Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

Bath and North East Somerset Clinical Commissioning Group and Bath & North East Somerset Council

NHS Continuing Healthcare and NHS Funded Nursing Care

Operational Policy

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Policy Number	TBC
Title	NHS Continuing Healthcare (CHC) and NHS-funded Nursing Care (FHC) Operational Policy
Date of Policy	20th June 2019
Purpose of Document	This CHC Operational Policy sets out the operating framework for CHC to ensure that the CHC service across BaNES CCG is delivered in accordance with the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (Revised 2018) and that close working arrangements are in place with health and social care staff in CCGs, Local Authorities and provider NHS Trusts.
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Sponsor	N/A
Reviewed by / on	18th April – Policy reviewed by Nursing & Quality team 30th April – Policy reviewed by Council / Social Care 22nd May – All comments submitted were reviewed by Carolyn Hamblett (Interim CHC Team Lead) & Sarah Jeeves (Senior Nurse Adult Individual Commissioning) 30th May – Further Policy review by Nursing & Quality Team (Version 1.1) 18th June – Policy Reviewed by Director of Nursing and Quality
Authors	Val Janson, Deputy Director of Nursing / Sarah Jeeves, Senior Nurse, Adult Individual Commissioning N.B. This policy aligns with Wiltshire CCG's Operational Policy, the authors of which are: Nita Hughes, Interim Head of CHC and Specialist Placements and Yvonne LeBrun, Independent Consultant.
Approved by / on	

Version	**Date**	**Comments**	**By Whom**
Version 1.1	30th May 2019	(BaNES draft - this policy is based on the Wiltshire CCG Policy.	Val Janson, Deputy Director of Nursing / Sarah Jeeves, Senior Nurse, Adult Individual Commissioning, Lisa Harvey, Director of Nursing and Quality

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1 Introduction

1.1 From 1st April 2013 the BaNES Clinical Commissioning Group (CCG) have held statutory responsibility for delivering CHC for adults (over the age of 18 years) who are registered with a BaNES CCG General Practice or who are resident within the BaNES CCG area and are not registered with a General Practitioner elsewhere.

1.2 The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (revised 2018) (referred to as the 'Framework') sets out the principles and processes for the implementation of CHC and FNC, which provides national tools to be used in screening, assessment, and applications for CHC, Fast Track (FT) and FNC referrals and applications.

1.3 This policy describes the processes that will be followed in BaNES CCG and should be read in conjunction with the following documents:

- National Framework for NHS Continuing Healthcare & NHS-funded Nursing Care incorporating practice guidance. (Department of Health 2018, revised) Reference 1
- Who pays? Establishing the Responsible Commissioner (DH 2013). Reference 2
- The National Health Service Commissioning Board and Clinical Commissioning Groups' Responsibilities and Standing Rules Regulations 2012. Reference 3
- Care Act 2014. Reference 4

2 Purpose

2.1 The purpose of the Operational Policy for CHC and FNC is to detail the processes which BaNES CCG and delegated commissioned care provider services to Virgin Care will follow for referring, assessing and agreeing eligibility for CHC and arranging and commissioning that care. It also covers processes for determining eligibility for FNC.

2.2 This policy ensures that the model and processes are consistent with national requirements and are robust and timely in their response ensuring that CHC teams; Virgin Care, under CCG contract terms, work in accordance with Framework requirements and develop and maintain close working arrangements with colleagues in Local Authorities and NHS Provider Trusts.

2.3 **'NHS continuing healthcare'** (CHC) means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS), where the individual has been assessed and found to have a 'primary health need' as set out in the National Framework. Such care is provided to an individual aged 18 or over, to meet health needs and associated social care needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group.

2.4 **'NHS-Funded Nursing Care'** (FNC) is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS-funded Nursing Care has been based on a single band rate. In all cases individuals should be considered for eligibility for CHC before a decision is reached about the need for NHS-funded Nursing Care.

2.5 This policy applies to all CHC applications for adults 18 years or older who are registered with a BaNES CCG General Practice or who are resident within the area covered by BaNES CCG CHC Service and are **not** registered with a General practitioner elsewhere. This includes all care groups including:

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

2.6 The CHC Operational Policy is to support health and social care teams and provider organisations who are working with patients for whom the CCG are responsible.

3 Key Principles

3.1 Eligibility for CHC is based on an individual's assessed needs. It is not disease specific; determined by either the setting where the care is provided; or by who delivers the care. Access to consideration and assessment is non-discriminatory; and not based on age, condition or type of health condition diagnosed.

3.2 The purpose of the CHC service is to implement the CHC eligibility criteria in order to provide appropriate funding to meet identified care needs. In order to achieve this, the implementation of the criteria and local application for CHC, in conjunction with the Local Authority, provider Trusts and other agencies, should meet the following principles and be:

- Needs led
- Equitable
- Culturally sensitive
- Person-centred
- Robust and transparent
- Easily understood
- Cognisant of guidance and best practice

3.3 The intention of the Department of Health in developing the National Framework was to improve consistency of approach and ease of understanding of CHC.

3.4 The principles underlying this policy support the provision of a consistent approach and fair and equitable access to CHC. All agencies involved in delivering the CHC pathway will work to the following principles:

- Health and social care professionals will work in partnership with individuals and their carers / families throughout the process
- All individuals and their representatives will be provided with information to enable them to participate in the process
- Decisions regarding eligibility for CHC or FNC are based on a person's assessed needs and are not financially led
- The CCG will support the provision of advocacy to individuals throughout the process of assessment for CHC funding (when required)
- The process for decision-making about eligibility for CHC will be transparent for individuals, their representatives and for partner agencies
- Assessment of health and social care needs will be undertaken jointly by relevant agencies using agreed local processes
- Assessment and decision-making about eligibility for CHC will be undertaken in a timely manner to ensure individuals receive the care they need in the appropriate environment without unreasonable delay (timeframes to be in line with the DoH framework)
- Individual's preferences and wishes will be taken into account whilst giving consideration to any risks posed as to how and where care will be delivered in line with appropriate use of CCG's resources.
- Individuals in vulnerable situations will be protected and partner agencies will work together to address any safeguarding concerns
- Each organisation has responsibility for ensuring their staff are competent in this field of practice, have a good working knowledge of the 2018 Framework and have completed the national CHC e-learning programme.
- Individual practitioners will be accountable for their own actions both organisationally and professionally
- All decision-making will be informed by an appropriate multi-disciplinary team assessment
- There will be thorough and effective mechanisms for responding to and managing requests for reviews of decision and disputes as per the BaNES CCG local arrangements and national guidance
- All management and processing of individual's data will be compliant with current legislation

4 Eligibility for CHC

4.1 The Framework provides guidance for establishing eligibility for CHC and tools to assist in making decisions on eligibility.

4.2 To assist is deciding which treatment and other health services it is appropriate for the NHS to provide under the NHS Act 2006 and to distinguish between those and the services that a LA may provide under the National Assistance Act 1948 and the Care Act 2014, the concept of a 'primary health need' has been developed. Where an individual has a 'primary health need' the individual is eligible for CHC and, the NHS is responsible for meeting all of that individual's assessed health and social care needs.

4.3 Further information on determining a 'primary health need' and the four key characteristics to support decision-making in CHC are outlined in App 1 paras 54-66.

5 Responsibilities

5.1 CHC is a 'whole system' responsibility requiring leadership across and within statutory agencies to ensure that the needs of individuals who might have a 'primary health need' are properly assessed and that services are commissioned to meet the assessed needs.

5.2 BaNES CCG is required to commission or deliver its obligations for CHC as per its statutory obligations under the NHS Act. Reference 5

5.3 CCGs are responsible and accountable for system leadership for CHC within their local health and care system, including:

a) Ensuring delivery of, and compliance with, the National Framework for NHS Continuing Healthcare (Revised 2018)
b) Promoting awareness of NHS Continuing Healthcare
c) Establishing and maintaining governance arrangements for NHS Continuing Healthcare eligibility processes and commissioning NHS Continuing Healthcare packages
d) Ensuring that assessment mechanisms are in place for NHS Continuing Healthcare across relevant care pathways, in partnership with the local authority as appropriate.
e) The Standing Rules require CCGs to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for NHS Continuing Healthcare. The Care and support statutory guidance should be used to identify the relevant social services authority.
f) Making decisions on eligibility for NHS Continuing Healthcare
g) Identifying and acting on issues arising in the provision of CHC
h) Commissioning arrangements, both on a strategic and an individual basis
i) Having a system in place to record assessments undertaken and their outcomes and the cost of CHC packages
j) Implementing and maintaining good practice
k) Ensuring that quality standards are met and sustained
l) Nominating and making available suitably skilled professionals to be members of Independent Review Panels
m) Ensuring training and development opportunities are available for practitioners, in partnership with the LA
n) Having clear arrangements in place with other NHS organisations and independent or voluntary sector partners to ensure effective operation of the Framework

5.4 Local Authorities are required to co-operate and work in partnership with CCGs to deliver on their responsibilities including:

5.4.1 Referring an individual to the relevant CCG if it appears that a person may be eligible for CHC

5.4.2 As far as practicable, providing advice and assistance when consulted by the CCG in relation to an assessment of eligibility for CHC

5.4.3 Arranging for persons to participate in multi-disciplinary meetings and responding within a reasonable timeframe prior to an eligibility decision being made or providing information when requested

5.4.4 Nominating individuals to be appointed as Local Authority members of Independent Review Panels when requested to do so by NHS England

5.5 BaNES CCG health and social care partners agree to the following shared responsibilities:

Who	Key Responsibilities
Health care staff referring clients for consideration of eligibility	• Referring clinicians who complete checklists should have received training on 'How to complete a CHC Checklist' • Obtain appropriate documented consent in line with policy and a Mental Capacity Assessment as required • Complete the appropriate documentation including a professional assessment, CHC Checklist, CHC Fast Track and an appropriate care plan fully and in line with the CHC National Framework • Ensure full engagement and co-operation in completing the DST within 28 days of the CCG receiving the Checklist. When required lead the DST process as the MDT Coordinator (see CHC Process section of Policy)
Social care staff referring clients for consideration of eligibility	• Obtain appropriate documented consent in line with policy and a Mental Capacity Assessment as required • Complete the required documentation including a professional assessment or CHC Checklist in line with the CHC National Framework • Ensure full engagement and co-operation in completing the DST within 28 days of the CCG receiving the Checklist. (see CHC Process section of Policy)
Continuing Healthcare Team (Virgin Care)	• Receive and review all CHC Checklists and CHC Fast Track applications to ensure the standards required are met and that they indicate eligibility for receipt of service or further assessment for eligibility • Maintain the CHC database ensuring all referrals are recorded and that all correspondence is kept for each individual patient • Facilitate the appointment of a case co-ordinator to oversee the assessment process • Review DSTs to ensure they are completed fully in accordance with the National Framework, supported by robust clinical evidence presented in an appropriate manner and that the MDT has clearly stated a recommendation • Ensure a social care practitioner has been invited to be part of the MDT/DST process. If a social care practitioner is not available to take part this must be recorded in the DST or the person's file • Verify Checklists and Fast Track assessments ensuring appropriate consent has been obtained and the documents are completed in line with the framework • Arrange for the DST to be verified by the CCG Nursing & Quality Team following the MDT recommendation (as per CHC Framework, Paragraph 156)

	• Write to referrer and patient or their representative with the outcome and how to request a review of the decision if they are dissatisfied with the decision • Once a person has been assessed as eligible for CHC or Fast Track, arrange the package of care based upon the assessed needs of the individual • Provide oversight and suitability of the care plans to safely meet the individual's care needs • Source a placement of care package to meet assessed needs • If the individual is found to be not eligible for CHC but entitled to FNC, arrange for the payments to be processed and made to the care home in a timely manner • Record all eligibility decisions in the individual's case records and ensure all communications of these decisions are undertaken in a timely and professional manner • Ensure patient case management arrangements are in place • Ensure reviews are undertaken in line with national policy and at other times as required on a priority basis • Undertake regular audit to ensure service is meeting agreed KPIs including patient, staff and customer feedback • Ensure the CCG is alerted to issues with care providers which may compromise quality of care
CCG	• Consider applications for CHC eligibility in a timely and robust manner and validate recommendations in line with the CHC framework • Undertake a random audit of cases to monitor for consistency of decision making and quality assurance • Validate the MDT recommendation for CHC eligibility in accordance with the submitted evidence in line with the CHC framework • Consider CHC applications that have been twice referred back to the MDT for review under the exceptional decision guidance in line with the Framework • Support the Local Resolution process and Retrospective CHC review process (when required)
CHC Brokering / Contracting / Commissioning (Virgin Care & CCG)	• Maintain a database of providers • Confirm that the providers on the list have CQC registration Negotiate prices and terms and conditions for services offered by providers with consideration of the purchasing framework • Arrange contracts with providers that ensure high quality care delivery and use resources effectively • Monitor all contracts • Forecast likely spend for each year based on historic trends • Complete CCG financial waiver forms when required to provide assurance of best use of financial resources
Finance Director	• Periodically review delegated limits for managers working in this area • Review and approve requests for waivers from Standing Financial Instructions • Authorise counter-fraud audits on a regular basis

6 Mental Capacity and Consent

6.1 As with any examination or treatment, the individual's informed consent should (if possible) be obtained before the start of the process to determine eligibility for CHC.

6.2 It should be made explicit to the individual whether consent is being sought for a specific aspect of the eligibility consideration process (e.g. completion of the Checklist or for the full process). An individual may withdraw their consent at any time in the process.

6.3 Where an individual lacks capacity, agencies will act in accordance with the Mental Capacity Act 2005 (Reference 6). If someone lacks the mental capacity to consent to or refuse an assessment, the principles of the Act will apply and in most circumstances an assessment will be provided in the person's best interest. A third party cannot give or refuse consent for an assessment of eligibility for CHC on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney, or have been appointed as a Deputy by the Court of Protection for Deprivation of Liberty cases.

6.4 If an individual does not consent to assessment of eligibility for CHC, the potential effect this will have on the ability of the NHS and LA to provide appropriate services should be carefully explained to them. If an individual does not consent this does not mean that the LA has an additional responsibility to meet their needs, over and above the responsibility it would have had if consent had been given. Where there are concerns that an individual may have care needs and the level of appropriate support could be affected by their decision not to give consent, the appropriate way forward should be considered jointly by the CCG and the LA, taking into account each organisation's legal powers and duties and safeguarding responsibilities.

6.5 If there is concern that the individual may not have capacity to give consent, this should be determined in accordance with the Mental Capacity Act 2005 and guidance set out in the Framework.

7 Carers

7.1 A carer is anyone who, usually unpaid, looks after a friend or family member in need of extra help or support with daily living.

7.2 When a CCG is supporting a CHC home-based package where the involvement of a family member or friend is an integral part of the care plan, it should agree with the carer the level of support they will provide and this should be documented.

7.3 The CCG may need to provide additional support to care for the individual if the carer has a break from his or her caring responsibilities and will need to assure carers of the availability of this support when needed.

7.4 Where informal care provision is identified in the assessment process a referral to the Local Authority should be made by the assessor (with the consent of the care giver) for a Carer's Assessment if one has not already been completed.

8 Advocacy

8.1 The Mental Capacity Act 2005 created a new statutory service, the Independent Mental Capacity Advocate (IMCA) service. Its purpose is to help vulnerable people who lack capacity and who are facing important health and welfare decisions. The NHS and LAs have a duty under the Act to instruct and consult the IMCA if those concerned are people who lack capacity in relation to the relevant decision and who have no family or friends that are available (or appropriate) for consultation on their behalf.

8.2 Even if an individual does not meet the criteria for the use of the IMCA service, and regardless of whether or not they lack capacity, they may wish to be supported by an advocate.

8.3 BaNES CCG will ensure access to advocacy services is available, where needed, to support those who are eligible and potentially eligible for CHC and will make individuals aware of local advocacy and other services that may be able to offer advice and support.

9 CHC Team Arrangements

9.1 CCGs have the lead statutory responsibility to deliver CHC in such a way that it is compliant with the Framework for all people aged 18 and over. The CHC team are required also to work with children's services to manage the transition into adult services and to ensure that appropriate referrals are made to support a young person who, on reaching adulthood, may have a need for services from the CCG. The needs of a young person, and any future entitlement to adult NHS Continuing Healthcare should be clarified as early as possible in the transition planning process, especially if the young person's needs are likely to remain at a similar level until adulthood.

9.2 The main functions of the CHC team are as follows:

- Ensure the completion of a comprehensive assessment of need for individuals who may be eligible for CHC
- Monitor the quality of assessments received and liaise with referrer
- Co-ordinate the assessment process, liaising with the Multidisciplinary Team (MDT), individual and family. This may also be supported by a provider service as per agreed contracts
- Undertake checklists and assessments as required (in line with the revised framework October 2018)
- Ensure that the MDT assessment is conducted using the national DST and application of the 'primary health needs' test in making the MDT recommendation. This should be supported by both evidence and a robust rationale for the eligibility recommendation prior to the decision being made by the CCG

- Communicate with individuals and families on the eligibility decision and ensure they understand the next steps in the pathway
- Make individuals and families aware that eligibility for CHC is not indefinite as needs may change
- Work closely with MDT colleagues to agree packages of care
- Arrange packages of care and residential placements for people who are eligible for CHC and ensure they are appropriately assessed, managed, monitored, evaluated and reviewed
- For individuals accommodated in a nursing home, where the decision is that the person is not eligible for CHC, the need for care from a registered nurse and eligibility for FNC is considered
- Support a local resolution process in line with the CHC Framework and each CCGs Local Resolution Policy
- Ensure that all retrospective reviews of eligibility for CHC are compliant with requirements from NHS England and the Parliamentary and Health Service Ombudsman
- Support the development and delivery of joint training programmes with the Local Authority and other providers regarding all process and policies (local and national) regarding eligibility for CHC and FNC and the delivery of Personal Health Budgets (PHB)

9.3 The contact point for the CHC team is as follows:

Virgin Care
Continuing Healthcare (CHC) Team 1 Milward House Bristol Road Keynsham BS31 2BA
Tel: 01225 831534

10 The CHC Process

10.1 The CHC process is described in the following 7 steps:

Step 1	**Screening and Referral for CHC**
Step 2	**Co-ordination of the Multi-disciplinary Assessment**
Step 3	**The MDT Assessment & Completing the DST**
Step 4	**Making a Decision**
Step 5	**Request to review a decision**
Step 6	**Agreeing & Commissioning Safe Care**
Step 7	**Case management and ongoing review**

11. Step 1: Screening and Referral

11.1 An individual is usually identified as in need of assessment for CHC through use of the nationally prescribed 'Checklist' screening tool. A copy is included in Reference 1. The individual/ their representative should participate wherever possible in the screening process and must be told the outcome of the screening process. Consideration should be given if those ineligible for a full assessment for NHS Continuing Healthcare may be eligible for NHS-funded Nursing Care.

11.2 The Standing Rules Regulations (Reference 3) require NHS Commissioners to take reasonable steps to ensure that individuals are assessed for CHC in all cases where it appears to them that there may be a need for such care. In that case the Checklist is the only screening tool that can be used. Therefore, health and social care staff should consider screening using the Checklist for consideration of CHC (subject to consent) in all the following situations:

- Whenever it appears that an individual may potentially be eligible for CHC
- Prior to any FNC determination and at each subsequent FNC review

11.3 A referral may take the form of a request to consider eligibility (e.g. a direct contact from an individual or their relative) and can be received by telephone, letter or email to the CHC Team. See Section 10.3 for relevant contact details.

11.4 Referrals in the form of a completed Checklist will be checked to ensure that all relevant details are available, appropriate consent is included and there is reference to supporting evidence.

11.5 Where there are concerns about the quality of the referral or where there is significant missing or conflicting information, the referrer will be contacted as soon as possible to respond to the queries. The CHC team will support all reasonable requests for a full assessment.

11.6 The 'Responsible Commissioner' will be checked and where the CCG is not the 'Responsible Commissioner' the referral will be redirected to where commissioning responsibility lies. This is usually, but not always, with the individual's registered GP.

11.7 The Checklist should be completed by NHS or Local Authority staff who have been trained in its use. However, if a professional who has not received training completes a Checklist appropriately, which indicates that the individual requires full consideration for CHC, the CHC team will act on this and arrange for CHC process to be followed.

11.8 Prior to applying the Checklist, it is necessary to ensure that the individual and their representative, where appropriate, understand that the Checklist does not indicate the likelihood that the individual will be found to be eligible for CHC – only that they are entitled to consideration for eligibility. At this stage, the threshold is set deliberately low to ensure that all those who require a full consideration of their needs do get this opportunity.

11.9 Where the Checklist has been used as part of the process of discharge from an acute hospital, and has indicated a need for full assessment of eligibility, consideration should also be given to the person's further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs

11.10 If completion of the screening Checklist indicates that the individual may be eligible for further assessment, the DST will be completed as part of the multi-disciplinary assessment process. The DST provides the overall picture of need and interaction between needs which, together with the evidence from relevant assessments, supports the process of determining eligibility and ensures consistent and comprehensive consideration of an individual's health and social care needs.

Timing of the Checklist

11.11 The Framework clearly states that "screening and assessment of eligibility for CHC should be at the right time and location for the individual and when the individual's on-going needs are known. The full assessment of eligibility should normally take place when the individual is in a community setting. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and on-going needs". (Framework paragraph108)

In the majority of cases it is preferable for CHC eligibility to be considered after discharge from hospital when an individual's on-going care needs should be clearer. Guidance in relation to CHC assessments in acute settings is clearly described within the updated Framework paragraph 109 to 115. If a DST is completed in an acute hospital setting clear justification for the location of this assessment must be provided.

12. Step 2: Co-ordination of the MDT Assessment

12.1 Where an individual has crossed the Checklist threshold and therefore requires full consideration for CHC, it is the responsibility of the CCG to identify an individual to co-ordinate the assessment process and the completion of the DST, including the eligibility recommendation. The role of the co-ordinator is explained in the Practice Guidance section of the 2018 Framework para PG 20.

12.2 Along with administrative support the CHC co-ordinator is the main point of contact for the individual during the assessment process.

12.3 Where someone is in a nursing home the CHC team members will act in the co-ordinating role.

12.4 In BaNES the co-ordination of the MDT Assessment is carried out by the CHC team.

13. Step 3: The MDT Assessment and Completing the DST

13.1 An MDT team, in this context, is at least two professionals, preferably one from healthcare and one from social care, but otherwise from two different healthcare professions.

13.2 All relevant assessment reports are gathered prior to the MDT to inform the decision-making process.

13.3 The DST has 12 domains and records an overview of the individual's needs. A copy is included in Reference 1.

13.4 The MDT uses the assessment information on an individual to complete a DST and then makes an evidence-based recommendation on whether the individual has a 'primary health need' as defined by the four key characteristics, i.e. whether or not they are eligible for CHC.

13.5 When considering whether someone has a 'primary health need', the MDT must take account of the limits of local authority responsibility and, wherever possible, consult with the relevant social services authority before making a recommendation on a person's eligibility for CHC.

13.6 The DST is completed by the multi-disciplinary team, and provides practitioners with a framework to bring together and record the various needs in care domains or generic areas of need. The practitioners use the DST to apply the 'primary health need' tests, ensuring that the full range of factors which may have a bearing on the individual's eligibility are considered, taking account of the principles of 'well managed need'.

13.7 The DST cannot directly determine eligibility, but it provides the basis from which decisions are made exercising professional judgment and in consideration of the 'primary health need' test. Once the multi-disciplinary team has reached agreement, they make a recommendation regarding eligibility. This is then submitted to BaNES CCG for validation and a decision.

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

13.9 BaNES CCG will review all applications for CHC received to ensure consistency and quality monitoring of recommendations. This in turn provides assurance and oversight of decision-making and ensures equity of access to CHC for individuals.

13.10 A person only becomes eligible for CHC once a decision regarding eligibility has been validated and agreed by the CCG, informed by a completed DST or Fast Track Pathway Tool. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue.

13.11 It is expected that CCG will normally respond to MDT recommendations within 48 hours (two working days), and that the overall assessment and eligibility decision-making process should, in most cases, not exceed 28 calendar days from the date that the CCG receives the positive Checklist (or, where a Checklist is not used, other notice of potential eligibility) to the eligibility decision being made.

13.12 Where individuals are found to be eligible for CHC, funding will be agreed from the date of the checklist if this is within 28 days of the Checklist being received or the 29th day following receipt of the Checklist by the CCG.

13.13 The requirement for assessments to be completed within the 28-day time frame requires joint working across the whole system of health and social care. The time frame identified is a key performance indicator for CHC and therefore is not optional. Delays and the reasons for delays in meeting this target will be required to be presented during CCG validation when the eligibility consideration takes place and will be closely monitored and recorded by the CCG.

14 Step 4: Making a Decision

14.1 The CCG receives and verifies the MDT recommendation on whether an individual has a 'primary health need', taking account of the requirements of the Framework. Only in exceptional circumstances, and for clearly articulated reasons, should the recommendation of the MDT not be followed. The CCG will be responsible for ensuring that the individual is notified of the decision in a timely manner.

14.2 The purpose of a validation process is to enable a CCG to discharge its responsibilities in relation to the determination of CHC eligibility and to provide a forum for quality assurance and peer review of decision making. Completed applications for CHC can be validated either through an in-office validation process or at a panel held in the CCG.

14.3 Following the CCG's validation process, the CHC co-ordinator and referrer will be informed by telephone or email of the decision within 24 hours of this being made and this will be followed by written confirmation within 5 working days. Copies of the documents will be uploaded to Liquid Logic (by the CHC team).

14.4 The CHC co-ordinator will inform the individual/representative of the decision as soon as possible after the decision on eligibility is made. The CHC administrator will write to the individual/representative informing them of the panel's decision within 5 days of the decision.

15 Step 5: Request to Review a Decision

15.1 If the individual does not agree with the eligibility decision, they can request a review of this decision.

15.1 The CCG must nominate and make available appropriately trained professionals in the first instance to review the decision.

15.2 If the decision is felt to be correct a local resolution meeting should be held with the individual and/or their representative(s), to explain the decision-making process and to consider, if relevant, any new evidence presented by them.

15.4 Where an individual has been found not eligible for CHC, they or their representative(s) can request a review of the decision by BaNES CCG within 6 months of the notification of eligibility decision.

16 Step 6: Agreeing and Commissioning Safe Care

16.1 If the individual has a 'primary health need' and is eligible for CHC funding, the CCG arranges and funds a safe care placement or home support package to meet all the individual's assessed health and social care needs.

16.2 The CCG will commission the provision of the CHC care package in a manner which reflects the choice and preferences of individuals as far as possible, but balances the need for the CCG to commission care that is safe, effective, and able to meet an individual's needs and that makes best use of financial resources. Therefore, in circumstances where there are concerns regarding the quality of care in a care home and the CCG cannot commission care in the home at that time, the CCG will work with individuals and their families to commission a suitable package of care within an appropriate environment.

16.3 Families may request that their relative is placed in a Care Home outside of the CCG's area. In these circumstances the family and the representative from the CHC Team will discuss the appropriateness of the placement to ensure the quality of care, safety of care and that the provider can meet the individual's assessed needs. The procurement of a care package outside of the CCG area will be progressed in line with 'Responsible Commissioner' Guidance. The CCG will also ensure a decision is made in the individual's best interest with a Mental Capacity Assessment if required. The receiving CCG will be informed of the placement by the CHC team.

16.4 In the light of the need to balance patient preference alongside safety and value for money, the CCG is working towards a BaNES CCG wide procurement and the development of a procurement strategy. Consequently, individuals will have a choice of providers that have a contract with BaNES CCG.

16.5 Agreeing the placement or package of care will include:

- The commissioning of placements or care packages
- Agreeing the care plan with the appropriate professionals and ensuring that care plans and risk assessments are received
- Agreeing the care package and costings with the provider
- Completing assurance checks with the Care Quality Commission and when placing a patient out of area contacting the local CCG

- Informing and updating the referrer, patient and if appropriate the family/carer
- Agreeing and informing the provider and relevant others, the monitoring and review arrangements of the care package
- Ensuring that the details and associated costs of the agreed packages are recorded accurately on Liquid Logic.

16.6 All new residential care providers and care agencies will receive a contract on completion of the financial negotiation and before the start of the placement or package. This is in accordance with the NHS Contract and service specifications.

16.7 In situations where it is necessary to revisit a previous decision on eligibility for CHC, or where there has been undue delay in reaching a decision on eligibility for CHC, the CHC team and the Local Authority in B&NES will follow national guidance regarding refunds and redress with reference to local agreements between these two statutory bodies.

16.8 The CHC team will work with the Local Authority to ensure that individuals are not disadvantaged during the assessment or commissioning process and their care needs continue to be met and funded by the appropriate organisation.

16.9 There will be some individuals who, although they are not entitled to CHC, have needs identified through the DST, that are not of a nature that the Local Authority can lawfully or solely meet. These individuals may require a joint care package or funding to meet an unmet health need. The CCG and Local Authorities in B&NES CCG will work in partnership to agree their respective responsibilities in a joint package of care. For details please refer to PG 51 of the Practice Guidance section of the updated Framework (Reference 1).

17 Step 7: Case Management and Ongoing Review

17.1 The CCG is responsible for ensuring that there is on-going case management/co-ordination for individuals eligible for CHC. The CCG must ensure that the care arrangements are regularly reviewed to ensure they are appropriate, are being provided to an agreed standard and meet needs.

17.2 Case reviews of commissioned care and care needs will be undertaken for individuals within three months following the eligibility decision and subsequently on an annual basis or where considered necessary. This will ensure that individual patients are receiving the care they need and that they remain eligible for CHC or FNC.

17.3 If there is a change in needs and it appears that an individual may no longer be eligible for CHC, a multi-disciplinary team must complete a new DST and make a recommendation to the CCG regarding on-going eligibility.

17.4 It is the responsibility of the initial referrer, case co-ordinator and case manager to ensure that the individual and their family/carer are made aware that these reviews will occur, and that CHC or FNC funding may be removed should the individual's level of assessed needs change. The initial referrer should, as a minimum, provide the individual and their family/carer with the NHS Continuing Healthcare and NHS-funded Nursing Care: Information Leaflet.

18 Not Eligible or No Longer Eligible for CHC

18.1 If an individual is not eligible for CHC they can ask for a review of that decision (please refer to p55 of the NHS CHC National Framework 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf.)

18.2 When a person is no longer eligible for CHC, NHS funding will cease from 28 days from the date of the letter stating the outcome of the decision on eligibility. The CHC service will also notify Local Authority Adult Social Care service that the person is no longer eligible for NHS funding. A social care assessment may be undertaken at this stage.

18.2 The transfer of care or funding between the CCG or LA must ensure that there is a smooth transition and that the individual or their representative is fully aware of and involved in the arrangements.

18.3 The CCG should liaise with health and social care partners to ensure that:

- Individuals **no longer eligible** for CHC have appropriate ongoing care and support in place that maintains their safety
- People assessed as **not eligible** for CHC have appropriate care and support in place that meets their assessed needs and maintains their safety which could include joint funding

18.4 There must be no gap in care provision for a vulnerable individual who has identified needs. Framework says: *It is a core principle that neither a CCG nor a local authority should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement e.g. self- funding of such care may be required. Therefore if there is a change in eligibility, it is essential that alternative funding is agreed, in order to ensure continuity of care. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change.*

19 Fast Track Applications

19.1 The Fast Track (FT) application is there to ensure that individuals who have a '**rapidly deteriorating condition which may be entering a terminal phase'** which demonstrates a 'primary health need', get the care they require as

quickly as possible. No other test is required. A copy of the Fast Track tool is included in Reference 1.1

19.2 Referring agencies must ensure that FT applications have been completed by an 'appropriate clinician' as described in the Framework para 220.

19.3 Appropriately qualified clinicians should complete the Fast Track Pathway Tool documentation setting out how their knowledge and evidence about the individual's needs lead them to consider that the patient has a rapidly deteriorating condition which may be in a terminal phase with an increasing level of dependency, requiring urgent intervention demonstrating a 'primary health need'.

19.4 Others involved in supporting those with end of life needs, including those in the voluntary and independent sector organisation, may identify the fact that the individual has needs for which use of the FT Tool would be appropriate. They should contact the appropriate clinician.

19.5 BaNES CCG supports the direct involvement of hospital and hospice staff in this process to ensure the timely discharge for these individuals, supporting end of life care decisions and providing clear accountability for decision-making.

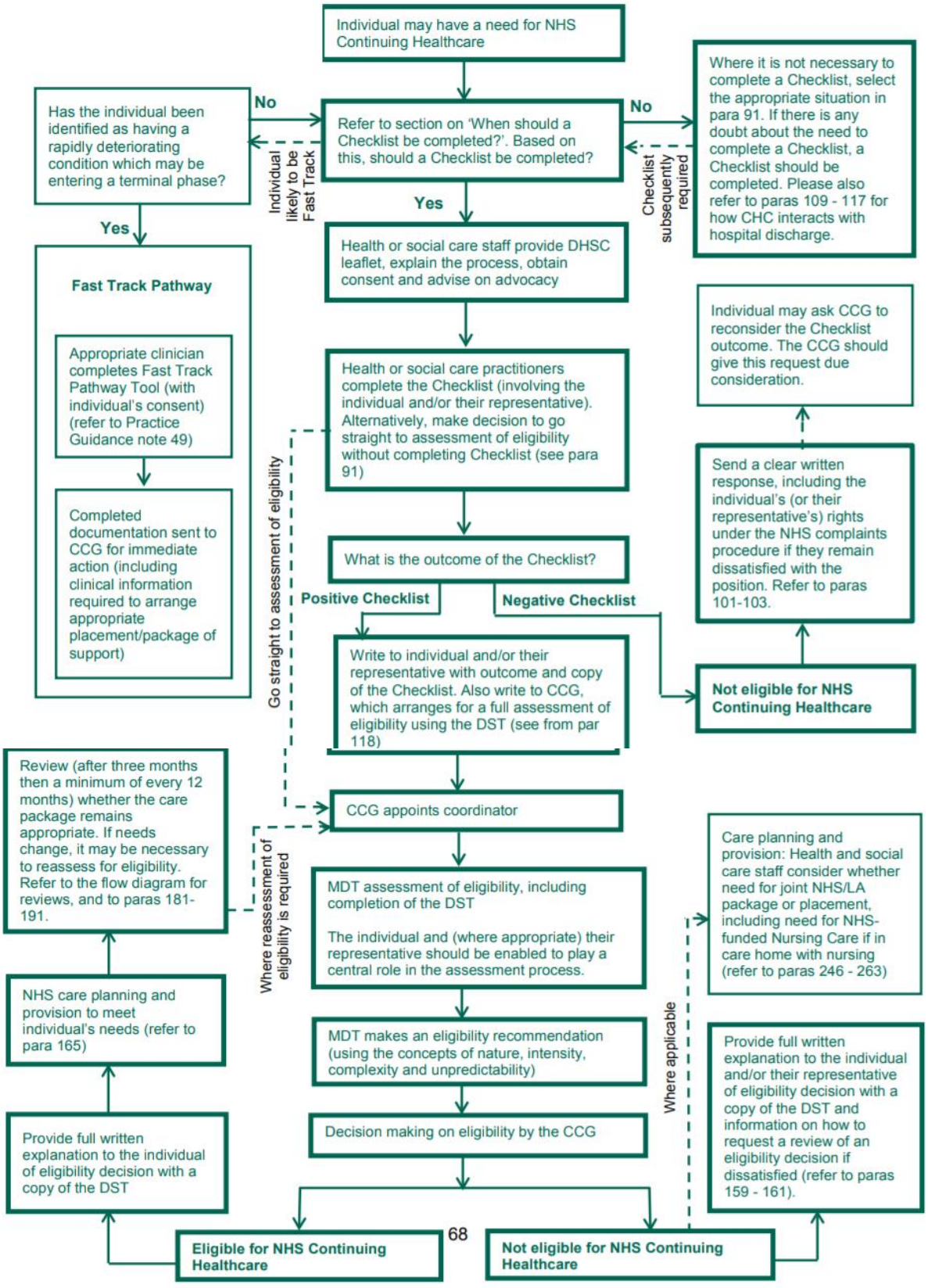
19.6 Neither a terminal condition nor palliative care needs alone are necessarily sufficient to warrant a Fast Track application. If a person receiving palliative care for a terminal condition does not have a rapidly deteriorating condition requiring an urgent decision to enable care needs to be met, the DST will still be used to consider eligibility.

19.7 Fast Track Pathway Tool applications should be submitted to the CCG in a timely way and they will be reviewed by the CCG, who will check to ensure that the recommendation is appropriately evidenced. In exceptional circumstances the CCG may return the application requesting additional supporting information.

19.8 Within three months of the fast track being completed there will be a requirement for a further full review of the fast track package of care to establish if any adjustments to the care package are required, in line with assessed health care needs.

19.9 There may be some situations where the fast track process is later found to have been inappropriate or the individual's condition may have stabilised or changed. In such situations the completion of a DST is required to consider CHC funding eligibility.

The following diagram is the approved process for CHC as detailed on p68 of the Framework



20 Equipment

20.1 Where an individual is in receipt of CHC and requires equipment to meet their care needs, there are several routes by which this may be provided:

- The care home setting may provide non-specialised equipment as part of their regulatory standards under the Care Quality Commission or as part of the contract with the CCG

- Some individuals may require bespoke equipment as assessed by an appropriate healthcare professional to meet specific assessed needs identified in their NHS Continuing Healthcare care plan. The CCG should make appropriate arrangements to meet these needs. In the event of a short prognosis the CGG may not be able to provide bespoke equipment

- Individuals who are entitled to CHC funding have an entitlement on the same basis as other patients to equipment. The CCG should ensure that the availability to those in receipt of CHC is taken into account in the planning, commissioning and funding arrangements for the joint equipment services. In the interim CHC is required to ensure equipment is provided to the individual as identified in their assessed needs that is not currently provided as part of their care package by other means

21 Dispute Resolution & Local Authorities

21.1 B&NES Social Workers are usually involved in making the MDT recommendation regarding eligibility. Once an MDT has made a recommendation regarding eligibility it is for the CCG to make the final eligibility decision

21.2 B&NES Council and their employees are, therefore, not able to request a review of a decision made by the BaNES CCG on behalf of a patient. Requests for review may only be made by individual applicants themselves in accordance with the CCG's Local Resolution Policy.

21.3 If a B&NES Council representative is in agreement with the decision on eligibility it is not appropriate for a dispute to subsequently be raised. If there is subsequent additional evidence that might materially impact on an individual's eligibility for CHC, a review of the assessment will be undertaken.

21.4 However, B&NES Council may dispute a decision that is made by BaNES CCG if it has not agreed with the recommendation and this has been noted via the MDT and verification process. In these circumstances the policy for the Resolution of Disputes in CHC for the relevant CCG should be implemented in line with the Framework.

21.5 BaNES CCG and B&NES Council subscribe to the principle that there should be no delay in the provision of services due to disagreements or disputes on the assessment recommendation or outcome of the decision on eligibility. Should such situations arise, the National Framework for CHC is explicit in stating that any existing funding arrangements cannot be unilaterally withdrawn without the agreement of the other party.

Therefore, anyone in their own home, or care home funded by the local authority or CCG, must continue to be funded by that body until the dispute is resolved. In line with the Disputes Policy any disputes will aim to be resolved with in 28days.

22 Complaints

22.1 If an individual or their representative(s) is dissatisfied with the manner in which the overall process has been conducted, rather than specifically the outcome regarding eligibility for CHC, they may make a complaint through the Virgin Care Complaints Procedure.

Complaints should be sent to:

Virgin Care Customer Experience Farnham Hospital Hale Road Farnham Surrey GU9 9QL	
Tel:	0300 303 9509
Email:	CustomerServices@virgincare.co.uk

All complaints will be addressed following the Virgin Care Compliments, Concerns and Complaints Policy.

If the complaint is not resolved satisfactorily, BaNES CCG PALS and Complaints may be contacted at:

NHS Bath and North East Somerset CCG Kempthorne House St Martins Hospital Clara Cross Lane Bath. BA2 5RP	
Tel:	0300 013 4762
Email:	bsccf.feedback@nhs.net

22.2 Out of Area Placements

23.1 The CHC team will inform all receiving CCGs of potential placements and confirm the placement after admission; providing a named contact for the receiving CCG.

22.3 The CHC team will contact out of area CCGs prior to any confirmed placements out of area, and follow this up in writing after admission with the details of the funded individuals and the contact details of a named individual in the CCG responsible for the care management of the individual.

22.4 The benefits of this process are as follows:

- The receiving CCG can advise of any concerns in relation to the nature of the provision and whether the provision can meet the health needs of people with complex needs
- The placing CCG can be aware of any risks in relation to the quality of care of the provider and put a plan in place to mitigate risks or manage health needs
- The receiving CCG can notify the placing CCG of any concerns in relation to the provider that arise after placement

23 Section 117 Aftercare

24.1 Under section 117 of the Mental Health Act 1983 (section 117), CCGs and Local Authorities have a duty to provide after-care services to individuals who have been detained under certain provisions of the Mental Health Act 1983 until such time as they are satisfied that the person is no longer in need of such services. After-care services under section 117 is a freestanding duty to provide after-care services to meet needs arising from the mental disorder and CCGs and Local Authorities should have in place local policies detailing their respective responsibilities including funding arrangements.

23.2 Responsibility for the provision of section 117 services lies jointly with Local Authorities and the NHS. Where a patient is eligible for services under section 117, these should be provided under section 117 and not under CHC. It is important for CCGs to be clear in each case whether the individual's needs (or in some cases which elements of the individual's needs) are being funded under section 117, CHC or any other powers, irrespective of which budget is used to fund those services.

23.3 It is not necessary to assess eligibility for CHC if all the services in question are to be provided as after-care under section 117. However, a person in receipt of after-care services under section 117 may also have on-going care/support needs that are not related to their mental disorder and that may, therefore, not fall within the provisions of section 117.

23.4 A person may be receiving services under section 117 and then develop separate physical health needs (e.g. through a stroke), which may then trigger the need to consider CHC only in relation to these separate needs, bearing in mind that CHC should not be used to meet section 117 needs.

23.5 Where an individual in receipt of section 117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase, consideration should be given to the use of the Fast Track Pathway Tool.

25 Personal Health Budgets (PHB)

25.1 With effect from 1st April 2014 BaNES CCG were required to be able to offer PHBs to people in receipt of CHC funding in order to provide individuals with better flexibility, choice and control over their care. A PHB helps people to get the services they need to achieve their agreed health and wellbeing outcomes (agreed between the individual and clinician).

25.2 Financially, PHBs can be managed in a number of ways:

- A notional budget held by BaNES CCG
- A budget managed on the individual's behalf by a third party
- A cash payment directly to the individual (a healthcare direct payment) enabling the individual to directly employ their own Personal Assistants if they wish

25.3 People in receipt of CHC funding have the right to a PHB if they choose. All recipients of CHC funding (living in their own accommodation) will be offered a PHB in line with the BaNES CCG PHB Policy.

25.4 The CHC case co-ordinator or case manager will work with the individual and/ or their carer(s) and representatives to agree health and wellbeing outcomes. They will then also work with the individual to think creatively about how they could best make use of their available budget to meet their health and wellbeing outcomes.

25.5 The case co-ordinator or case manager will then create a final budget and care plan, which will be reviewed and agreed by the CCG in line with the CCG PHB Policy. Once a Care Plan has been agreed the case co-ordinator will work to put the Care Plan in place. Support services will be provided to help people with healthcare direct payments and support and advice will also be provided for those wishing to employ Personal Assistants directly.

25.6 Care Plans will be reviewed as per the National Framework guidance (at three months after the Care Package has been put in place and a minimum of every 12 months thereafter).

26 NHS Funded Nursing Care (FNC)

26.1 FNC is only appropriate where it has been established that the individual is not eligible for CHC and the individual requires placement in a care home with nursing.

26.2 In most cases, the individual will already have been considered for CHC and will have had an associated assessment, which should provide sufficient information to determine the need for nursing care in residential accommodation. In certain circumstances, an individual who has been found not to be eligible for CHC at the Checklist stage may still need an assessment to be completed, such as provided at Annex A of the NHS-funded Nursing Care Practice Guide. Reference 9.

26.3 If the NHS is commissioning, funding or providing any part of an individual's care, a review should be undertaken within three months after the initial eligibility decision, in order to review care needs and to ensure that those needs are being met. The review plays a critical role in ensuring that the needs of the individual are being appropriately met and provides an opportunity to review the goals set in the care plan. It may be pertinent to consider whether the individual's level of independence has improved to the point where permanent admission to a care home providing nursing is no longer appropriate and, if so, whether other models of care and support should be considered.

26.4 When reviewing the need for FNC, potential eligibility for CHC must always be considered, and full consideration should be carried out, where indicated. Where the Checklist indicates that a full DST should be completed an MDT should complete a full DST with the following exception. A DST will not be required where:

- the person has previously had a positive checklist and full DST completed by an MDT

and

- there has been no material change in their needs that might lead to a different eligibility decision regarding CHC and (by implication) FNC

26.5 In order to determine this, the previously completed DST must be available at the FNC review and each of the domains and previously assessed need levels considered as part of the review by the reviewer, in consultation with the person being reviewed and any other relevant people who know the person who are present at the review. The reviewer should annotate each domain to indicate they have been considered, indicating any changes in need levels.

26.6 When notifying the person of the outcome of the review they should be advised that they have been assessed as meeting the Checklist threshold but that a full DST has not been completed because there has been no significant change in their need levels. A copy of the annotated DST should be given to the person concerned with information as to how they can request a review of the outcome of the NHS-funded nursing care review.

26.7 Where there has not been a previous DST completed by an MDT or where the NHS-funded nursing care review indicates a possible change in eligibility, a positive Checklist should always be followed by an MDT-completed DST and a recommendation on eligibility regarding CHC.

26.8 Reviews should then take place annually, as a minimum. Some cases will require a more frequent review, in line with clinical judgement; anticipated changing needs, or if there is a significant change in the healthcare needs of the individual.

26.9 If the LA is also responsible for any part of the care, both the CCG and the LA will have a requirement to review needs and the service provided. In such circumstances, it would be beneficial for them to conduct a joint review where practicable. Where the review is not carried out jointly it is important for both parties to share relevant information with each other that may have an impact on their respective commissioning responsibilities e.g. relating to a change in need or safeguarding concerns

26.10 The decision about whether support should be provided in the form of a care home with nursing should take into account the individual's needs, based on what is known about the individual's condition.

26.11 Accommodation and personal care costs are met by the LA and/or the individual (subject to the outcome of means-testing).

26.12 If the individual is dissatisfied with the outcome and a decision relating to their eligibility for NHS-funded nursing care, they are entitled to ask for a review of that decision. If they remain dissatisfied following local re-consideration, they can pursue the matter through the NHS Complaints procedure.

27 Discharge Planning

27.1 Applications for CHC **should not delay** timely discharge.

27.2 In a hospital setting the Checklist should only be completed (if required) once an individual's acute care and treatment has reached the stage where their needs on discharge are clear.

27.2 The National Framework highlights the need for practitioners to consider whether the individual would benefit from other NHS-funded care in order to maximise their abilities and provide a clearer view of their likely longer-term needs before consideration of CHC eligibility. This should be considered before completion of the Checklist as well as before completion of the DST.

27.3 In a minority of cases it might be appropriate for both the Checklist and the DST to be completed within the hospital setting. This should only be undertaken where it is possible to accurately identify a person's longer-term support needs while in hospital and where an appropriate placement/ package of care/support can be identified that takes into account the individual's views and preferences.

28 Retrospective Reviews of Care and Continuing Health Care Redress

28.1 BaNES CCG can only consider requests for retrospective reviews where it is satisfied that one or more of the following grounds for the review exist:

- B&NES CCG failed to carry out an assessment of the claimant's eligibility for CHC funding when requested to do so
- Family requests a retrospective review for periods of unassessed care

28.2 In the absence of evidence of any of the above, BaNES CCG are not obliged to and will not undertake a retrospective review of a claimant's eligibility for such funding.

28.3 Where a retrospective review of eligibility for CHC is approved, appropriate arrangements will be made for financial recompense, in accordance with the Department of Health Redress Guidance for CHC (2015) Reference 10. Pension and benefits payments will also be taken into account in any calculation of sums reimbursed.

28.4 Calculation of interest payments will be in line with National Reimbursements Guidance and CCG policies.

29. Choice

29.1 The Framework states:

'*Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health and associated social care needs'.*

1.1 BaNES CCG will commission the provision of CHC funded care in a manner which reflects the choice and preferences of individuals as far as is reasonably possible, ensuring patient safety, quality of care and making best use of resources. Cost has to be balanced against other factors in each case such as an individual's desire to live at home.

1.2 Patient safety will always be paramount in planning a care package and will not be compromised. Therefore, in circumstances where there are concerns about the quality of care in a care home and BaNES CCG cannot commission care in that home at that time, BaNES CCG will work with individuals and their families to commission an alternative package of care elsewhere.

1.3 BaNES CCG is required to balance the individual's preference alongside safety and value for money. Consequently, individuals will have a choice from amongst providers that have a contract with BaNES CCG and have agreed their quality and pricing structure.

30. Transition from Children's Services to Adult Continuing Health Care Services

30.1 The Framework and the supporting guidance and tools only applies to people aged 18 years and over. It is important that both the Adult and Children's Frameworks consider transition.

30.2 BaNES CCG will ensure that it is actively involved in the development and oversight of the local transition planning process with their partners and that their representation includes those who understand and represent adult CHC. They will ensure that adult CHC is appropriately represented in all transition planning meetings regarding individual young people whenever the individual's need suggests that there may be potential eligibility.

30.3 The CCG recognises as best practice that future entitlement to adult CHC should be clarified at an early stage in the transition planning process, especially when the young person's needs are likely to remain at a similar level until adulthood. Professionals responsible for children's transition into adult CHC should identify those young people for whom it is likely that CHC will be necessary and should notify the responsible CCG. This should occur when a young person reaches the age of 14 and should be followed up by a formal referral for screening at age 16 to the Adult CHC Team.

31. Training

31.1 Training on the Framework will be provided to hospital staff, community staff and adult social care staff involved in the implementation and application of the Framework. Training will be provided in the use of the National Tools, the identification of a 'primary health need', the application process and the timescales for completion of assessments.

31.2 Training is delivered by the CHC team in a planned programme and at various venues. The CHC Service will keep a record of numbers of staff trained for audit purposes and for ensuring the training is in line within any changes to regulations relating to CHC and FNC. Records of numbers / sessions are available through The Learning Enterprise (TLE).

31.3 All those applying the Checklist, participating in an MDT and completing a DST must have been trained in the use of the tools. A link to e-learning for CHC is provided below, which all staff are recommended to use to gain greater understanding of the process.

http://www.e-lfh.org.uk/programmes/continuing-healthcare/

32. Public Information

32.1 The CCG will have a link from its website to NHS England/DH's website to ensure that the public can readily access information on CHC.

33. Audit Monitoring and Governance Within The CCG

33.1 CHC processes and commissioning will be audited and monitored through reports to relevant bodies within The CCG e.g.

- Finance committees
- Quality/Clinical Governance committees
- Governing bodies

33.1 Care will only be commissioned from care providers who are registered with the Care Quality Commission.

33.2 The CCGs will commission the provision of CHC in a manner which balances the need for CCGs to commission care that is safe and effective and makes best use of resources.

33.3 In circumstances where the quality of a care provider is poor and the CCGs cannot commission from that provider at the time, the CCGs will work with individuals and their families to commission suitable care from another provider.

34 Governance Across The STP

34.1 Implementation and delivery of the requirements of the National Framework for CHC and NHS-funded Nursing Care (Revised 2018) will be governed across the STP through performance reports to CCG's STP Board and the STP Quality Committee.

35 References

No.	Reference
1	https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care
2	https://www.england.nhs.uk/who-pays/
3	http://www.legislation.gov.uk/uksi/2012/2996/contents/made
4	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
5	http://www.legislation.gov.uk/ukpga/2006/41/pdfs/ukpga_20060041_en.pdf
6	https://www.legislation.gov.uk/ukpga/2005/9/contents
7	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/193700/NHS_CHC_Public_Information_Leaflet_Final.pdf
8	https://www.legislation.gov.uk/ukpga/1983/20/contents
9	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/764197/NHS-funded_Nursing_Care_Practice_Guidance_2018.pdf
10	https://www.england.nhs.uk/wp-content/uploads/2015/04/nhs-cont-hlthcr-rdress-guid-fin.pdf

36 Definitions

NHS Continuing HealthCare (CHC)	Care arranged and solely funded by the NHS
Care Packages	Suite of services (nursing, therapies, home care, etc.) that are designed to match the assessed needs of the individual
Care Plan	Plan drawn up by a clinician to meet the needs of an individual
Decision Support Tool (DST)	A standardised needs assessment tool used by clinicians to assess the needs of an individual. The outcome of the DST is to make a recommendation regarding the eligibility of an individual for an NHS funded package
Case Co-ordinator	Named professional responsible for: • Drawing up a Care Prescription • Maintaining contact with the individual / their representative and relevant professionals • Monitoring and reviewing the needs of the individual receiving a care package and assessing the suitability of the package
Budget Holder	Person responsible under the Scheme of Delegation for authorising the release of NHS resources.

36. Joint Discharge Process for Adult Hospital Discharges