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Practice Guidance

National Health Service Continuing Health Care

Dartington

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PRACTICE TOOL

National Health Service Continuing Health Care

Introduction

This practice tool is aimed at practitioners and managers. It provides an overview of the law, in England and Wales, in relation to National Health Service (NHS) Continuing Health Care (CHC) and includes resources to support practical, fair and effective decision-making.

The tool supports:

- Good quality decision-making about continuing health care.
- Effective handling of disputes and tensions that can arise.

What is CHC?

CHC is a package of care funded by the NHS for adults - generally not in hospitals - who have such complex healthcare needs that they amount to a primary health need:

> *...a package of care that is arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness.*

It arose out of concerns that patients with complex health needs which would once have been met in hospital (and so funded by the NHS) were increasingly receiving care in the community funded by local authorities. Attempts to address this led to criticisms that criteria and outcomes were inconsistent between local health authorities. This paved the way for the current *National framework for NHS continuing healthcare and NHS-funded nursing care* (National Framework): **www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care**

National Health Service Act 2006 (s.3) provides that:

(1) A Clinical Commissioning Group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility:

(a) hospital accommodation
(b) other accommodation for the purpose of any service provided under this act
(c) medical, dental, ophthalmic, nursing and ambulance services
(d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children [as the group considers are appropriate as part of the health service]
(e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness [as the group considers] are appropriate as part of the health service
(f) such other services or facilities as are required for the diagnosis and treatment of illness.

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Part 6 of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (the 'Standing Rules') governs the provision of CHC and the responsibilities of bodies in relation to it.

The National Framework is the statutory guidance supporting the Standing Rules and provides considerable detail on how they are to be applied and the roles of CCGs and local authorities.

Who is responsible for CHC?

CHC is funded by the NHS and, accordingly, it is NHS bodies who have the ultimate responsibility for decisions on eligibility and what package of care will be provided.

For most people, the body responsible for CHC will be the Clinical Commissioning Group (CCG) for their area.

The Standing Rules (Reg.20 (2)) defines who is responsible for providing CHC.

In effect, CCGs will be responsible for CHC for everyone except prisoners, other detainees, serving armed forces and their families. NHS England has responsibility for these groups. For simplicity, this Practice Tool will refer to CCGs but it should be borne in mind that these exceptions exist.

Under the *NHS Act 2006* (as amended by the *Health and Social Care Act 2012*), CCGs are responsible for:

- people provided with primary medical services by GP practices who are members of the CCG
- people who are usually resident in the area covered by the CCG.

For further information see NHS England's *Who Pays? Determining responsibility for payments to providers' guidance* (2013):
www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Local authorities may have a role to play in the assessment process for CHC. They may also have responsibilities to someone who is eligible for CHC under their *Care Act (CA) 2014* duties. However, local authorities do not fund CHC and the ultimate decision on eligibility and care provided rests with the NHS.

Eligibility for CHC funding

A person is eligible for CHC if they have a 'primary health need'.

This is assessed by reference to a person's needs across the following categories:

- Breathing
- Nutrition
- Continence
- Skin (wounds, ulcers)
- Mobility
- Communication
- Psychology and emotional needs
- Cognition
- Behaviour
- Drug therapies and medication
- Altered states of consciousness
- Other (significant care needs).

CCGs have a duty to take reasonable steps to assess eligibility in respect of a person they have responsibility for where it appears there may be a need for such care, or that an individual who is receiving care may no longer be eligible for it. Further information can be found in the Standing Rules (Reg.21 (2)).

The threshold for assessment is low: the CCG comes under the duty to assess once they have sufficient information to enable them to determine that someone 'may' be eligible (Bristol County Council, ex p Penfold [1998] CCLR 315 (QBD)). This information can come from anywhere: information could, for instance, come from those treating a patient, or from local authority social services.

Assessment process

Initial screening – the NHS CHC Checklist:

For most people, the first step in the assessment process is for the CCG to screen out those who are not eligible using the Checklist.

This can be completed by a doctor, nurse, other healthcare professional, or by a social worker. The person completing the Checklist should have had training in its use.

Under the Standing Rules, if a CCG wishes to carry out an initial screening process they must use the Checklist. The decision to carry out initial screening must be recorded and the individual informed in writing (Reg.21 (4)).

However, the Checklist does not need to be completed for individuals with rapidly deteriorating conditions which may be entering a terminal phase: in these cases, the Fast Track Pathway Tool should be used (see further below). Other circumstances in which it may not be necessary to complete the Checklist are identified in the National Framework.

The Checklist is completed by grading each of the care domains from A to C (where C indicates lower levels of need and A more severe levels). Blank copies of the Checklist can be downloaded (see the resources section at the end of this Practice Tool).

A full assessment for CHC is required if there are:

- two or more domains selected in column A
- five or more domains selected in column B, or one selected in A and four in B

or

- one domain selected in column A in one of the boxes marked with an asterisk (i.e. those domains that carry a priority level in the Decision Support Tool – breathing, behaviour, drug therapies and medicine, and altered states of consciousness).

Meeting the threshold for a full assessment to be carried out does not necessarily mean that a person will be eligible for CHC when assessed.

Full CHC assessment:

Under the Standing Rules (Reg.21 (5)), a CCG must ensure that a multi-disciplinary team (MDT):

- undertakes an assessment of the individual's needs, or has undertaken an assessment of needs, that is an accurate reflection of that person's needs at the date of the assessment of eligibility for CHC
- uses that assessment of needs to complete the Decision Support Tool for CHC issued by the Secretary of State.

The CCG must make a decision about whether the individual has a primary health need. If so, the CCG must also decide if that person is eligible for CHC.

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Primary health need

The test for whether an individual has a primary health need is determined by applying the Decision Support Tool (DST).

The DST is a document that brings together information on the needs across the 12 different care domains. Needs are assessed from low to high. Breathing, nutrition, tissue viability, mobility, cognition, behaviour, drug therapies and other significant care needs can also score as severe.

Four needs (breathing, behaviour, drug therapies and medication, altered states of consciousness) may also be at such a level of seriousness that they can be identified as priority needs.

Once a person's needs have been identified, consideration needs to be given to the four key characteristics of nature, intensity, complexity and unpredictability:

- **Nature**
  The particular characteristics of an individual's needs and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.
- **Intensity**
  The extent ('quantity') and severity ('degree') of the needs and the support required to meet them, including the need for continuity in care.
- **Complexity**
  How the needs present and interact, and the effect this has on the level of skill required to monitor, treat and/or manage the needs. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.
- **Unpredictability**
  The degree to which needs fluctuate and create difficulties in treating them. The level of risk to the person's health if adequate and timely care is not provided is also relevant. An individual with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

These should be considered in relation to the totality of the person's needs. Consideration should be given to how needs interact with each other and whether this creates additional complexity, intensity or unpredictability.

Care must be taken around **well-managed needs**. An individual who has a need which is managed successfully still has that need. It is only where the management of the need has ***permanently*** **reduced or removed** an ongoing need that it should not be taken into account.

So, for example, when assessing behaviours that may be challenging, behavioural needs should not be discounted if they are managed by appropriate therapies if the reality is that, were that therapy to be withdrawn, the needs would reassert themselves. Guidance on well-managed needs and how to assess them is contained in the framework.

An individual will normally be eligible for CHC if they have any priority need, or a total of two or more severe needs.

If an individual has:

- one or more severe needs, combined with others needs
- a number of high and/or moderate needs

...careful consideration needs to be given to the four key characteristics and a decision reached overall as to whether, in light of those, the individual has a primary health need.

In making the decision, the CCG must consider whether the nursing (or other healthcare) required is:

a. more than incidental or ancillary to the provision of accommodation which their local authority would have to provide
b. of a nature beyond that which a local authority can be expected to provide having regard to the limits of their responsibilities as set out in the *Care Act 2014*.

The four key characteristics play an important role in assessing (b) and whether the quality and/or quantity of needs goes beyond what can be expected of a local authority to address as part of their social services responsibilities.

In this context the MDT means a team consisting of:

- two professionals who are from different healthcare backgrounds

or

- one professional who is from a healthcare profession and one who is responsible for assessing a person's needs under the *Care Act*, most usually a social worker.

If there is a disagreement amongst professionals on the MDT as to what the appropriate level for a need to be recorded at is, then the highest level identified should prevail. The rationale for the different points of view should be recorded in the DST.

A decision on eligibility should be made **within 28 days**: if it takes longer, the CCG risks having to reimburse costs incurred by the person after this point.

Once a decision on eligibility has been taken, it is for the CCG to identify what package of care, or equipment, will be provided and coordinate its provision. However, local authorities should work with CCGs in the planning and commissioning of care where appropriate.

Reviews and appeals

Three and twelve month review

Automatic reviews must take place three and twelve months after a person is found to be eligible for CHC, and thereafter there should be a review at least annually.

The purpose of these reviews is primarily to check whether the care package is appropriate for the person's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility (National Framework s.183). However, sometimes the review may identify that there should be a fresh assessment and this will require a new DST to be undertaken.

The local authority should be involved in the review. If the review identifies changes to funding, neither the CCG nor the local authority should withdraw from the existing arrangements until future arrangements are confirmed.

Individual's rights of review

An individual can ask the CCG to review an eligibility decision.

CCGs should have local resolution procedures in place. The local resolution procedure is the first port of call.

The National Framework contains the following guidance on local resolution procedures (s.195). All CCGs must have an NHS Continuing Healthcare local resolution process. They should therefore develop, deliver and publish a local resolution process that is fair, transparent, includes timescales and takes account of the following guidelines:

- There should be an attempt to resolve any concerns, initially through an informal two-way meaningful discussion between the CCG representative and the person and/or their representative. There should be a written summary of this for both parties. The discussion should be an opportunity for the individual or their representative to receive clarification on anything they have not understood.

  The CCG should explain how it has arrived at the decision regarding eligibility, including reference to the completed DST and primary health need assessment. Where required, this should also be an opportunity for the individual or their representative to provide any further information that had not been considered.

- Where a formal meeting involving the person and/or their representative is required, this should involve someone with the authority to decide next steps on behalf of the CCG (for example, to request further reports, or seek further clarification/reconsideration by the MDT).

  The person should be able to put forward the reasons why they remain dissatisfied with the CCG's decision. There should be a full written record of the formal meeting for both parties. The CCG will agree next steps with the person or their representative.

- Following the formal meeting and outcome of the next steps, the CCG will either uphold or change the original eligibility decision.
- A key principle of the local resolution process is that, as far as possible, if the CCG does not change the original decision, the individual or their representative has had a clear and comprehensive explanation of the rationale for the CCG decision.
- Where individuals wish to move straight to a formal meeting, this should be considered. CCGs should use every opportunity to learn from these meetings, and should consider how they share their learning with other CCGs.
- CCGs may choose to prioritise cases for individuals currently in receipt of care.

If the dispute is not resolved through the local resolution procedure, people can apply to NHS England for review of the decision. Individuals can apply if they are unhappy either with the decision on eligibility itself or the procedure which was followed.

It is normally the case that local processes should be used before an application is made for independent review, but NHS England does have discretion to agree to proceed straight to independent review.

The review is conducted by an independent review panel, composed of an independent chair appointed by NHS England and a representative from a CCG and a local authority (but not the CCG/local authority involved in the eligibility decision). The independent review panel scrutinises the evidence and receives representations from all parties. The panel issue a recommendation: this is not binding, but should normally be followed.

Practical considerations

Capacity and consent

Informed consent should be obtained before someone is assessed, and if consent is withheld the assessment cannot proceed. A discussion would then need to take place with the individual to carefully explain the consequences of not giving consent. Such a decision may well affect the ability of the NHS and the local authority to provide appropriate services to them and no assumption should be made that the local authority will have additional responsibility to meet their needs (National Service Framework s.73).

In some cases there may be a concern as to whether or not the individual has the capacity to consent. Bear in mind the principles of the *Mental Capacity Act (MCA) 2005*. In particular:

- a person **must be assumed to have capacity** unless the contrary is established
- capacity is **time and issue** specific: a person may have capacity to make some decisions but not others.

Further guidance is available here:
www.39essex.com/wp-content/uploads/2016/08/Capacity-Assessments-Guide-August-2016.pdf

The National Framework contains guidance on how to deal with patients refusing assessment. It should, however, be borne in mind that individuals have a right to refuse treatment. The CCG is only under a duty to take 'reasonable steps' to assess eligibility.

Fast Track Pathway

If a person has a condition that is deteriorating rapidly and may be entering a terminal phase, they may require 'fast-tracking' for the purposes of CHC. This means that they are assessed as being eligible for CHC without having to go through the normal assessment process.

Decisions in these cases should be made by use of the Fast Track Pathway Tool (blank copies are available – see the resources at the end of this Practice Tool).

In Fast Track cases, an 'appropriate clinician' (either the doctor responsible for the diagnosis, treatment and care of the patient or another registered nurse or medical practitioner) determines whether an individual is eligible for CHC.

Hospital discharge

There may be difficulties in assessing people who are awaiting discharge from hospital. In particular, individuals may have the capacity to further improve their potential once out of hospital, such that an assessment of their needs would not give an accurate picture.

The guidance in the National Framework is that in the majority of cases it is preferable for assessment to take place once people have been discharged (s.109).

There is, however, some tension with the duty laid on CCGs by the Standing Rules, which is that the duty to take reasonable steps to assess arises when there is sufficient information that a person may be eligible for CHC. This is a duty imposed by Regulations: statutory guidance can assist with carrying it out but cannot override it. At the very least it would be prudent for CCGs to be alive to this point and carry out an assessment as soon as it can be accurately completed.

Disputes between local authorities and CCGs

The CCG is under a duty to consult with the relevant local authority prior to making any assessment of eligibility for CHC: this will normally be discharged through involving the local authority in the assessment process as part of the MDT.

Local authorities, in turn, have a duty to cooperate with the CCG. This includes providing advice and assistance when consulted by the CCG, and taking part in the MDT if requested.

Disputes may, however, arise between CCGs and local authorities in relation to:

- eligibility decisions (notwithstanding that the CCG is ultimately the decision-maker)
- where an individual is not eligible for CHC, the contributions which may still be made in respect of a joint package of care
- the operation of the refunds guidance at Annex E of the National Framework.

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There should be an agreed dispute resolution procedure for such circumstances. It will always be simpler to attempt to resolve disputes in accordance with a pre-agreed mechanism. The requirement for an agreed procedure is clearly identified in the National Framework, which further recommends that procedure addresses the following elements:

- A brief summary of principles, including a commitment to work in partnership and in a person-centred way.
- The CCG duty to consult with the local authority and the local authority duty to cooperate with the CCG. This should include arrangements for situations where the local authority has not been involved in the MDT and in formulating the recommendation.
- An 'informal' stage at operational level, whereby disagreements regarding the correct eligibility recommendation can be resolved - this might, for example, involve consultation with relevant managers immediately following the MDT meeting to see whether agreement can be reached. This stage might include seeking further information/clarification on the facts of the case or on the correct interpretation of the National Framework.
- A formal stage of resolving disagreements regarding eligibility recommendations involving managers and/or practitioners who have delegated authority to attempt resolution of the disagreement and can make eligibility decisions. This stage could involve referral to an inter-agency NHS Continuing Healthcare Panel.
- If the dispute remains unresolved, the dispute resolution agreement may provide further stages of escalation to more senior managers within the respective organisations.
- A final stage involving independent arbitration. This stage should only be invoked as a last resort and should rarely, if ever, be required. It can only be triggered by senior managers within the respective organisations who must agree how the independent arbitration is to be sourced, organised and funded.
- Clear timelines for each stage.
- Agreement as to how the placement and/or package for the person is to be funded pending the outcome of dispute resolution and arrangements for reimbursement to the agencies involved once the dispute is resolved. People must never be left without appropriate support whilst disputes between statutory bodies about funding responsibility are resolved.
- Arrangements to keep the individual and/or their representative informed throughout the dispute resolution process.
- Arrangements in the event of an individual requesting a review of the eligibility decision made by the CCG.

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Resources

Legislation

Care Act 2014:
www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Health and Social Care Act 2012:
www.legislation.gov.uk/ukpga/2012/7/contents/enacted

NHS Act 2006:
www.legislation.gov.uk/ukpga/2006/41/contents

Regulations

NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (the 'Standing Rules'):
www.legislation.gov.uk/uksi/2012/2996/contents/made

Guidance and Practice Notes

Capacity assessments:
www.39essex.com/wp-content/uploads/2016/08/Capacity-Assessments-Guide-August-2016.pdf

Mental capacity and ordinary residence:
www.39essex.com/mental-capacity-law-guidance-note-mental-capacity-ordinary-residence

Care Programme Approach:
www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach

Who pays?
www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

Fast Track Pathway Tool for NHS Continuing Healthcare October (Revised 2018)
Fast Track Pathway Tool:
https://briscomhealth.org.uk/wp-content/uploads/2015/02/NHS_continuing_healthcare_fast_track_pathway_tool_-_October_2018_revised...pdf

National framework for NHS continuing healthcare and NHS-funded nursing care (revised 2019):
www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

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