North Central London

Appendix A

Continuing Healthcare Guidelines September 2011

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Contents

Glossary

Continuing Healthcare Assessor – A collective named assigned by Islington PCT for anyone who co-ordinates the assessments carried out by the Multi-disciplinary team and who completes the London Decision Support Tool

Continuing Healthcare Manager – A collective name assigned by Islington PCT for anyone who is the allocated co-ordinating manager responsible for a patients CHC package after a decision has been made following Complex needs panel that a patient is eligible for NHS CHC.

Fully Funded NHS Continuing Healthcare – A care package which is to be completely funded by the NHS. This will include payments by the NHS for care not normally associated with the NHS. I.e. payment for a carer to do shopping, cleaning. The term continuing care (CHC) is used for Fully Funded NHS Continuing Healthcare.

Domains- The National Framework for NHS CHC uses 11 domains to assess eligibility for NHS CHC. They are behaviour, cognition, psychological and emotional, communication, drugs and therapies, nutrition, altered states of consciousness, skin, continence, mobility and breathing.

1. Introduction

This document provides information to all practitioners involved in the process of NHS Continuing Healthcare (CHC) to understand their responsibilities in relation to NHS CHC within the North Central London (NCL) Primary Care Trusts (PCTs).

CHC is every practitioner's responsibility and it is important for everyone to be involved in the process in order that appropriate patients are recognized as meeting the eligibility criteria for NHS CHC with the intention that they receive both the necessary care and appropriate financial support.

These guidelines provide information on the process from identifying a patient who may be eligible for CHC through to managing a CHC package of care.

Some individuals may be eligible for either a joint funding arrangement between their PCT and their borough's social services. NCL has developed guidance for these Joint Funding arrangements (Please see protocols for joint funding for Young Physically Disabled (YPD) and Adults and Older People).

The guidelines may also be read by patients or representatives to support understanding of the process.

These guidelines should be read in conjunction with the Department of Health's *National Framework for Continuing Healthcare and NHS-funded Nursing Care* (revised 2009) Gateway reference: 11509, and with NCL's CHC Policy (September 2011).

2. Background

NHS CHC has been evolving since 1994 when the Health Services Ombudsman published a report on a case in Leeds entitled, 'Failure to provide long term NHS care for a brain-damaged patient' (Reid, 1994).

In July 1999, the Court of Appeal judged in the Coughlan case (DOH, 2007) that funding responsibility was dependant on the legal limit of what could lawfully be provided by a Local Authority (i.e. health care that is merely incidental or ancillary to the provision of accommodation).

In March 2001 the Department of Health issued a National Framework for Older People which referred to the provision of free nursing care in nursing homes but didn't include guidance on CHC. By June 2001 the Department of Health provided guidance on funding responsibilities and laid out 3 categories; NHS, shared responsibility and social services, (DOH 2001).

By 2003 North Central Sector Strategic Health Authority (NCL SHA) developed their own Eligibility Criteria NHS CHC, as did all other SHAs across the country. However over the next three to four years there was a strong push for a National Framework for NHS CHC to eliminate the postcode lottery that had developed. The Grogan Judgement assists the process to move forward, DOH, 2007.

On 1st October 2007, the National Framework for NHS CHC and NHS Funded Nursing Care was implemented after two to three years of consultation. With the introduction of the new framework came national tools to standardise the approach to CHC.

In 2009 the National Framework for NHS CHC and NHS-funded Nursing Care was revised. The revisions clarify the decision making and funding process and explain more clearly the types and levels of need that staff look for and record when they assess needs, complete the tools used to support decision-making and ultimately make a recommendation about eligibility.

Best practice guidance was issued in March 2010 and provides a practical explanation of how the Framework should operate on a day-to-day basis and gives examples of good practice.

NCL will commission CHC in a manner which reflects the choice and preferences of individuals but balances the need for the PCT to commission care that is safe and effective and makes best use of resources. Therefore, in circumstances where the quality rating of a care home is poor and the PCT cannot commission care in the home at that time, the Trust will work with individuals.

These guidelines should be read in conjunction with:

- National Framework on Continuing Healthcare and NHS funded nursing care (Revised July 2009)
- PCT Health and Safety Policies
- PCT Policy and Procedure for Safeguarding Adults

- The NHS Constitution
- NCL Continuing Care Policy (September 2011)

3. The Responsible Commissioner

The PCTs in NCL are responsible for those patients who have an NCL General Practitioner (GP) at the time of assessment even if they do not reside in NCL. If those patients have been placed out of borough, the PCT will be responsible either until death or until they no longer meet the criteria for NHS CHC, (DOH, 2006). However if a patient independently moves out of the borough without the assistance of the PCT then they become the responsibility of the receiving borough.

Therefore if a patient is placed in NCL PCT by another Local Authority (LA), registers with an NCL PCT GP, and after three months meets the criteria for NHS CHC, then they will be the responsibility of the NCL PCT. The reverse is true of those placed by NCL LA into another borough.

4. The Continuing Healthcare Team

Experts in CHC are available in PCTs and provider services to guide and assist patients, their carers and practitioners involved in the process.

The CHC team might involve:

- **A Commissioner** – The Head of Joint Commissioning is responsible for commissioning CHC packages for older people and people with physical disabilities. She/he will have overall responsibility for the purchase of care
- **A Continuing Healthcare Lead** – Who is responsible for the overall management of CHC processes in Islington PCT. She/he is responsible for managing the CHC team and developing CHC nursing services across Islington. She/he will have overall responsibility for the safety and appropriateness of nursing care.
- **A Continuing Healthcare Community Matron** – Who is responsible for providing guidance and support to all professionals both within the community and secondary care as well as co-workers in Social Services. She/he is also responsible for the care management of :-
    - Complex CHC packages in the community
    - All CHC packages in care homes both within Islington and outside of the borough

  She/he is not responsible for the care management of the under 65s with mental health problems or those with learning disabilities.
- **A Continuing Healthcare Specialist Nurse** – Who supports the CHC Community matron and holds his/her own caseload. She/he is also responsible for maintain the training and assessment of formal carers in packages of care within the home setting.
- **A Funded Nursing Care Assessor** – Who is responsible for assessing and reviewing all residents in Nursing Homes for Funded Nurse Contributions. She/he presents any patient to panel who meets the threshold for a full CHC assessment. She/he provides cover for the CHC Community Matron in his/her absence.
- **A CHC Administrator** – Who is responsible for coordinating papers and taking minutes for the weekly complex care panel and informing both family and care managers of the outcome of the panel. She/he also provides administration to the CHC team.
- **A Brokerage Manager** – Who is responsible for finding appropriate nursing home placements to meet the needs for those agreed for NHS CHC in liaison with the CHC Community Matron. She/he is also responsible for negotiating the cost of a placement and finalizing a Service level agreement with providers.

5. Who is eligible for a full CHC Assessment?

Eligibility for NHS continuing healthcare is based on an individual's assessed health needs. The diagnosis of a particular disease or condition is not in itself a determinant of eligibility for NHS continuing healthcare.

Any patient in any setting is entitled to a full CHC assessment if CHC assessors or patients themselves consider that needs may be sufficiently complex to warrant a full assessment. *The National Framework for CHC*,(DOH, 2009) provides a 'Check List' for CHC assessors (see Suffix 2). This check list, as with all assessments in the CHC process should always be completed in conjunction with the patient and/or their relative or carer.

The aim of this tool is to support a decision as to whether a full CHC assessment is required, or not. A variety of staff, in a variety of settings, could refer individuals for a full consideration of NHS CHC eligibility. For example, the tool could form part of the discharge pathway from hospital, a GP or a nurse could use it in an individual's home, and Social Services workers could use it when carrying out a review for Community Care. This list is not exhaustive, and in some cases it may be appropriate for more than one person to be involved in the assessment process.

How to use this tool
Descriptions of need should be compared to the needs of the patient and boxes ticked as appropriate. All the descriptions should be considered. If the patient's need meets or exceeds the description given, tick the box in the first column (column A). If there is need in some or all of these areas, but the level of need falls just below that described in the main statement, tick the box in the second column (column B). If the patient clearly does not meet the described need, tick the box in column C.

A full consideration of eligibility is required if there are:

- Two or more ticks in column A.
- Five or more ticks in column B; or one tick in A and four in B.
- One tick in column A in one of the boxes marked with an asterisk (ie, the domains which carry a priority level in the Decision Support Tool), with any number of ticks in the other two columns.

There may also be circumstances where a full consideration for NHS CHC is necessary even though the patient does not apparently meet the indicated threshold.

Regardless of whether the patient requires a full CHC assessment, the rationale for the decision, the CHC assessor's signature and the date the Checklist was completed, should be recorded and kept in the patient records. The patient and/or carer should be informed of the decision (written if appropriate). The CHC assessor should explain to the patient and/or their carer that if they feel dissatisfied with the decision not to complete a full CHC assessment, it may be more appropriate to carry out a full CHC assessment. This may prevent an appeal at a later stage.

6. Which CHC Assessor is responsible for coordinating an assessment?

A process chart (Suffix 1) is provided to ensure clarity for CHC assessors with regards responsibility for taking a patient through initial assessments to identify CHC eligibility. Patients can be identified for a full CHC assessment in a number of settings; Acute hospitals, the community or in care homes. Some of these patients will already have allocated social workers and/or district nursing staff. In these instances it is these staff members who will be responsible for completing the full CHC assessment by collating information provided by professionals involved, the patient, and/or their carer. These CHC Assessors will be required to visit the patient in hospital or their current place of residence in order to gain a clear understanding of the needs of the patient.

CHC Training should be provided on a quarterly basis to educate staff about the process familiarize themselves with policy and provide an opportunity for staff to familiarise themselves with the relevant documents.

Some patients will not yet be known to services. If they are in hospital, the ward staff will be responsible for coordinating the assessment. If they are in care homes, either the residential review team social workers or the CHC nurse will be the responsible assessor.

In mapping out responsibilities in this way Islington PCT endeavours to prevent gaps or duplication of the process.

7. A Full Continuing Healthcare Assessment

For those patients who meet the threshold of the check list, a full assessment is required to ascertain if a patient has a primary health need and therefore meets the criteria for NHS CHC.

The appropriate CHC assessor is responsible for co-ordinating a Multi-Disciplinary Team (MDT) approach. The person responsible is highlighted in Suffix 1. It is the responsibility of this person to gather assessment information from all MDT staff involved with this patient. A health clinician is responsible for completing London Health Needs Assessment (HNA) but additional reports may be collected in order to gather an overall assessment of the patient. A social work assessment should also be submitted. Once the assessment of needs is completed the MDT should then complete an assessment of CHC eligibility. Eligibility is assessed using the National Decision Support Tool (DST). The MDT is then required to make a recommendation to the PCT as to whether the individual is eligible, including the reasons for making this recommendation.

When completing the DST, it is essential to involve both the patient and their relatives/carers in the assessment process. CHC is a complex process and good patient, relative and carer involvement throughout the process improves satisfaction and prevents undue appeals at a later stage.

A public information leaflet can be found in on the following website:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079515

Each CHC assessor will supply patients and/or relatives and carers with this booklet to guide them through the process as well as a copy of The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing care (see below):
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288

Capacity to make the decision
A mental capacity assessment should always be carried out for the DST. Capacity should always depend on the decision being made at that time. A major placement or treatment decision may accompany the assessment for CHC; if the patient lacks capacity to make such a decision and does not have a relative to act in their best interests, an Independent Mental Capacity Advocate (IMCA) may be required.

Patients requiring rehabilitation
Patients who are deemed to require a period of rehabilitation to meet their potential and have not completed this rehabilitation should not be presented for a CHC assessment until the full potential has been reached. The panel will always check if this has been fully explored. If not, they will reject the case until further rehabilitation has taken place.

ALL reports including the DST should be sent to the CHC administrator. The administrator will ensure that all papers have been submitted correctly and will book a slot on the CHC panel. If eligibility is clear, and the patient is ready to be discharged, an out of panel

ratification can take place. In these circumstances the administrator will forward all documentation to the CHC Lead for approval

8. The Complex Needs Panel

The role of the Panel is to ratify recommendations made by the MDTs. Only cases that are for Older People and Young People with Physical Disabilities are seen at this panel. Learning disabilities and Adult Mental Health have separate panels.

The Complex Needs Panel might consists of the following representatives:

- A Consultant Geriatrician
- A Consultant Psychiatrist for Older Age
- A member of the Community Rehabilitation Team
- A Social Service manager
- A Senior Nurse from the PCT
- An Administrator to take minutes

CHC assessors will present their cases to the Panel and provide any additional information. Relatives, and/or Carers are encouraged to attend the Panel meeting.

The Panel will ratify the eligibility decision made by the MDT using evidence provided and discussing each domain individually. Usually the Panel will ratify immediately, however in some circumstances insufficient evidence may mean the case will be deferred to gain further evidence. Normally delays in decision making should not affect the patient's discharge or search for a suitable placement.

At the end of Panel it is the responsibility of the CHC Administrator to add all new patients agreed for fully funded NHS CHC on the CHC datbase. The CHC administrator is also responsible for updating all relevant data on this database as it arises.

If the MDT recommends that an individual does not meet the eligibility criteria, the patient's case should be presented to a separate Community Panel. It is the responsibility of the patient's care manager to present the case to the Community Panel. However the administrator of the Complex Panel will be required to forward documentation regarding the decision along with an explanation to the Community Panel in the afternoon.

A process chart outlining the responsibilities of all individuals involved following the panel is outlined in Suffix 2.

9. Fast Track

Some patients whose condition is deteriorating very rapidly may need to have a fast track assessment in order to agree CHC to enable them to be discharged from hospital and die at home. The CHC Lead can agree CHC outside of the Panel.

The care manager should contact the Chair to warn them of the imminent fast track tool given the importance and speed with which the patient will need to be agreed for CHC.

10. Communication of the Decision

Minutes from the Panel regarding a specific patient are distributed by the CHC administrator to the CHC Assessor and CHC Manager if different, providing information on the overall decision as well as an explanation of the reasons for the decision. A letter is also sent to the patient and/or relatives/cares as appropriate with details of the panel's decision.

Patients and or their relatives/carers are informed to write to follow the PCT's complaints procedure if they would like to appeal the decision. A copy of Islington The PCT's complaints procedure is sent with the letter to the patient and/or relatives/cares.

11. Appeals Process

Please Suffix 3 for guidance on appeals.

If patients and relatives are involved in the process at the beginning appeals are less likely to occur.

12. Approval of CHC Packages at Home or in a Nursing Home

PCTs should seek to find suitable placements and packages of care to meet the needs of patients who meet NHS CHC funding. Placements and packages are required to be cost effective and take into account the patient's/carers personal preferences. (See Suffix 1 for a process map).

Placements in Nursing Homes
Placements to nursing homes both within NCL are the responsibility of the individual PCT Brokerage Managers. In liaison with the CHC Community Matron, the Brokerage Manager will find a placement suitable for the needs of the patient and agreeable to both patient and relatives/carers. Once a suitable placement is found, the Care Home manager completes a pre-admission assessment of the patient to verify they are able to meet the patient's needs. The Brokerage Manager requests a breakdown of the fees from the provider along with a total fee and forwards to the CHC Community Matron.

Users Service Information
The CHC Community Matron then completes a Users Service Information form (USI) which outlines the total cost of the proposed placement. Packages or placements under £1,000 per week are agreed by the CHC Community Matron and those over £1,000 need the approval of the CHC Lead.

When the placement fees are agreed by the Assistant Director for Adults and Older People, the Brokerage Manager sends the home manager a Service Level Agreement (SLA) to sign and returns it to the Brokerage manager. The Assistant Director for Adults and Older People then signs the SLA which is finally sent back to the care home manager along with instructions to send invoices to the Assistant Management Accountant in IPCT.

CHC Packages at Home

If the placement is in the patient's own home, a suitable care package is proposed by the CHC manager (usually a district nurse).

Users Service Information
The CHC manager completes a USI form which is authorised by the CHC Community Matron and forwarded to The Assistant Director for Adults and Older People for approval. Further discussions may be required with the CHC Community Matron and the Assistant Director for Adults and Older People to reach an agreement. Once it has been approved the Assistant Director for Adults and Older People sends it to Finance.

USIs are completed for ALL patients who receive CHC packages at home whether they require funding from the CHC budget or not. Eg. if a patient receives Marie Curie, Night Sitter or Carelink the indicative cost of this is highlighted in the USI to enable the true cost of CHC to be established.

13. CHC Managers role for patients who meet NHS CHC

Refer to the suffixes
CHC Assessors representing the MDT's recommendation to the complex needs panel may be Social Workers or hospital staff. If an individual meets eligibility for NHS CHC they will always be care managed by health care managers. District Nurses will care-manage all palliative care patients and the CHC Community Matron and her team care manages all other cases.

CHC managers are responsible for agreeing a care package to meet the patient's needs in the most appropriate care setting. Placements for all patients are dependent on a safe care package. Risk assessments may be required for patients who would like to remain at home but where care needs are very complex. Please refer to Commissioning Policy

Once the patient is established in the appropriate care setting, it is the responsibility of the CHC manager to complete an initial review within 3 months or earlier, as required. Statutory reviews should then be completed yearly following this unless the condition of the patient changes.

Cases may need to be re- presented to panel if their needs improve. They may not at this point be entitled to fully funded NHS CHC. Typical examples are young physical disabilities whose needs tend to settle once in a stable environment.

References

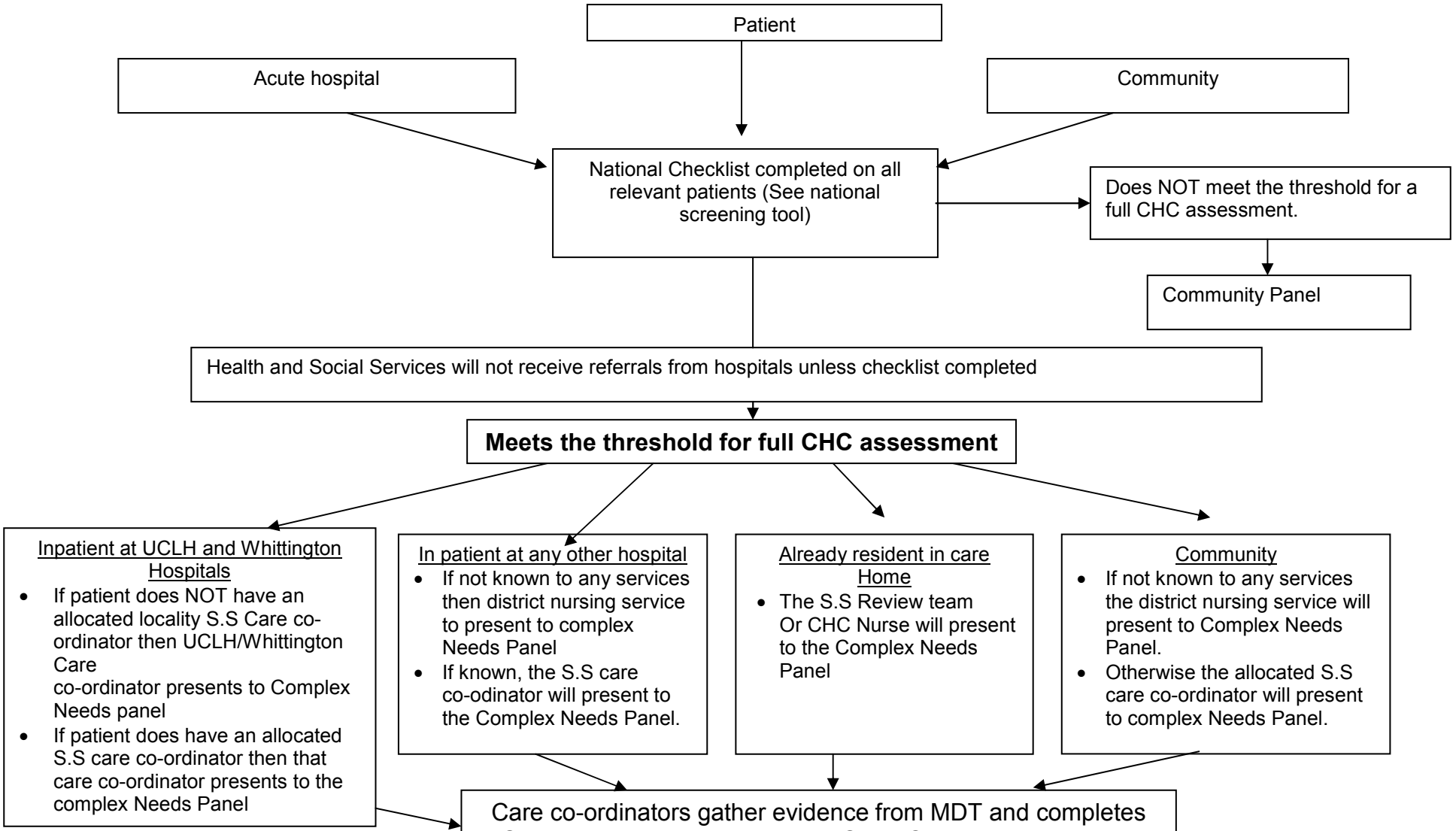
Reid, W, 1994: *Failure to provide long term NHS care for a brain-damaged patient* http://www.ombudsman.org.uk/improving_services/special_reports/hsc/care03/care03_rep.html

Department of Health, July 2009: *The National Framework for NHS Continuing Healthcare & NHS Funded Nursing Care* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288

Department of Health, 2001: *Continuing Healthcare: NHS and Local Council's responsibilities* (HSC 2001/015:LAC (Now superseded by the *National Framework for NHS Continuing Healthcare & NHS Funded Nursing Care*)

Department of Health, 2006: Revision: *Establishing the responsible commissioner: Guidance for PCT commissioners on the application of the legal framework on PCTs' secondary care commissioning responsibilities*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069634

Suffix 1: Older People and Young Physical Disabilities - CHC Process



Suffix 2 - Protocol for CHC

From presentation to panel to provision of Continuing Healthcare

- Patient is presented to Complex Care Panel by the CHC assessment coordinator – Relatives to always be invited to panel

- Panel members go through paperwork presented, ask further questions to coordinator and ratify the patient needs using the National Framework for NHS Continuing Healthcare Criteria.
- Minutes of the panel discussions are taken.
- If the panel feels there is not enough information to ratify a decision, the case is deferred.

- The administrator will send to the **patient/family** a copy of the minutes including an explanation of the scoring, identifying the care coordinator along with covering letter explaining the panel's decision. A copy of the IPCT Complaints Procedure copy of the national framework criteria is also sent. If the decision is 'patient does not meet the CHC Criteria' and therefore the patient/family have the right to challenge/appeal.
- Minutes of the relevant patient is sent to the **care coordinator** of the case by administrator of the panel.
- The panel administrator enters the patient details on the CC data base.

Challenge:

- Patient follows the Complaints procedure.
- Complaint to be investigated by CHC Lead, following National Framework for CHC. Keeps accurate records and liaises either with SHA London or Ombudsman as necessary.
- CHC Lead liaises with Finance.

Meets CHC Criteria:

- Care coordinator receives panel minutes sent by Chair
- Patient receives a letter and the minutes informing him/her of the decision.

CHC provision:

At home – Older People and Younger People Disabilities

These patients could be care managed by either

District Nursing/Generalist and specialist C Matrons

or

CC Community Matron.

District Nursing/Generalist and specialist C. Matrons care co-ordinators.
↓
Care co-ordinators provide the care with support from Marie Curie Nurses and Agency Nurses and Healthcare Assistants.
↓
A USI is completed and sent to CC C Matron for agreement along with a copy of the care plan. USI to include total the cost of the package, including Marie Curie, agency nursing and district nursing cost.
↓
USI sent to AD Adults.
↓
If a change in care package required a new USI is required and the process starts again.
↓
AD Adults to send UIS to Finance.

CC Community Matron
CC C Matron arranges a discharge planning meeting with patient and family.
↓
CC C Matron develops a plan of care and gets a costing from the agency and incorporates district nursing cost if appropriate.
↓
If District Nurses are included in the package then they are responsible for their care plan and the CC C Matron will co-ordinate the whole package.
↓
CC C Matron to complete a care management report and review weekly for first month.
↓
CC C Matron to agree care plan with AD Adults by sending him/her a USI
↓
AD Adults to send USI to Finance.
↓
If a change of care plan is required then new USI is required and agreement sought from AD adults again.

Key

CC C Matron – CHC Community Matron.
SLA – Service Level Agreement
USI – User Service Information

Nursing Homes – Older People and Younger People Disabilities

Social Worker informs family and gives details of the CC CMatron.

CC C Matron care manages these patients.

Nursing Homes
CC C Matron discusses with family location of Nursing Home – in Islington or out of borough.
↓
CC C Matron liaises with the Brokerage Manager with a detailed breakdown of patient's needs along with papers from panel.
↓
Brokerage Manager identifies a suitable home and links back with CC C Matron with details.
↓
CC C Matron contacts family and family visit the home.
↓
If the family rejects the home, CC C Matron will inform the Brokerage Manager who will find another suitable home.
↓
Nursing Home carries out a pre-admission assessment and provides the Brokerage Manager with a full breakdown of the costs.
↓
A breakdown of the costs to be sent to the AD adults for agreement.
↓
If the placement is not agreed by the home or AD Adults, the Brokerage Manager to identify another home.
↓
If the placement is agreed, Brokerage Manager to send home Service level agreement (SLA) for the home manager to complete and return to Brokerage Manager. This is then sent to AD adults for a signature and a signed copy is sent back to the home.
↓
AD Adults to send a breakdown of costs to finance.

Payment of Invoices

- Finance enters patient details in financial database, once an agreed SLA is received.
-
- Finance receives invoices, either for Nursing Homes or for CC at Home packages. Checks them against SLA. If correct, enters them on Finance Database and sends them to CHC Lead for authorisation and signing and then AD Borough commissioning. If invoices are incorrect, Finance sends them to provider advising them they are incorrect.

Suffix 3 - Local Resolution Process for Disputes from Individuals Regarding Eligibility for Continuing Healthcare

1.0 Background

Fully Funded NHS CHC is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing healthcare needs that satisfy the criteria for the funding. The term 'continuing care' is used in this policy as an abbreviation for 'fully funded NHS continuing care'. You can receive Continuing Healthcare in any setting, including your own home or a care home. NHS Continuing Healthcare is free, unlike help from Social Services, for which a financial charge may be made depending on your income and savings.

When it is identified that an individual may have ongoing healthcare needs, he or she should be assessed by appropriate professionals to consider eligibility for Continuing Healthcare using the tools provided within the National Framework for CHC and NHS Funded Nursing Care issued by the Department of Health.

The National Framework sets out in detail the process for considering a person for Continuing Healthcare funding, including the principles and legal framework about eligibility.

In summary, to qualify for Continuing Healthcare an individual must have a Primary Health Need. Professionals will use the available evidence and assessment material to look at the totality of the individual's needs to agree whether or not the individual has a primary health need. There are three different tools available within the National Framework to aid decision making.

I. The Fast Track Pathway Tool - is used to gain immediate access to NHS Continuing Healthcare funding where an individual needs an urgent package of care.

II. The Checklist tool – is a screening tool used to help practitioners identify individuals who may need a referral for a full consideration of eligibility for NHS Continuing Healthcare funding.

III. The Decision Support Tool (DST) – is used when the checklist indicates that the person may be eligible for Continuing Healthcare, or if the professionals decide this without using the Checklist. A multi-disciplinary assessment should be used by the multi-disciplinary team (MDT) to complete a DST. The multi-disciplinary team should use the DST to decide whether or not to recommend the person has a primary health need and is therefore entitled to full NHS continuing care funding.

IV. The recommendation is then passed to` The Primary Care Trust (PCT) for approval.

When an individual or (if appropriate) their representative does not agree with the decision about eligibility for continuing care funding, the PCT will aim to resolve the matter. This document sets out below the process to be followed if this happens. The timescales set out in this document are a guide of what to expect, but there may be exceptions depending on the circumstances of each case.

The process will not be the same when an individual or their representative asks for a retrospective review.

2.0 What happens if a person does not agree with the outcome of the Checklist.

When a Checklist is completed, a copy of it should be given to the individual or (where appropriate) their representative in a timely manner. The Checklist should include enough information to understand how the decision was made. If the Checklist indicates that a full consideration for Continuing Healthcare is not required, then the individual does have the right to request a review of the decision if they disagree with it. PCT contact details are included with the Checklist.

The PCT will give such requests due consideration, taking account of all the information available, including additional information from the individual or his or her carer or representative. The PCT may decide to arrange for a full multi-disciplinary assessment and DST to be completed if there is evidence to suggest it should. If not, then a clear and written response should be given to the individual or their representative, as soon as possible (within 4 weeks). The response should also give details of the individual's rights under the NHS complaints procedure

3.0 Local Review Process – what happens when an individual or their representative does not agree with the decision on the DST.

The PCT will write to all individuals who have been considered for Continuing Healthcare using the DST will be sent a letter by the PCT explaining that the panel have ratified the recommendation. The letter will be sent within two weeks of the ratification process and will include the contact details of the named officer at The PCT, to write if they disagree with the decision or would like more information. The letter should ask them to write within two weeks.

If the individual (or representative) contacts the PCT about the decision, the PCT will provide details of the named coordinator who will be the point of contact for the duration of the local review process.

Some individuals may need support to understand or challenge a decision made about their continuing healthcare needs. The PCT will supply information of local advocacy and other services that may be able to offer advice and support within the response letter. Information will be included about the local Independent Complaints Advocacy Service (ICAS) arrangements.

From this point forward in this document 'the individual or (if appropriate) their representative' will be referred to as 'the applicant'.

The named coordinator at the PCT will offer to meet with the applicant or arrange a telephone call, whichever the applicant prefers. The date and time of the meeting or booked call will be confirmed in writing with a copy of the PCT's published Local Resolution Process. The meeting will take place within two weeks from the meeting or telephone call.

If the applicant is not satisfied by the end of the discussion in the meeting or by the end of the booked call, The PCT will need to gather and scrutinise additional evidence appropriate to the case to take account of the specific concerns raised by the applicant. The new evidence and DST should be considered by the PCT Panel. In this document, we will refer to this Panel as a Local Review Panel (LRP). The Local Review Panel membership should be different to the original decision makers where practicable, however it is accepted this is not always possible. The applicant will always be invited to attend the Local Review Panel.

The PCT has a reciprocal agreement with a neighbouring PCT and will ask that they consider any new information and make a decision. This should not be allowed to cause undue delay. If The PCT does choose to send the case to another PCT for an independent decision, the PCT will be prepared to accept the decision made by the independent PCT. The applicant should be invited to attend the Panel whatever approach is taken, with adequate notice being given to the applicant and enough time allocated at the LRP for the applicant's full involvement with the discussion.

The decision of the Local Review Panel should be given to the applicant without delay. Applicants will usually be asked to leave prior to the Panel's deliberations and therefore would not find out the decision of the Panel on the same day. However the PCT will notify the applicant of the decision in writing, which includes a detailed rationale for how the decision was made. The letter will be sent within 2 weeks of the date of the Panel. The letter from the PCT will give details of how to request a review by NHS London's Independent Review Panel if they remain dissatisfied.

The PCT will ensure that, the essential parts of the process as set out in Annex A, are completed at a local level before a case is referred to NHS London.

4.0 Independent Review Panel

NHS London is the Strategic Health Authority for London and is responsible for appointing Independent Chairs and Panel members to consider requests by individuals for an Independent Review.

Applicants should contact NHS London to request the Independent Review within two weeks of the date of the PCT's decision letter unless there are exceptional circumstances. NHS London should acknowledge this request within one week of receipt of the letter.

Included with the acknowledgment letter will be a Public Information Leaflet 1 explaining the role of the Panel and how the process works and a questionnaire (unless one has already been completed) which asks for some additional information about why the applicant does not agree with the decision.

If the applicant's request for a review is appropriate and accepted by NHS London, papers will be requested from the PCT, with a view to the Review Meeting taking place within three

months of the date of the PCT's Local Review Panel. In order to achieve the three month deadline, it is important that the PCT gathers and scrutinises all appropriate additional evidence at their local review panel.

If, for whatever reason, it proves impossible to arrange the Review Meeting within three months of the PCT's Local Review Panel, NHS London may need to ask The PCT to refresh the assessment of the individual, and re-visit the decision about eligibility for Continuing Healthcare funding.

The Independent Chair allocated by NHS London for the Review Meeting will "preview" the file, to ensure that the case is ready for the Review Meeting. In the event of there being flaws in the local process which would or could affect the fair and comprehensive consideration of the individual's needs, the case may be sent back to the PCT or questions may be put to The PCT.

Tasks to be completed by the The PCT prior to referring a case to NHS London for Independent Review

All reasonable attempts will be made to resolve a dispute at local level by The PCT. PCTs in London are asked to observe the process above and whilst it is accepted that each PCT may have a slightly different method of local resolution, the basic principles within the National Framework must be included.

In order not to waste time, or misdirect individuals, the PCT will check the tasks listed below have been completed. If any of the tasks have not been completed then the PCT will review and strengthen the local process before they advise the applicant to request an Independent Review.

1) Has there been a comprehensive multi-disciplinary assessment of the individual's heath and social care needs?
2) Was the DST completed by an appropriately constituted MDT and does it include a proper recommendation?
3) Was the recommendation of the MDT accepted by the PCT?
4) Was the individual or their representative given the opportunity to be involved at all stages of the process
5) Has adequate local resolution taken place which includes:
    a. Offer of a face to face meeting with the individual or their representative (the applicant) or telephone call if preferred
    b. Consideration of the concerns raised by the applicant
    c. Gathering and scrutiny of any additional evidence relevant to the case
    d. Referral to a Local Review Panel at which the applicant should be invited to attend
    e. A comprehensive letter sent to the applicant which explained in detail the reasons for the Local Review Panel's decision

Suffix 4 - Service User Information Form

This form should be completed for new Service Users (S/U) or to report changes any changes to a CHC package. Please send to Anne Conoulty, CHC Community Matron based at Hornsey Rise Health Centre

Patient's Last Name:

S/U First Name/s:

Date of Birth:

Patient's Address:

Name and Address of Next of Kin:

Provider Details:

Care Type:

Date of Start of Care:

Expected Length of Care Period:

Patient Diagnosis:

Care home charge rates:

Care Package details:

Shifts	Hours	Charge	Total Cost
Week Days			
Saturday			
Sunday			
Week Nights			
Bank hol			
Total weekly charge excluding Bank Hols			
Total annual charge including Bank hols			

Temporary variance to care package:

Name and designation of person completing form:

Appendix B

Memorandum of Understanding for Continuing Healthcare At Home

THIS AGREEMENT is made **between**

(1) _____ **Primary Care Trust**, ("the **PCT**")
Located at: _____

(2) [Insert name of Individual] of [Insert Address] ("**you**" or "[Insert Name]);

(3) [Insert name of any carer who will be involved in the provision of the service] ("the Representative")

BACKGROUND

You/[Insert Name] have been assessed as eligible to receive NHS Continuing Healthcare funding and this Memorandum of Understanding sets out the agreement reached between the PCT in relation to the provision of your care.

[Insert name of patient] has been deemed not to have capacity to make the decision as to where they wish to receive care.] The [Representative] [you] has requested that you receive the care package at Home.

The PCT has agreed that a home care package is provided on the terms set out in this Memorandum of Understanding.

1 Provision of Care

1.1 The PCT has agreed to provide the Care Package as set out in your Care Plan which has been assessed to meet your current assessed care needs.

1.2 The Care Package will be provided at the following address ("Home"):
[Insert Address]

2 Review

2.1 The Care Package will be reviewed regularly by your care manager and the Continuing Health Care team. An initial review will take place within three months of the start of the package and at least once a year thereafter to see if your health needs are being met. Reviews will be undertaken more frequently if your needs or outcomes change substantially. You will be informed by either your Care Manager or Continuing Healthcare Nurse Adviser about the date of the review.

2.2 You or your Representative may request a review to be undertaken by the PCT if you think your care needs have changed or the care package is not meeting your assessed needs.

2.3 In the event that the assessed care needs have increased, the PCT will consider whether the care provision needs to change in order to meet those care needs. Where the care provision increases, the PCT will assess whether it remains appropriate for the care at home package to be provided. In doing so, the PCT will take the considerations set out in the PCT's Choice Policy and the cost of alternative care packages that would meet your assessed needs.

2.4 If you are assessed as no longer eligible for receipt of NHS Continuing Healthcare then the PCT will inform the Local Authority so that a joint assessment can be carried out.

3 Patient and Representative Obligations

3.1 You and your Representative agree to co-operate with a review of your needs.

3.2 You and your Representative acknowledge and recognise that if your care needs change then the PCT will need to re-assess the continued provision of the care at home package. If the PCT considers that the care package is no longer appropriate or cost effective then you agree to co-operate with the PCT in choosing and moving to alternative arrangements.

3.3 You and your Representative acknowledge that the PCT can issue a withdrawal of care notice if it considers that the provision of the care at home package is no longer appropriate. If you decide not to take up alternative package of care offered by the PCT then you will be considered to be refusing NHS funding.

3.4 You and your Representative agree to treat all care workers with dignity and respect and will take all the action that you and your Representative are required to do in the Risk Assessment.

3.5 You and your Representative will make sure that the care workers have the appropriate facilities so that they can provide your care. This includes clean and accessible bathroom and kitchen facilities.

3.6 You and your Representative acknowledge that the PCT will take any action it considers necessary in the event that it considers that there is a risk to the health or safety of any of its staff or agents including withdrawing the provision of care.

I have read, understand and agree with the Memorandum of Understanding, the Care Plan and Risk Assessment attached.

Name of Individual receiving care:

…….....

Signed by: ……
Individual Receiving Care

Printed Name ……

Date…….....

Signed by: ……
Representative

Printed Name: ……
Representative

Date…….....

……Date……
Signed by PCT

Relevant Care Manager……Tel…….