklist threshold they will have a full MDT assessment to establish the level of their needs in order to determine whether they are eligible for NHS CHC.

- Whether or not they cross the Checklist threshold they will still have access to care and support as required.
- Whether or not they cross the Checklist threshold their circumstances and needs might change, so they may need to be reconsidered at a later stage.

4.6 The implications to be explained if the individual crosses the Checklist threshold include:-

- If found eligible for NHS CHC, they will receive care fully funded by the NHS and will not be liable for a charge for this care.
- NHS CHC can be provided in any appropriate setting and the care arrangements will be decided by the CCG in consultation with them.
- If they require care home accommodation the choice of placement may be limited by factors such as clinical need, risk assessment, location, capacity in the system and cost. The individual would need to discuss this with the CCG, who should provide advice, information and as much choice as possible.
- Where an individual is found eligible for NHS CHC but requires a package of support at home every effort will be made to accommodate their choices and preferences. This might include equipment and/or assistive technology as well as direct care. In such cases the CCG will consider, in discussion with the individual/their representative, the most appropriate package to meet the individual's needs, as the CCG will have ultimate responsibility for the arrangements. The assessor should avoid raising expectations in advance of discussion with the CCG.
- If they are currently in receipt of local authority Direct Payments, these will cease if found eligible for NHS CHC. However, anyone in receipt of NHS CHC has the right to ask for a Personal Health Budget (PHB) and from October 2014 has 'the right to have' a PHB. This can include them receiving a 'direct payment for healthcare' which is very similar to a direct payment for social care. The CCG will do all it can to ensure continuity of care and to make sure they have as much choice and control as possible.
- Eligibility for NHS CHC is not indefinite – if found eligible the individual's situation will be reviewed on a regular basis and it is possible that at some future point they will be found to be no longer eligible.
- Certain benefit payments are affected by whether or not they receive NHS CHC. For example, if the individual currently receives Attendance Allowance (AA) or Disability Living Allowance (DLA) and lives (or will be living) in a care home, these benefits will normally cease on the 29th day after the CCG starts funding care (or sooner if they have recently been in hospital). People getting AA or DLA who go into hospital or a care home that is funded by NHS CHC must notify the Attendance Allowance Unit or Disability Living Allowance Unit (phone 08457 123456). If the individual is in receipt of Independent Living Fund (ILF) payments, these will cease if they become eligible for NHS CHC. However, AA and DLA are not affected if they receive NHS CHC in their own home and the state pension is not affected by NHS CHC wherever they live.

4.7 It should be made clear to individuals that they can withdraw their consent to the process, or to sharing information, at any time, though the implications of them doing so must also be made clear as this could potentially affect the ability of the NHS and the LA to provide appropriate services [PG 6].

Mental Capacity

4.8 Where the individual appears to lack capacity the principles and processes specified in the Mental Capacity Act and associated Code of Practice apply [see paras 48 to 51 in the Framework]. In essence, if it is established that the individual lacks capacity (to make the relevant decision(s) at the time in question), and there is no-one who has been given legal power to make these decision on their behalf (i.e. a court appointed deputy or someone with Lasting Power of Attorney), then a 'best interest' decision must be made as to whether to embark on the process of determining eligibility for NHS CHC. The assumption is that in most cases it will be in the individual's best interest to do so, but each case must be judged on its merits [PG 7].

Advocacy

4.9 Anyone who is being considered for NHS CHC should be advised that they are entitled to nominate an advocate to represent their views or speak on their behalf. This could be a family member, friend, or someone independent who has an advocacy role, which might well be available from a not-for-profit organisation such as one of the national charities. Individuals do **not** need to have legal representation through the eligibility process but occasionally people choose to have a legally qualified person to act as their advocate. In such situations it is important to note that this legally qualified person has the same status in the process as any other advocate nominated by the individual concerned would have. Even if the advocate is a solicitor they are not acting as a legal representative in this context, they are acting as an advocate and are there to support the individual to play a full part in the process. The CCG should be able to advise on, or make a referral to, local advocacy services which can help ensure the individual receives impartial information and feels listened to and supported.

Referral using the Checklist

4.10 If an individual or their representative wishes to refer themselves for consideration of NHS CHC they shouldn't complete the Checklist themselves but instead ask the CCG to arrange for one to be completed for them. The Checklist should only be completed by NHS or LA staff who have been trained in its use. Exceptionally the CCG may have an arrangement with a nursing home for their staff to use the Checklist. However, if a professional who hasn't received training completes a Checklist appropriately, which indicates that the individual requires full consideration for NHS CHC, the CCG will act on this and arrange for a DST to be completed. Where the CCG receives a request to complete a Checklist it should normally act on this within 14 days [PG 25]. The Checklist must be based on a thorough assessment of the individual's needs, drawing on relevant and up to date evidence. Poor quality Checklists can waste a great deal of valuable time.

Timing of the Checklist

4.11 Where the individual is recovering from an acute episode the Checklist should be completed once longer-term needs are clear. Where the individual is in hospital and requires a placement/care package to enable safe discharge consideration should always be given to NHS CHC as part of the discharge planning process. However, if

there is potential for further rehabilitation or recovery which might make a difference to the level of independence achieved, consideration should be given to providing this rehab before undertaking the process of determining eligibility for NHS CHC. In such circumstances the Checklist should be completed when the rehabilitation programme has been completed. The 'delayed discharges' procedures (such as the issuing of section 2 and section 5 notices under the Community Care (Delayed Discharges etc.) Act 2003) are not triggered until the NHS body is satisfied that the relevant individual is not entitled to NHS CHC (this could be because they have not crossed the Checklist threshold or because, having crossed the Checklist threshold, the recommendation from the MDT, and the decision of the CCG, is that the individual is not eligible for NHS CHC). However, LAs should respond promptly and positively to requests to be involved in completing Checklists and participating in MDTs to consider eligibility for NHS CHC without the necessity for formal section 2 or section 5 notification under delayed discharges procedures.

Outcome of Checklist

4.12 Whatever the outcome of the Checklist it is best practice for a copy of it to be sent to the relevant CCG, preferably through secure email/electronic arrangements. If the Checklist indicates the need for full consideration of NHS CHC this consideration must be started as soon as possible bearing in mind that the whole process (from the CCG receiving the properly completed Checklist/referral to the eligibility decision) should normally be completed within 28 days.

4.13 Care should be taken to ensure the individual understands that crossing the Checklist threshold does not indicate that they will be found eligible for NHS CHC. If the Checklist indicates that full consideration of NHS CHC is not needed this should be recorded on the case record and the 'negative' Checklist forwarded to the CCG for monitoring purposes. Either way, the individual should be given a copy of the Checklist and informed in writing of the outcome [para 76 of Framework and para 23 of Checklist notes].

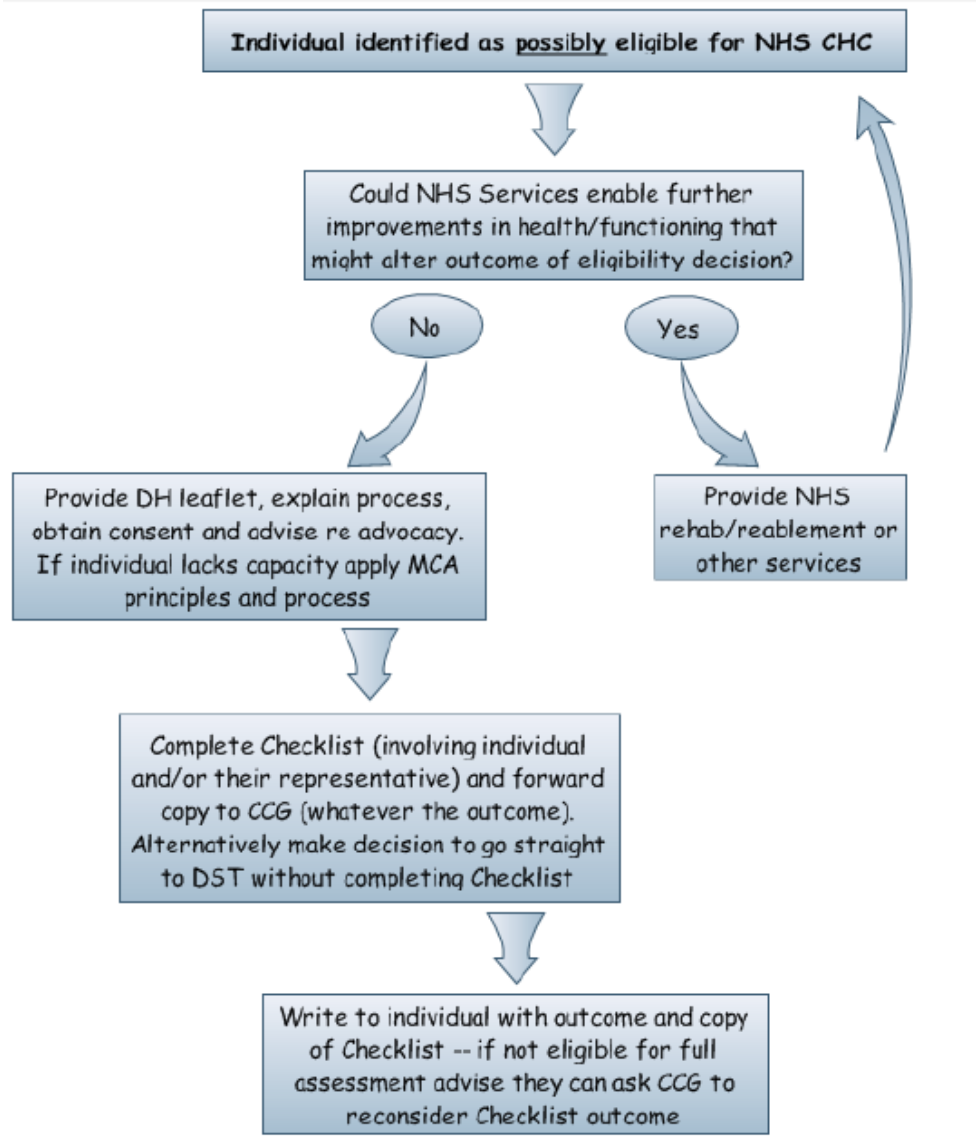
4.14 If the individual does not cross the Checklist threshold they should be told that they can ask for the CCG to review this decision. If they are to be placed in a care home with nursing they should have an assessment for NHS-funded nursing care.

4.15 The Checklist should include references to relevant evidence (e.g. citing an OT assessment or medical notes) and should include an overall explanation of why the individual should or should not be referred for full assessment of NHS CHC eligibility. However, it is not necessary to provide detailed evidence with the completed Checklist. If, exceptionally, the CCG receives a Checklist which is of particularly poor quality, it will treat it as a referral for a Checklist to be properly completed and discuss this with the relevant member of staff, offering training where necessary.

4.16 If a Checklist has been completed properly and indicates that the individual does not require full consideration of NHS CHC the individual can request a review of this decision. However, once the CCG has fully re-considered the situation, possibly by completing a further Checklist or full CHC assessment, then this will not normally be repeated again unless there is evidence of significant change in need. There is no formal requirement for the CCG to review negative Checklists, although if the

individual is in receipt of FNC the need for a full assessment for NHS CHC will be considered at each FNC review.

Flow Chart for use of Checklist



5 THE PROCESS – FULL CONSIDERATION OF ELIGIBILITY FOR NHS CHC USING THE DST

Appointing a Co-ordinator

5.1 Where an individual requires full consideration for NHS CHC (usually because they have crossed the Checklist threshold), the CCG should arrange for a 'co-ordinator' to be appointed. The role of the co-ordinator is set out in the Framework [PG 26] and in summary includes:-

- Receiving and acting upon the referral for consideration of eligibility for NHS CHC
- Identifying suitable MDT members and securing their involvement

- Helping MDT members understand their role and decide what assessments are needed
- Supporting the individual and their representatives to play a full role in the process
- Managing the timetable (the expectation is that eligibility decisions will normally be made within 28 calendar days of the referral being received by the CCG)
- Ensuring that all necessary reports have been provided to enable the MDT to assess all of the patient's care needs
- Ensuring compliance with framework
- Being an impartial resource to the MDT and ensuring that it makes a clearly reasoned recommendation which is sent to the CCG in good time

Points for the Co-ordinator to remember:

- Check where the individual is registered with a GP (if not from the local CCG then contact the relevant one)
- Check that consent is in place, both for undertaking the NHS CHC process and for sharing information
- Check whether the individual is subject to s117 or an order under the MHA
- Check whether there are specific communication issues re involvement of the individual
- Is a mental capacity assessment required?
- Ensure family/representative has genuine and realistic opportunity to be involved (and record attempts to involve them)
- Would the individual benefit from advocacy support?
- Are there existing care/support arrangements in place that could inform care planning if found eligible?
- Are any specialist assessments required?

The MDT

5.2 MDTs are formed every day when colleagues from different professions work together to assess and address people's needs. However, the MDT in relation to NHS CHC has a specific role and purpose, albeit that it might comprise the same professionals who would otherwise come together to work with the individual. An MDT in this context is specifically set up to consider and recommend eligibility or ineligibility of the individual for NHS CHC. MDTs should usually involve a colleague from social care alongside at least one nurse or other healthcare professional. Apart from a social care practitioner the MDT could involve a range of professionals including nurses, medics, allied health professionals or care staff. The LA will determine which of its staff are appropriate to be involved in MDTs but it is important that any such staff have received relevant training.

Assessment information required by the MDT

5.3 Guidance anticipates that the MDT will usually include professionals who already have direct knowledge of the individual, and who therefore will themselves have prepared or are in the process of preparing relevant assessment reports. However, often assessment information will be required from staff who are not formally part of the MDT and, where this is the case, such staff should normally supply their report within 7 days of it being requested. These reports should be provided to the co-ordinator within the time limit specified and should include the name and contact details of the assessor as well as the individual patient/service user's name and NHS number.

MDT Meeting and Completion of the DST

5.4 The Framework envisages that, for the purposes of completing the DST and making a recommendation regarding eligibility for NHS CHC, the MDT will normally hold a meeting at which the individual's needs are discussed, the appropriate weighting on each of the DST domains is decided, and an agreed eligibility decision is reached. In doing this the MDT will be drawing on the overall assessment of the individual's needs and on any relevant records and reports from professionals involved. The Framework requires a meaningful multidisciplinary discussion about the correct recommendation to be made. In any event, it is important to involve the individual and/or their representative as fully as possible in this process, though the CCG may decide not to have them present for the part of the meeting where the eligibility recommendation itself is discussed. The DST is set out in such a way that the evidence is recorded first in a text box before consideration is given to what this means in terms of the level of need (e.g. high, moderate, severe) given to that 'domain'. It is important to complete the DST in this way rather than attempt to pick the level of need first and fit the evidence to this. There are a number of points to remember in this process:-

- It is important to make this process as 'person-centred' as possible. Bear in mind that it can be very distressing for friends/relatives to hear about the details of their loved one's needs. It might be particularly difficult for them to hear about, for example, challenging behaviour. It might be helpful for them to have some preparatory explanation regarding the nature of the MDT meeting and the fact that the DST is solely focused on needs. It might also be helpful to discuss less contentious domains first (though 'other significant care needs' should always be left until the end in case there are significant needs that genuinely could not be reflected in the other 11 domains).
- The MDT is reliant on having good quality evidence-based assessments and clinical information on which to judge levels of need and the correct eligibility recommendation. If crucial information is missing then further assessment may be required.
- If it proves impossible to include particular professionals in the MDT meeting within a reasonable timescale, or the meeting has to be 'virtual', it is nonetheless essential that there is a meaningful dialogue about the appropriate domain levels to choose and the correct eligibility recommendation to make.
- Every effort should be made to resolve disagreements about what domain level is appropriate, bearing in mind the guidance on this [Framework PG 35].

Unresolved disagreements should be recorded and reported back to the CCG. However, bear in mind that there will be many situations where the individual weighting given to a particular domain does not materially affect the outcome of the decision-making process.

- If the individual concerned or their representative does not agree with the domain level proposed then this should be discussed and recorded, and full account should be taken of their views. However, the individual/representative is not a member of the MDT and it is up to the MDT members to decide on the correct domain levels and the correct eligibility recommendation.

Eligibility Recommendation

5.5 The MDT should always make a recommendation regarding eligibility unless there is a fundamental disagreement such that it is necessary to invoke the formal dispute resolution process between the LA and the CCG (see below). It is vital that this recommendation is carefully considered in the light of all the available evidence because, except in exceptional circumstances, the CCG is obliged to accept the recommendation of the MDT.

5.6 The DST gives some guidance on when a particular combination of levels on the domains is expected to translate into a recommendation that the individual has a primary health need [see para 31 of DST User Notes] but in many situations the correct recommendation will not be obvious just from the domain scores. In all cases the MDT must consider whether the overall pattern of needs constitutes a primary health need (as described above) taking account of the limits of lawful local authority responsibility and the quantity and quality of nursing/healthcare required. The four characteristics of **'nature', 'intensity', 'complexity' and 'unpredictability'** must be considered and the rationale for the eligibility recommendation should explain how these, individually or in combination, lead to the conclusion that the individual does or does not have a primary health need.

5.7 The Framework [PG 3] outlines the sorts of questions that each characteristic generates. By answering these questions a good understanding can be gained of their meaning and relevance to the needs of the individual concerned. Bear in mind that these questions are only examples - other questions might be added and not all the questions will be relevant in every case:-

'Nature' *is about the characteristics of both the individual's needs and the interventions required to meet those needs. Questions that may help to consider this include:*

- *How does the individual or the practitioner describe the needs (rather than the medical condition leading to them)? What adjectives do they use?*
- *What is the impact of the need on overall health and well-being?*
- *What types of interventions are required to meet the need?*
- *Is there particular knowledge/skill/training required to anticipate and address the need? Could anyone do it without specific training?*
- *Is the individual's condition deteriorating/improving?*
- *What would happen if these needs were not met in a timely way?*

*‘**Intensity’** is about the quantity, severity and continuity of needs. Questions that may help to consider this include:*

- *How severe is this need?*
- *How often is each intervention required?*
- *For how long is each intervention required?*
- *How many carers/care workers are required at any one time to meet the needs?*
- *Does the care relate to needs over several domains?*

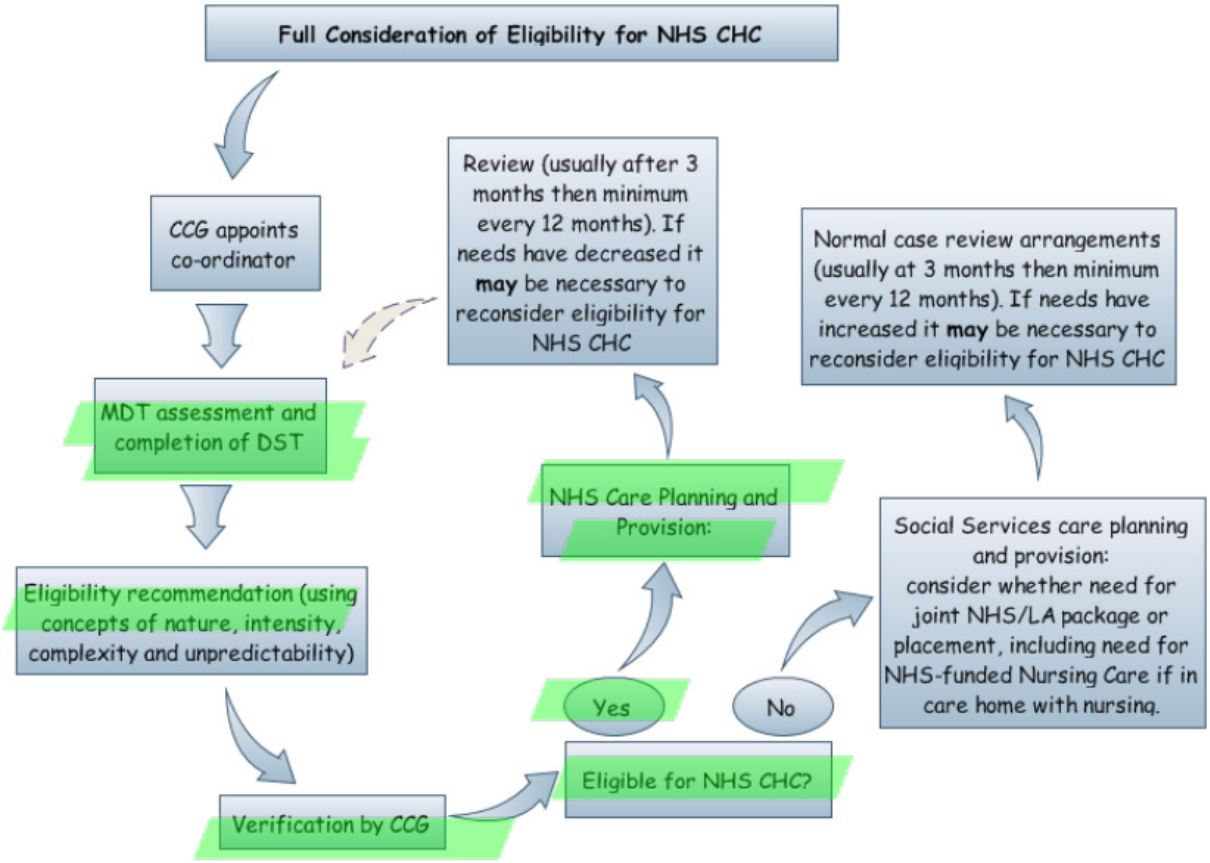
*‘**Complexity’** is about the level of skill/knowledge required to address an individual need or the range of needs and the interface between two or more needs. Questions that may help to consider this include:*

- *How difficult is it to manage the need(s)?*
- *How problematic is it to alleviate the needs and symptoms?*
- *Are the needs interrelated?*
- *Do they impact on each other to make 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?*

*‘**Unpredictability’** is about the degree to which needs fluctuate and thereby create challenges in managing them. Questions that may help to consider this include:*

- *Is the individual or those who support him/her able to anticipate when the need(s) might arise?*
- *Does the level of need often change?*
- *Does the level of support often have to change at short notice?*
- *Is the condition unstable?*
- *What happens if the need isn’t addressed 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?*

Flow Chart – Full Consideration Using DST



6 DISPUTES AND APPEALS

Different sorts of dispute

6.1 The Framework [PG 68] explains that there are two different kinds of dispute that may arise in relation to NHS CHC:-

a) Disputes between a CCG and an LA regarding eligibility (which could also have additional complications arising from the two organisations being from different geographical areas).
b) Challenges (including requests for reviews) by the individual or their representative in relation to the process or decisions made.

6.2 The latter may occur in situations where the LA and the CCG are in agreement about the recommendation regarding NHS CHC eligibility, but the individual/representative disagrees. In these situations the local resolution process will be applied but if this fails the individual has the right to appeal to NHS England, and ultimately to the Health Service Ombudsman.

Principles for Dispute Resolution between Statutory Bodies

- Local authorities and NHS organisations should foster a spirit of problem solving and partnership.
- Formal disputes between agencies should only be invoked when efforts to resolve matters informally have failed.
- Operational staff/members of MDTs should endeavour to resolve issues between themselves wherever possible in accordance with the National Framework.
- Where practitioners are unable to reach agreement, the reasons for the disagreement need to be clearly documented. Disputed recommendations between professionals may be resolved by reference to a panel or whatever the agreed local mechanism is. Operational staff should have timely and ready access to an appropriate lead manager for NHS CHC within their organisation who is expected to try to resolve disputes with their counterpart.
- Individuals and their carers should not be drawn into disputes between statutory bodies. Where necessary they should be informed that decision making has been delayed and be advised of the likely timescale for decisions being reached.
- Whether the dispute is between statutory bodies, or between the individual and a statutory body (or bodies), it is essential that appropriate care is provided to the individual in a suitable setting whilst the dispute is resolved.
- Disputes about eligibility must not delay the individual receiving the care they require in whatever is the most appropriate setting. In order to achieve this it may be necessary for one of the statutory bodies to fund care on a 'without prejudice' basis until the dispute is resolved. If there is an existing funding arrangement for care which remains appropriate to meet needs, then this should continue. If new/different care arrangements need to be made the CCG and LA concerned should agree interim funding without prejudice and refunding arrangements should be arranged in line with DH guidance on refunds [Annex F in Framework]. Every effort must be made to resolve disputes in a timely manner.

Disputes at Checklist Stage

6.3 The Checklist threshold has been set deliberately low to ensure that all individuals who might be eligible for NHS CHC are given the opportunity to be fully considered for this. It is expected that a significant proportion of those who cross the Checklist threshold will not be found eligible for NHS CHC. Therefore, provided that the Checklist has been completed by an appropriate health or social care professional, the outcome of the Checklist should usually be accepted and actioned by the CCG. If a 'negative' Checklist is being challenged by the individual the reasons for the challenge should be set out in writing, with a clear rationale, and sent to the Continuing Healthcare Lead.

The Framework [PG 69.3] states:
'*Where an individual or their representative wishes to challenge a Checklist outcome, they should contact the relevant CCG, using the contact information supplied with the written decision. The CCG should give this request prompt and due consideration, taking account of all the information available, including any additional information from the individual or carer. The response should be given in writing as soon as possible. If the individual remains dissatisfied, they can ask for the matter to be considered under the NHS complaints procedure. Details of how to do this should*

be included with the written decision. At any stage, the CCG may decide to arrange for another Checklist to be completed or to undertake the full DST process, notwithstanding the outcome of the original Checklist.'

Disputes between Statutory Bodies at DST/Recommendation Stage

6.4 By practitioners working in partnership and following national guidance it should be possible to resolve many disagreements regarding eligibility recommendations through the normal MDT process without the need to invoke formal dispute resolution procedures. In many situations there will be debate about the appropriate level to choose in a given domain, but in only a limited number of cases should such debates over individual domains be of such key significance that they alter the final eligibility recommendation. However, wherever disputes arise they should be documented, and where the MDT finds itself completely unable to reach an agreed recommendation then this may be resolved through a panel or other dispute resolution arrangements. The Framework and Regulations require that the CCG and LA have an agreed formal dispute resolution procedure in place.

6.5 Where MDT members agree on a recommendation but the individual (or his/her representative) disagree, then the individual can seek a review of the decision by contacting the Continuing Care Lead in the CCG. If they remain dissatisfied after further attempts to resolve the matter, they can apply directly to NHS England for the case to be considered by an Independent Review Panel (IRP).

APPENDIX A

Key Documents and Resources

1. The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care *November 2012 (Revised)*

2. What is NHS Continuing Healthcare? Easy Read.

3. NHS Continuing Healthcare Checklist *November 2012 (Revised)*

4. Decision-Support Tool for NHS Continuing Healthcare *November 2012 (Revised)*

5. Fast Track Pathway Tool for NHS Continuing Healthcare *November 2012 (Revised)*

6. NHS-funded Nursing Care: Practice Guide *July 2013 (Revised)*

7. The NHS Continuing Healthcare (Responsibilities of Social Services Authorities) Directions 2013

8. The Delayed Discharges (Continuing Care) Directions 2013

   1 to 8 above available at https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

9. NHS Continuing Healthcare and NHS-funded Nursing Care Public Information Leaflet available at https://www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet

10. Part 6 of National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 available at http://www.legislation.gov.uk/uksi/2012/2996/contents/made

11. National E-learning (NHS portal) http://www.e-lfh.org.uk/projects/nhscontinuinghealthcare/

12. National E-learning (LA portal) http://nhscontinuinghealthcare.e-lfh.org.uk/

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As a self-employed independent consultant Jim has specialised in NHS Continuing Healthcare (CHC). He provides support on CHC to LAs on behalf of ADASS and convenes the ADASS National Reference Group. He worked closely with the DH on the review of the National Framework during 2009, was part of the team which wrote the national Practice Guidance in 2010, and also the 2012 update of the National Framework. He remains a member of the National Policy Advisory Group, he currently chairs the National Stakeholder Group for CHC, and was part of the team that wrote the national CHC E-Learning Programme. He also runs a masters level module on CHC at Essex University.

Jim has undertaken reviews of CHC arrangements in a number of areas and has also trained health and social care staff on this subject in many parts of the country.