Staffordshire and Stoke-on-Trent Integrated Care System

NHS Continuing Healthcare (CHC) Joint Operational Protocol

August 2024

(Updated May 2025)

Contents

1.Introduction

1.1 The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) is committed to working in partnership with all other organisations with a stake in NHS Continuing Healthcare, including other NHS trusts, independent service providers, voluntary organisations and those representing the interests of individuals and the public. The processes described herein have been coproduced with ICS system partners, underpinned by the ICS Leadership Compact values. We will utilise the ICS continuous quality improvement process as a framework to review the implementation of the protocol periodically, to aid future development and improvement.

1.2 The revised National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-Funded Nursing Care.

1.3 The revised version of the National Framework was implemented in July 2022. It includes Practice Guidance to support staff delivering NHS Continuing Healthcare.

1.4 At the heart of the National Framework is the process for determining whether an individual is eligible for NHS Continuing Healthcare or NHS-Funded Nursing Care.

1.5 An individual is eligible for NHS Continuing Healthcare if they have a 'primary health need'. This is a concept developed by the Secretary of State to assist in determining when the NHS is responsible for providing all the individual's assessed health and associated social care needs.

1.6 To determine whether an individual has a primary health need, a detailed assessment and decision-making process must be followed, as set out in this National Framework. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for commissioning a care package that meets the individual's health and associated social care needs.

1.7 This National Framework is underpinned by Standing Rules Regulations, issued under the National Health Service Act 2006. These regulations, referred to as henceforth as the Standing Rules, require Integrated Care Boards (ICBs) to have regard to the National Framework.

1.8 The revised National Framework takes account of legislative changes brought about by the Care Act 2014, which preserves the existing boundary and limits of local authority responsibility in relation to the provision of nursing and/or healthcare.

1.9 The individual, the effect their needs have on them, and the ways in which they would prefer to be supported should be kept at the heart of the process. Access to assessment, care provision and support should be fair, consistent and free from discrimination.

1.10 ICBs, the National Health Service Commissioning Board (referred to throughout this National Framework as NHS England) and Local Authorities have legal duties and responsibilities in relation to NHS Continuing Healthcare.

1.11 Those eligible for NHS Continuing Healthcare continue to be entitled to access the full range of primary, community, secondary and other health services.

1.12 This Protocol has been agreed collaboratively and in partnership with the statutory partners and key stakeholders of the ICS as follows:

- Staffordshire County Council (SCC)
- Stoke-on-Trent City Council (SoTCC)
- Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB
- Midlands Partnership NHS Foundation Trust (MPFT)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)

1.13 The SSOT ICB can commission an organisation to deliver a CHC service on its behalf and therefore delegate assessment, clinical oversight, and case management function responsibilities as part of this. There is no formal delegation for decision making, this remains the statutory responsibility of the ICB.

1.14 Similarly, Midlands Partnership Foundation Trust (MPFT) acts within delegated responsibilities for Staffordshire County Council in relation to Adult Social Care.

2.Key Definitions

- **NHS Continuing Healthcare** 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 this National Framework. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen because 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. Eligibility for NHS Continuing Healthcare is not determined by the setting in which the package of support can be offered or by the type of service delivery.

- **NHS-Funded Nursing Care** 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 NHS Continuing Healthcare before a decision is reached about the need for NHS-Funded Nursing Care.

- **Fast Track** Individuals with a rapidly deteriorating condition that may be entering a terminal phase can be considered for Fast Track Funding to facilitate an urgent package of care with no requirement to complete a DST**.** This includes the end-of-life care pathway.

- **Primary Health Need** is a concept developed by the Secretary of State for Health to assist in deciding when an individual's primary need is for healthcare (which it is appropriate for the NHS to provide under the 2006 Act) rather than social care (which the Local Authority may provide under the Care Act 2014). To determine whether an individual has a primary health need, there is an assessment process, which is detailed in this National Framework. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for providing for all that individual's assessed health and associated social care needs, including accommodation, if that is part of the overall need.

- **Integrated Care Board** (ICB) is intended to include any individual or body authorised by the ICB to exercise any of its functions on its behalf in relation to NHS Continuing Healthcare. Where an ICB delegates such functions, it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework. The ICB cannot delegate its final decision-making function in relation to eligibility decisions and remains legally responsible for all eligibility decisions made (in accordance with Standing Rules).

- **Discounted** If an initial referral (checklist) has been made for CHC assessment and then fully NHS funded interim care is provided by exception, the initial referral will then be discounted. At the point the interim care has come to an end and / or the individual has stabilised, and a DST is requested again (either by carrying out another checklist or by direct referral for the DST to take place without carrying out another checklist), this counts as a new referral as it relates to a different period of care (i.e. from the end of the interim care onwards rather than from the original / first referral onwards which was covered by fully NHS funded interim care). If the interim care is not fully funded (e.g. part NHS funded and part social care or self-funded by the individual) the referral should not be discounted. If following the interim care, the individual is found to be NHS CHC eligible, the funding would normally need to be reimbursed to day 29 of the initial referral to cover the time the individual was paying for their own care. The original referral should therefore not be discounted and 28 days counting still applies until the point a verified decision on eligibility is made.

- **Withdrawn** means given due consideration to any Mental Capacity Act implications, if an individual or their representative decline to be considered for NHS Continuing Healthcare at any stage of the process, they must be made aware of the implications of this decision. Such as this may affect their eligibility for any social care funded support. It should also be noted that an individual does not have to consent/participate in an assessment for CHC, but consent to for sharing of information to third parties. It should also be recorded that this has been shared with the individual(s) wishing to withdraw their participation and detailed in their care records. A checklist submitted as positive may also be withdrawn by the ICB if, upon Quality Assurance checks and following checks with the checklist submitter to resolve such queries, the ICB deems the checklist to be scored incorrectly and is a negative rather than positive checklist (i.e. NHS CHC Assessment is not required, and the case should not have been referred).

3.Roles and Responsibilities

3.1 NHS England

- NHS England's functions include providing strategic leadership and organisational and workforce development and ensuring that local systems operate effectively and deliver improved performance. NHS England holds ICBs accountable and therefore engages with them to ensure that they discharge their functions. In carrying out this role, NHS England should be aware of the range of responsibilities that ICBs hold in relation to NHS Continuing Healthcare, as detailed in paragraph above.
- NHS England is also responsible for appointing individuals to act as chairs of independent review panels (IRPs) and establishing a list of IRP members drawn from local authorities and ICBs, in accordance with Standing Rules.
- In some limited circumstances, NHS England may also have commissioning responsibility for some individuals who are either prisoners or serving military personnel and their families. Where NHS England does have such responsibility, this

National Framework will apply. Where a ICB is referred to throughout the National Framework, the responsibilities will also apply to NHS England in these limited circumstances.

- For other exceptions or queries please see the NHS England 'Who Pay's' responsible commissioner guidance. https://www.england.nhs.uk/who-pays/

3.2 **ICBs**

- ICBs are responsible and accountable for NHS Continuing Healthcare within their local health and social care economy (refer to paragraphs 40-41 of the National Framework), including:
  - Ensuring delivery of, and compliance with, the National Framework for NHS Continuing Healthcare.
  - Promoting awareness of NHS Continuing Healthcare.
- Establishing and maintaining governance arrangements for NHS Continuing Healthcare eligibility processes and commissioning NHS Continuing Healthcare packages.
- Ensuring that assessment mechanisms are in place for NHS Continuing Healthcare across relevant care pathways, in partnership with the local authority as appropriate. The Standing Rules require ICBs to consult, as far as is reasonably practicable, with the relevant social services authority before making a decision on an individual's eligibility for NHS Continuing Healthcare (the Care and support statutory guidance should be used to identify the relevant social services authority).
- Making decisions on eligibility for NHS Continuing Healthcare.
- Identifying and acting on issues arising in the provision of NHS Continuing Healthcare.
- Commissioning arrangements, both on a strategic and an individual basis.
- Having a system in place to record assessments undertaken and their outcomes, and the costs of NHS Continuing Healthcare packages. It is important that any such system should clearly identify those receiving NHS Continuing Healthcare as a distinct group from those being supported via joint packages or any other funding routes.
- Implementing and maintaining good practice.
- Ensuring that quality standards are met and sustained.
- Nominating and making available suitably skilled professionals to be members of independent review panels (in accordance with Standing Rules).
- Ensuring training and development opportunities are available for practitioners, in partnership with the local authority or where there is a delegated function.
- Having clear arrangements in place with other NHS organisations (e.g. Foundation Trusts) and independent or voluntary sector partners to ensure effective operation of the National Framework.

3.3 Have a system in place to record assessments undertaken and their outcomes, and the costs of NHS CHC care packages.

3.4 Implementing and maintaining good practice.

3.5 Ensuring quality standards are met and maintained.

3.6 Nominating and making available sustainably skilled professionals.

3.7 Ensuring training and development opportunities are available for practitioners, in partnership with LA.

3.8 Identifying and acting on issues arising in the provision of NHS Continuing Healthcare.

3.9 Informing commissioning arrangements on both a strategic and an individual basis.

3.10 Ensure referral management processes are robust to receive and record all Fast Track Tools, CHC Checklists, DSTs, FNC Assessments, Review Documentation; and non CHC referrals.

3.11 Appoint a CHC Coordinator / CHC Nurse Assessor to oversee, facilitate and complete the CHC process where relevant.

3.12 Ensure the standards required are met in respect of all referrals (CHC Checklist, Fast Track, CHC, FNC and NON CHC) in accordance with the National Framework. Ensuring all applications are supported by robust clinical evidence in a timely and appropriate manner.

3.13 Ensuring that assessment mechanisms are in place for NHS Continuing Healthcare across relevant care pathways, in partnership with the local authority as appropriate. The Standing Rules require ICBs to consult, as far as is reasonably practicable, with the relevant social services authority before making a decision on an individual's eligibility for NHS Continuing Healthcare (the Care and support statutory guidance should be used to identify the relevant social services authority).

3.14 **Local Authority**

- Where it appears that an individual may require a full assessment for NHS Continuing Healthcare, the local authority must refer the individual to the relevant ICB/ their delegated health partner, via a Checklist.

- There are specific requirements for local authorities to cooperate and work in partnership with ICBs in number of key areas.

- Where it appears that a full CHC assessment may not be appropriate or necessary in line with the Framework guidance, the Local Authority must consider 'when not to

checklist' and document the rationale for the decision within the individual care records.

- Local authorities must, as far as is reasonably practicable, provide advice and assistance when consulted by the ICB in relation to an assessment of eligibility for NHS Continuing Healthcare. This duty applies regardless of whether an assessment of needs for care and support under Section 9 of the Care Act 2014 is required (refer to paragraphs 124-130). Where the local authority has carried out such an assessment of needs it must (as far as it is relevant) use information from this assessment to assist the ICB in carrying out its responsibilities (refer to paragraph above). This should also include application of the Mental Capacity Act (2005) where it's pertinent to the individual.

- A local authority must, when requested to do so by the ICB, co-operate with the ICB in arranging for an individual or individuals to participate in a multidisciplinary team, in a reasonable timescale.

- It is also good practice for local authorities to work jointly with ICBs in the planning and commissioning of care or support for individuals found eligible for NHS Continuing Healthcare wherever appropriate, sharing expertise and local knowledge (whilst recognising that ICBs retain formal commissioning and care planning responsibility for those eligible for NHS Continuing Healthcare).

- Regulations state that local authorities must nominate individuals to be appointed as local authority members of Independent Review Panels (IRP) where requested to do so by NHS England. This duty includes both nominating such individuals as soon as is reasonably practicable and ensuring that they are, so far as it is reasonably practicable, available to participate in IRPs.

3.15 System Partners

- Obtain appropriate documented consent in line with policy and a Mental Capacity Assessment as required.

- Complete the appropriate documentation including a professional assessment of health and wellbeing needs with reference to supporting evidence, as pertinent to a CHC Checklist, Fast Track Determination or a Nursing Assessment to determine FNC eligibility.

- Ensure full engagement and co-operation in completing the Fast Track documentation or equivalent processes if the individual is being supported through the End-of-Life Care Pathway.

- Professionals referring individuals for consideration of eligibility should:
  - 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 ICB receiving a positive Checklist.

4.Purpose

4.1 The purpose of this local Protocol is to set out the process by which the ICB and its partners assess an individual's health needs in respect of their eligibility for NHS Continuing Healthcare; how the Staffordshire and Stoke-on-Trent ICB decide on their eligibility for NHS Continuing Healthcare funding; and how it commissions that care.

5.Scope

5.1 In Scope

- This Protocol applies to all residents over the age of 18 who are registered with a GP in Staffordshire and Stoke-on-Trent. However, when a young individual reaches their 17th birthday eligibility should be determined against the adult National Framework for CHC (July 2022).
- Staffordshire and Stoke-on-Trent integrated Care System (ICS), inclusive of both Staffordshire County and Stoke-on-Trent City Councils are working in collaboration to deliver the National Framework for NHS Continuing Healthcare and NHS -Funded Nursing Care (July 2022).

5.2 Out of Scope

5.3 This protocol does not apply to applications for CHC or FNC for Staffordshire and Stoke-on-Trent residents who are registered with a GP outside of Staffordshire and Stoke-on-Trent, referrals for those individuals should be made to the relevant ICB as determined by the individual's GP. Please refer to NHS 'Who Pays' Determining which NHS commissioner is responsible for making payment to a provider' August 2020.

6.Screening and Assessment processes

6.1 Consent

6.1.1 Consent As per the National Framework (revised 2022), where the individual has relevant capacity, their explicit consent is required for the sharing of personal data with third parties other than health or social care professionals (for example family, friends, advocates, and / or other representatives).

6.1.2 Every effort should be made to encourage the individual or representative (with relevant authority) to participate actively in the assessment process. In the minority of cases where an individual might not wish to participate actively, ICBs and local authorities should consider the case and determine each organisation's responsibilities and the most appropriate way forward. (Page 122 of National Framework).

6.1.3 The Information Commissioning Office has set out general principles around consent in their 'When is consent appropriate?' guidance (reference 11). Consent | ICO

6.1.4 For consent to be valid for these purposes it must be explicit, specific, informed and freely given. The individual must be aware that they can withdraw their consent to share information at any time.

6.1.5 Consent is not required from the individual for sharing their information with those who have statutory involvement in the NHS CHC assessment process, for example Health and Social Care professionals. This is because there is a legal requirement for sharing to take place between organisations and professionals involved in the NHS CHC assessment process.

6.2 NHS CHC Checklist

6.2.1 Screening for CHC should be at the right time and location for the individual and when the individual's ongoing needs are clearer. This will help practitioners to correctly identify individuals who require a full assessment of eligibility. It is good practice for referrers to share availability if a multi-disciplinary team meeting (MDT) is scheduled to complete a Decision Support Tool (DST).

6.2.2 Where an individual requires a long-term care home placement with nursing or has significant support needs, a checklist would be expected to be completed (unless the decision is made to go straight to the completion of a Decision Support Tool (DST)).

6.2.3 There may be situations where it is not necessary to complete a checklist. These include:

- It is clear to practitioners working in the health and care system that there is no need for CHC now. Where appropriate/ relevant this decision and its reasons should be recorded. If there is doubt between practitioners a checklist should be undertaken.
- The individual has short-term health care needs or is recovering from a temporary condition that has not yet reached their optimum potential (if there is any doubt between practitioners about the short-term needs it may be necessary to complete a checklist.
- It has been agreed by the ICB that the individual should be referred directly for a full assessment of eligibility for CHC.
- The individual has a rapidly deteriorating condition and may be entering a terminal phase. In these situations, the Fast Track Pathway Tool or local equivalent pathways, such as End-of-Life (EOL) should be used instead of the checklist.
- An individual is receiving services under Section 117 (S117) of the Mental Health Act that meet all of their assessed needs.
- It has previously been decided that the individual is not eligible for CHC and it is clear that there has been no change in needs.

Please refer to the flow diagrams in the supporting appendices for further detail.

6.2.4 If the checklist is negative, indicating there is no requirement to complete a full CHC assessment; the referrer should send an outcome letter and copy of the checklist to the patient/patient representative and to the ICB. This reinforces the principle of always 'considering' if a checklist should be completed or not, as if it is not appropriate to do so no further actions other than recording a rationale are required.

6.2.5 The outcome and rationale for the decision should be recorded on the Checklist document.

6.2.6 The individual should be informed of the Checklist outcome and given a copy along with a full explanation of the rationale together with a copy of the CHC Public Information Leaflet.

6.2.7 Using the National Framework guidance notes to correctly complete the CHC checklist tool will prevent delays for the individual and help ensure they receive a full CHC assessment within the 28 days possible.

7. Screening for CHC using the checklist

7.1 Where possible the Checklist and Consent Template should be submitted as an e referral through Sproc.net with all referrals, which will be submitted as an e-referral by 31 March 2025. If you cannot submit via Sproc.Net, send the Checklist with the Consent Template to aaccinitialreferral@StaffsStoke.ICB.nhs.uk.

7.2 The 28-day KPI (28 calendar days) commences when the ICB receives a checklist referral and has verified that it is positive.

7.3 The ICB have a responsibility to check the quality of completion of all CHC checklists received. This includes:

- Is there evidence of consent received with the CHC checklist, to demonstrate the individual has been informed of the CHC process and consents to information sharing?
- The checklist requires practitioners to record a brief description of the need and source of evidence used to support the statements selected for each domain.
- Do the scores indicate the need for full CHC assessment?

7.4 If it is deemed that the referral is not appropriate, for whatever reason, the ICB will share an outcome letter with both the individual and referrer explaining this. If additional queries are identified, the ICB will inform the referrer, allowing 4 working days to respond. If no response is received, the referral will be **withdrawn.** If additional information is required and assurance is met, the case will proceed to MDT for DST.

7.5 The requirement for assessments to be completed within 28 days from the original positive checklist is a nationally mandated key performance indicator and requires joint working across the whole system of health and social care.

8. Assessment of eligibility for CHC using the Decision Support Tool (DST)

8.1 Scheduling the Multi-Disciplinary Team Meeting (MDT)

Dependent on the location of the individual, the coordination and scheduling of the MDT to complete the DST will vary as detailed below. In all scenarios, A blank DST or link to the NHS DST will be shared by the ICB with patient and/or their representative prior to the DST meeting to assist in their preparation/readiness.

Community Referrals	The ICB scheduling team will arrange the appointment for the MDT and invite the individual, their representative, the care provider, and all MDT health and social care professionals involved in the care of the individual. All health and social care professionals will be requested to provide copies of needs assessments (Care Act Assessment, DN assessment, etc.) which can be used to collate assessment information for completion of the Decision Support Tool documentation. The MDT will be scheduled on or before the 10th day of the 28 days from date of referral receipt. The local authority will receive at least 10 days operational notice to attend the DST or, for a mutually convenient date to be agreed.
Individuals on the End-of-Life Pathway	Checklist and DST completed by Palliative Care Coordination Centre (PCCC).
Individuals in Discharge to Assess (D2A) (pathway 2 and 3 beds)	Where an individual is placed in a pathway 2 or 3 D2A bed wither in a Care Home or Community Hospital, the relevant ward/ unit/ team will schedule and coordinate the MDT, including social care to complete the DST. The responsibility for completion of the DST is dependent on the location of the individual.
Individuals in acute settings	Where an individual is in an acute setting, and it has been agreed with the ICB that an assessment can take place by exception. The ward/ hospital discharge team will be responsible to reschedule and coordinate the MDT, including social care to complete the DST.

8.2 Completing the DST

8.2.1 The DST should be completed accurately, clearly, and comprehensively and include all relevant information. This can include verbal evidence as highlighted in the 2022 framework.

8.2.2 The DST is a summary document which includes evidence from all available assessment information and multi-disciplinary opinions regarding the individuals' level of needs, based on descriptors in each care domain.

8.2.3 The assessment coordinator should ensure conflicting opinions are clear and evidenced.

8.2.4 Needs should be described in measurable terms providing necessary details e.g. frequency intervention, response to interventions, using clinical expertise and supported with the results from appropriate and validated assessment tools where relevant.

8.2.5 Actual and potential risks should be included based on professional judgement.

8.2.6 DST informs consistent decision making and the multi-disciplinary teams must make a recommendation as to whether an individual's needs indicate a primary health need considering the nature, complexity, intensity and unpredictably of their needs.

8.2.7 The individual (or their representative) should be involved in the completion of the DST and receive a copy of the completed document including guidance notes.

8.2.8 It is vital that the individuals (or their representatives) contribution and opinion (verbal or otherwise) of the assessment is recorded on the DST.

8.3 Making a recommendation of eligibility to the ICB

8.3.1 The MDT is required to make a recommendation to the ICB as to whether or not the individual has a primary health need, bearing in mind that where the ICB decides that the individual has a primary health need they are eligible for NHS Continuing Healthcare (refer to Practice Guidance note 34). In coming to this recommendation, the MDT should work collectively using professional judgement

8.3.2 The written recommendation needs to be clear and concise whilst providing sufficient detail to enable the ICB and the individual to understand the underlying rationale for the recommendation

8.3.3 The Standing Rules set out how 'primary health need' should be considered in the context of considering eligibility for NHS Continuing Healthcare. Paragraphs 55-67 of the National Framework explain the primary health need test in some detail. It is important to understand that this test is about the balance of needs once all needs have been mapped onto the DST.

8.3.4 "An individual has a primary health need, if having taken account of all their needs it can be said that the **main** aspects or **majority** part of the care, they require is focused on addressing and/or preventing health needs.

8.3.5 Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality."

- MDT members should make a recommendation at the CHC MDT, discussion and agreement of the recommendation should be completed as professionals and not in the presence of the individual (or their representative). If additional or new evidence is available, the MDT including the individual (or their representative) should reconvene to consider and update the DST as appropriate.
- If the new evidence suggests a potential change to the recommendation, this should be considered by the MDT professional and not in the presence of the individual (or their representative). Consideration should be given to whether a new CHC MDT and DST is required.
- MDT members will receive a copy of the completed DST before signing the recommendation sheet, this will be emailed to the email address provided. MDT members need to adhere to the 28-day national KPI, the DST should be signed and returned to the ICB aaccinitialreferral@StaffsStoke.ICB.nhs.uk within 2 working days of the MDT meeting date.
- If a DST is sent to MDT members and not signed and returned within 2 working days, the ICB will submit the DST for verification based on the verbal agreement at the CHC MDT.
- CHC MDT members are required to make a recommendation at the MDT, unless there are exceptional circumstances, in which case these should be documented on the DST with agreed next steps and the date the MDT will reconvene to agree the recommendation, this should be within 2 working days.
- CHC MDT members will make a CHC eligibility recommendation based entirely on the individuals care needs as identified in the Decision Support Tool.

- It is important that as part of the DST MDT meeting, that the DST process and timescales are shared with the individual or their representative, including what happens if the recommendation is not eligible.

8.4 Four Key Characteristics

Nature

- This describes the characteristics of an individual's needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type (quality') of interventions required to manage them.

Intensity

- This relates both to the extent (quantity') and severity (degree') of the needs and to the support required to meet them, including the need for sustained/ ongoing care (continuity').

Complexity

- This is concerned with how the needs present and interact to increase the skill required to monitor the system, treat the condition (s) and/ or manage care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.

Unpredictability

- This describes the degree to which needs fluctuate and therapy creates challenges in managing them. It also relates to the level of risk to the individual's health if adequate and timely care is not provided. An individual with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of the care required to meet the individual's needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered when completing the DST.

9.Fast Track/ End of Life (EoL)

9.1 Locally, the SSOT ICS has implemented a community-based end of life pathway where all referrals for individuals deemed at the end of life (previously fast track) are supported via a Single Point of Access via the Palliative Care Coordination Centre.

9.2 For individuals in a 24-hour care home with nursing in receipt of FNC, where needs suggest end of life presentation these cases will be managed by the ICB via the unscheduled care review process.

9.3 The completed referral should demonstrate clear reasons why the individual fulfils the criteria and evidence clearly that an individual is both rapidly deteriorating and may be entering terminal phase. This in itself is sufficient to establish appropriateness for the

pathway or Fast Track eligibility if transitioning from FNC to Fast Track, for individuals in a 24-hou care home setting.

9.4 The EOL referral and/ or Fast Track Tool should be completed by the most appropriate **clinician** who is involved in the care and treatment of the individual. It is imperative that consent is received, or evidence of a best interest decision is documented.

9.5 An 'appropriate clinician' is defined as an individual who is:

- responsible for the diagnosis, treatment or care of the individual under the 2006 Act in respect of whom an EOL referral or Fast Track Pathway Tool is being completed; and
- a registered nurse or a registered medical practitioner.

9.6 An 'appropriate clinician' can include clinicians employed in voluntary and independent sector organisations that have a specialist role in end-of-life needs (for example, hospices), when they have been trained in use of the National Framework and have approval from the ICB.

9.7 The EOL referral or Fast Track Pathway Tool replaces the need for a Checklist and DST to be completed.

9.8 However, an EOL referral or Fast Track Pathway Tool can also be completed after a Checklist if it becomes apparent at that point that the criteria are met.

9.9 The completed EOL referral and/or Fast Track Pathway Tool should be supported by a prognosis, where available. However, strict time limits that base eligibility on a specified expected length of life remaining should not be imposed.

9.10 The individual and or their representative must be advised about their condition and prognosis and agree to the end-of-life care pathway.

9.11 End-of-life referrals managed by PCCC should be submitted PCCC@mpft.nhs.uk.

9.12 Where an individual is in receipt of FNC funding in a 24-hour care setting, a request for an urgent unscheduled review should be submitted to the ICB aaccspa@StaffsStoke.ICB.nhs.uk.

9.13 This is to ensure the quality assurance process is completed to identify there is sufficient evidence to indicate that the individual has a rapidly deteriorating condition that may be entering a terminal phase.

10. Funded Nursing Care Applications (FNC)

10.1 NHS-funded Nursing Care is the funding provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible for NHS-funded Nursing Care.

10.2 If an individual is not eligible for NHS Continuing Healthcare, the need for care from a registered nurse may need to be determined.

10.3 An individual is eligible for NHS-funded Nursing Care if:

- The individual has such a need; and
- It is determined that the individual's overall needs would be most appropriately met in a care home with nursing.

10.4 The registered nurse input is defined in the following terms: 'Services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse'.

10.5 Where an individual may have a nursing need a nursing needs assessment, which specifies the day-to-day care and support needs of the individual, should be used to assess whether an individual is eligible for NHS-funded Nursing Care.

10.6 It must be an NHS employed nurse who determines if a person is eligible for NHS Funded Nursing care. Where a nursing assessment is completed, this should be submitted by the nurse completing it to the ICB at aaccinitialreferral@StaffsStoke.ICB.nhs.uk and where there is an ASC Practitioner involved, copying them in, so that both parties can then see if this is accepted(see 10.9 below) and to enable any queries to be resolved between the respective clinicians.

10.7 It is recognised in some instances that individuals may be admitted to a Care Home with nursing in an emergency scenario or as part of a planned respite provision, either by themselves (or their representative), or via Adult Social care.

10.8 Where an individual is placed as an emergency admission as a self-funder, it is the responsibility of the Care Home to arrange completion of the Record of Nursing Needs (RONN) form to enable FNC payments for a maximum of 6 weeks. During this time, a checklist will be completed by the ICB to determine the need for further assessment as appropriate.

10.9 Where an individual is placed as an emergency by Adult Social Care, preferably a nursing assessment should be completed to reflect a nursing recommendation for FNC eligibility prior to the admission, or where this is not achievable as soon as possible following admission and during the person's stay. A verbal or email confirmation of the nurse's recommendation for nursing care to the ASC Practitioner is acceptable, pending their full written assessment being provided to enable the correct care to be sourced in an emergency. The source of this should be referenced in the person's Adult Social Care record. Where the admission takes place and a full written nursing assessment and recommendation for nursing care hasn't been provided, ASC should advise the care home to submit a (RONN) form to the ICB to ensure FNC payments are made from the date of admission and until such time as the nursing assessment is completed and submitted to the ICB. Once the ICB receives the nursing assessment, they will complete a checklist during the initial 6 weeks of an individual's stay as part of their Quality Assurance and confirm that the individual is eligible for FNC, or not.

10.10 Referrals should be submitted to the ICB aaccinitialreferral@StaffsStoke.ICB.nhs.uk and will be responded to within 2 working days working days either confirming FNC eligibility based on the information provided, or queried with the referrer, who has 4 working days in which to respond, concluding in either resolution and acceptance of FNC eligibility or FNC being declined.

10.11 Continence needs must be identified on the nursing assessment or the DST where payment is needed.

10.12 Where disagreements occur between the assessing / submitting nurse and the response from the ICB on FNC eligibility (whether this be via a standalone nursing assessment where a DST hasn't been progressed to or following a DST where when CHC eligibility isn't supported but FNC is recommended).

10.13 Responsibility to identify nursing needs and how they may pertain to FNC eligibility is an NHS Nurse responsibility and then ultimately for the ICB to endorse or not, the recommendation on FNC eligibility.

10.14 It is recognised that this may have implications, where the LA is needing this clarification to enable funded sourcing of eligible care home (with nursing) provision, so whilst Adult Social Care are unable to make this determination, except in short term emergencies, it is acknowledged that Adult Social Care also need to be satisfied due consideration on FNC eligibility has taken place, which in most cases is resolved between the submitting clinician/nurse and the ICB's clinical response to this.

10.15 If the ICB are unable to verify recommended eligibility for FNC, in the first instance they will convey the reasons back to the submitting nurse, in acknowledgement that they are the professional who has directly seen/assessed the person, inviting them to clarify/provide additional information on why they deem the person eligible for FNC. In the majority of cases this will enable a resolution either way to be reached. In the event the two clinicians cannot reach an agreement, the submitting nurse will raise this with their line manager for escalation to the ICB.

10.16 Other routes that may help with difference of professional opinion regards FNC eligibility.

10.17 The submitting nurse should ensure a handover of nursing care to community/district nursing, in the event of FNC not being agreed, which again is a check and balance that this is then agreed and accepted by them. In the event this is queried/not agreed by community / district nursing, this may inform the original submitting nurse to represent their assessment back to the ICB for verification. Likewise, if Adult Social Care receive responses back from care home without nursing (residential care), when brokerage are attempting to source suggesting the person requires nursing care, again this feedback can be provided to the assessing/submitting nurse to represent their assessment back to the ICB.

10.18 In the event Adult Social Care remain of the view the person does require nursing care and should be FNC eligible; after assessing nurse to ICB communication has resulted in agreed non eligibility for FNC, the Adult Social Care professional can raise the case with the relevant Strategic Service Delivery Lead Senior Social Care Lead/Manager for escalation with the ICB.

11. The NHS Continuing Healthcare and Funded Nursing Care Verification process

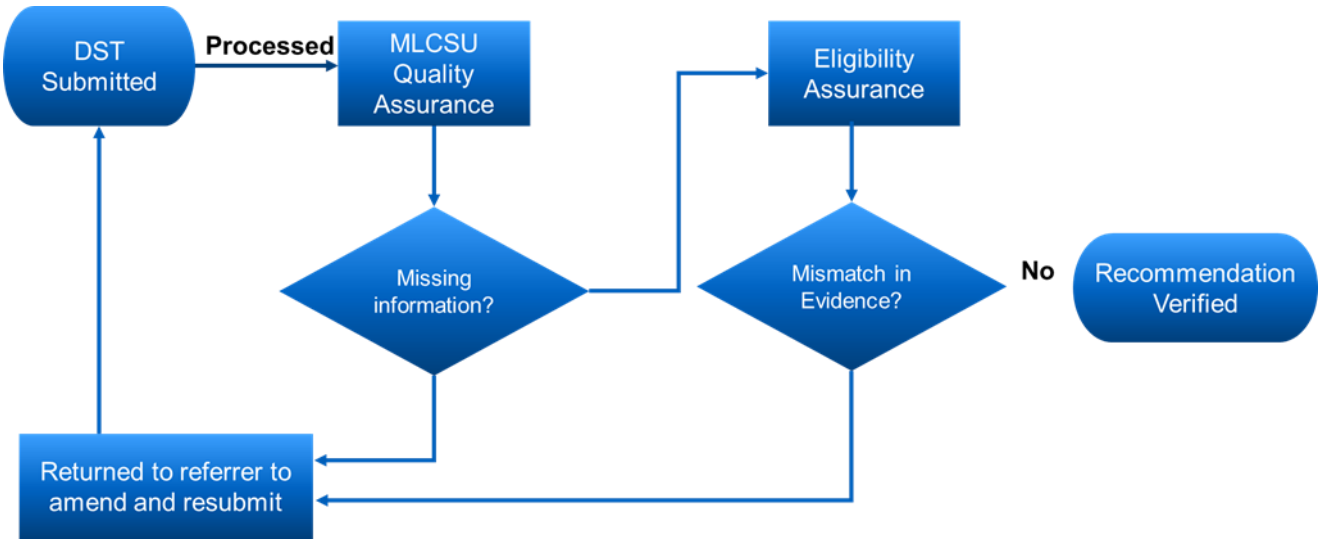
11.1 Once an MDT has made a recommendation regarding eligibility it is for the ICB to make the final eligibility decision.

11.2 The referrer/ lead coordinator of the DST should submit CHC assessment to aaccpanel@StaffsStoke.ICB.nhs.uk including the following documents:

- CHC Checklist
- Decision Support Tool
- Evidence of Consent/mental capacity assessment
- Written contribution from individual/representative (if provided)
- Social care contribution

11.3 Applications will be quality checked, and recommendations verified. The quality assurance process will be managed by the ICB and will ensure that all relevant information is captured within DST, this shall include confirmation and assurance that the individual has received all appropriate input to maximise ability and recovery and appropriateness to assess long-term care needs, e.g. at the right time/ right place.

11.4 The following quality assurance process is in place to support verification.



11.5 Exceptional circumstances where these eligibility recommendations may not be accepted by an ICB include:

- Where the DST is not completed fully (including where there is no recommendation).
- Where there are significant gaps in evidence to support the recommendation.
- Where there is an obvious mismatch between evidence provided and the recommendation made.
- Where the recommendation would result in either authority acting unlawfully.

11.6 In such cases the matter should be sent back to the lead coordinator with a full explanation of the relevant matters to be addressed after discussion between CHC lead nurse who screened the assessment and the referrer/ lead coordinator. Where there is an urgent need for care/support to be provided, the ICB (and LA where relevant) should make appropriate interim arrangements. The involvement of the individual or their representative is paramount.

11.7 The referrer/ lead coordinator and where the ASC representative present will receive email confirmation of the verified outcome at the time of decision the individual and/or representative will receive the outcome letter within 5 working days of the decision.

12. Commissioning, Care-planning Care management and provision

12.1 It is the responsibility of the ICB to make reasonable offers of services to individuals eligible for CHC to meet their assessed needs. If offers of reasonable services are made to individuals to meet their assessed needs and refused, the ICB has discharged its legal duty to those individuals.

12.2 The ICB has a CHC Equity Policy that sets how they will commission care and support for individuals eligible for NHS CHC funding and for whom the ICB is the commissioner responsible. The ICB has developed this policy to ensure best use of NHS resources whilst providing services that are Personalised, high quality, safe, sustainable, and equitable (fair).

12.3 If the individual is deemed eligible for NHS Continuing Healthcare the ICB will commission an appropriate care package in line with the agreed CHC Equity Policy.

12.4 It is recognised that some individuals may not be eligible for NHS CHC but have care needs over and above social care and core community services, where this is the case the ICB will work with ICS system partners to establish a joint funding mechanism to make a contribution to meet the individuals' assessed health needs.

13. Care Planning

13.1 The CHC team will be responsible and ensure that care planning processes are central to the commissioned and provision of care to meet an individual's assessed need.

13.2 The CHC team will ensure that this is the case and determine what the appropriate package should be. In doing so, the service will have due regard to the individuals' wishes and preferred outcomes, where possible.

13.3 The CHC team has a duty to consider a request for a Personal Health Budget (PHB) for individuals eligible for CHC, following the ICB PHB Policy.

14. Case Management

14.1 Once an individual has been found eligible for CHC/ FNC, the AACC team is responsible for case management, including monitoring the care they receive and arranging regular reviews.

14.2 The CHC team will ensure arrangements are in place for an ongoing case management role for individuals eligible for CHC. This could be through joint arrangements with the local authority, subject to local agreement. CHC will assign a named case manager or named point of contact for individuals in receipt of CHC.

14.3 If the individual is deemed not to be eligible for either NHS Continuing Healthcare or NHS-funded Nursing Care, the local authority will offer to assess the individual's needs and determine if they are eligible for support.

15. Care Package Reviews and De-commissioning

15.1 Decommissioning of care packages when an individual is no longer eligible for NHS Continuing Healthcare, eligibility will cease from the date that the Integrated Care Board (ICB) verifies the muti-disciplinary team (MDT) of 'not eligible'.

15.2 Where a person is deemed no longer eligible to remain on the End-of-Life care Pathway, both Local Authorities have agreed to process these requests for assessment and care provision being brokered (where eligible) within 10 calendar days for assessment and 10 calendar days for care brokering/sourcing.

15.3 The CHC service will issue an outcome letter within 48 hours of the eligibility decision to the individual (or their representative), referrer and relevant Local Authority to enable Care Act Assessment/ financial assessment where applicable.

15.4 The ICB will continue to fund the care package for up to a maximum of 28 days from the date of verification.

15.5 If an individual declines a Care Act assessment, or follows a Care Act Assessment, it is not eligible for Local Authority funding e.g. they are responsible for funding their own care, the individual will become responsible for their own funding arrangements from the 29th day following the ICB eligibility decision.

16. CHC Review

16.1 A review should be undertaken within three months of the eligibility decision being made. After this, further reviews should be undertaken on at least an annual basis, although some individuals will require more frequent review in line with clinical judgement and changing needs.

16.2 The review should primarily focus on whether the care plan and commissioned care arrangements remain appropriate to meet the individual's needs.

16.3 It is expected that the most recent complete Decision Support Tool (DST) will normally be available for review and should be used as a point of reference to identify any potential change in needs. Where there is clear evidence of a change in needs to such an extent that it may impact on the individual's eligibility for NHS Continuing Healthcare, then the ICB should arrange a full reassessment of eligibility for NHS Continuing Healthcare.

16.4 Where reassessment of eligibility for NHS Continuing Healthcare is required, a new DST must be completed. A CHC administrator will invite an individual/ representative, care provider, social care and any other health professional involved to attend MDT meeting as detailed above in this document.

17. FNC Review

17.1 Potential eligibility for CHC must always be considered, however:

- Where a checklist or DST has previously been completed with the result the individual was not eligible for CHC.
- And it is clear there has been no material change in need.
- It is not necessary to repeat the checklist or DST, and this should be recorded and the individual informed.
- To determine whether there has been a material change in need each domain and previously assessed level of need should be considered as part of the review.
- The individual should be informed of the outcome of FNC review in writing and provided with a copy of the annotated checklist or DST.
- Where there is a change in need to indicate a full CHC assessment is required – a new CHC checklist will be completed and full CHC/MDT process followed.

18. Equipment and Access to other NHS Provision

18.1 Where individuals in receipt of NHS Continuing Healthcare require equipment to meet their care needs, there are several routes by which this may be provided:

- If the individual is, or will be, supported in a care home setting, the care home may need to provide certain equipment to meet regulatory standards or as part of its contract with the ICB. Further details of the regulatory standards can be found on the Care Quality Commission's website.
- Individuals who are eligible for NHS Continuing Healthcare should have the same access to standard joint equipment services as other people. Therefore, when planning, commissioning, and funding joint equipment services ICBs should ensure that the needs of current and future recipients of NHS Continuing Healthcare are considered.
- Some individuals in receipt of NHS Continuing Healthcare will require bespoke equipment (or other non-bespoke equipment that is not available through routes above to meet specific assessed needs. ICBs should make appropriate arrangements to assess and meet these and any subsequent equipment needs that might arise, including responsibility for any essential servicing and repair that might be required for items of equipment.

18.2 **Equipment Definitions**

Standard Equipment:

- "All items of equipment that are required to adequately and sufficiently meet Service User care requirements. Includes all equipment which does not fall under the definition of Bespoke Equipment."

Bespoke Equipment:

- "Equipment is considered bespoke if it is designed or moulded specifically for a single individual, cannot be reused for another service user and is not within the usual remit of the Provider 's service."

Equipment Requirements

The provider will be expected to provide any Standard Equipment required to meet specific needs of service users accepted.

- The provider will be expected to fund all items of Standard Equipment.
- The Provider will make sure that aids, adaptations and equipment are suitable, available and properly maintained and will ensure that appropriate care is given safely, according to the individually assessed needs of each service user in order to maintain and promote independence.
- The Provider will carry out pre-admission assessments in order to identify potential Service user's current and likely future need for equipment.

18.2.1 If under exceptional circumstances, Bespoke Equipment is deemed as being required by an individual Service User, the ICB will agree to the level of contribution on a case-by-case basis. The Commissioner will only consider requests to pay for specific items of equipment where a Service User's needs have substantially changed during their placement and are now deemed to be exceptional or bespoke in nature and any such request should be supported by an advanced complex assessment which has been undertaken by a trained and competent individual. These Bespoke Equipment requests will be considered on the basis of the individual's needs, by the Commissioner. The Provider/ Service User shall not hold Commissioners responsible for contributing towards funding any equipment without Commissioners explicit prior approval.

18.2.2 ICBs should ensure that there is clarity about which of the above arrangements is applicable in each individual situation, including responsibility for any essential

servicing and repair that might be required for items of equipment. ICBs are reminded of their ability to utilise Personal Health Budgets as a means of meeting equipment needs (including servicing and repair).

18.2.3 Where an individual is assessed in a hospital setting as being eligible for NHS Continuing Healthcare, ICBs must have systems in place to minimise discharge delays due to equipment provision.

19. Training

19.1 An ongoing program of training jointly planned and provided by the ICBs with the Adult Social Services, Staffordshire County Council, Stoke City Council, Midlands Partnership Foundation Trust and North Staffordshire Combined Healthcare NHS Trust, will support relevant NHS, Local Authority and other staff and members in their implementation of the National Framework and any other relevant training needed.

20. Individual Appeals, Retrospective reviews and Complaints

20.1 Integrated Care Boards (ICBs) and Local Authorities (LAs) have agreed local processes as directed within the National Framework for NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC), July 2022.

21. Appeals

21.1 Where an individual or their representative asks the ICB to review the eligibility decision, this should be addressed through the local resolution procedure, which is normally expected to resolve the matter. ICBs should deal with requests for review in a timely manner. Individual/representatives are provided with details of how to request an appeal in the decision outcome letter.

Funding arrangements during the appeals process are as follows:

21.2 If social care representation is present at the Decision Support Tool (DST) and agree the individual no longer meets Continuing Healthcare but the individual/family appeal, the proceeding steps should continue as normal i.e. the appeal goes on in the background. If the individual wins their appeal, reimbursement for actual care costs paid for the period deemed eligible will be funded in line with national guidance.

21.3 If an individual is receiving care via CHC from a provider that is not registered as a contracted provider in either Staffordshire County or Stoke-on-Trent City Councils contract framework, then in taking on the responsibility of care and ongoing funding, the relevant authority may seek to transfer the care to an alternative contracted provider.

21.4 If the individual is in a care home placement, consideration will be given to the cost of that placement. The Local Authority will explore the possibility of the most cost-

effective options that will continue to meet the individual's needs, and this will inform the maximum amount the Local Authority will pay.

21.5 During the appeal period, individuals will be required to undertake a contributions assessment from the relevant local authority and pay any contributions identified. This needs to be made clear as individual's do refuse to pay their contributions whilst the appeal takes place.

22. Retrospective reviews

22.1 Where/when an individual/representative requests an assessment for a previously unassessed period of care they should be advised to make an application in writing to the retrospective team at Staffordshire and Stoke-on-Trent Integrated Care Board, Smithfield One Building, Leonard Coates Way, Stoke-on-Trent, ST1 4FA.

23. Complaints

23.1 Where/when an individual/representative wishes to make a formal complaint in relation to CHC they should be advised to submit in writing to:
Staffordshire and Stoke-on-Trent Integrated Care Board
Smithfield One Building
Leonard Coates Way
Stoke-on-Trent
ST1 4FA
Telephone: 0300 123 1461

24. Interagency Escalation and Resolution

24.1 Collaboration between partners (including local government and NHS) within an integrated care system is essential to sustain joined-up, efficient and effective services.

24.2 A fundamental principle is for ICBs and local authorities to minimise the need to invoke formal inter-agency dispute resolution procedures to enable early resolution of cases, as such the revised Joint Operational Protocol (JOP) has removed the previous formal dispute protocol and process and has replaced this with a focus on early resolution of cases through discussion and collaboration. This will be achieved through the following:

- Creating a culture of genuine partnership working across all agencies involved in the NHS CHC assessment process in an open and transparent manner in line with the ICS Leadership Compact.
- Ensuring that eligibility decisions are based on thorough, accurate and evidence-based assessments of the individuals' needs.
- Keeping the individual at the centre of the process and ensuring a person-centred approach to decision-making

- Dealing with genuine disagreements between practitioners in a professional manner without drawing the individual concerned into the debate in order to gain support for one professional's position or the other.

24.3 The process defined in appendix 4 of this protocol provides the steps to be taken by professionals from the system when supporting and resolving escalated cases, moving away from the previous formal dispute resolution process.

25. References:

CHC National Framework (Revised July 2022)
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care
NHS CHC Checklist (July 2022) NHS CHC Decision Support Tool (July 2022), NHS Public Information leaflet
https://www.gov.uk/government/publications/nhs-continuing-healthcare-checklist
https://www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool
https://www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet
The National Health Service Commissioning Board and Clinical Groups (Responsibilities and Standing Rules) Regulations (2012)
National Health Service Act (2006)
https://www.legislation.gov.uk/ukpga/2006/41/contents
https://www.legislation.gov.uk/ukpga/2012/7/section/234
Section 22 of the Care Act (2014)
http://www.legislation.gov.uk/ukpga/2014/23/section/22/enacted
Department of Health and Social Care and support statutory guidance
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
Department of Health and Social Care, Regulation 3(5) of the Care and Support (Provision of Health Services) Regulations 2014
http://www.legislation.gov.uk/uksi/2014/2821/made

Children and Young People's Continuing Care National Framework 2016
https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework

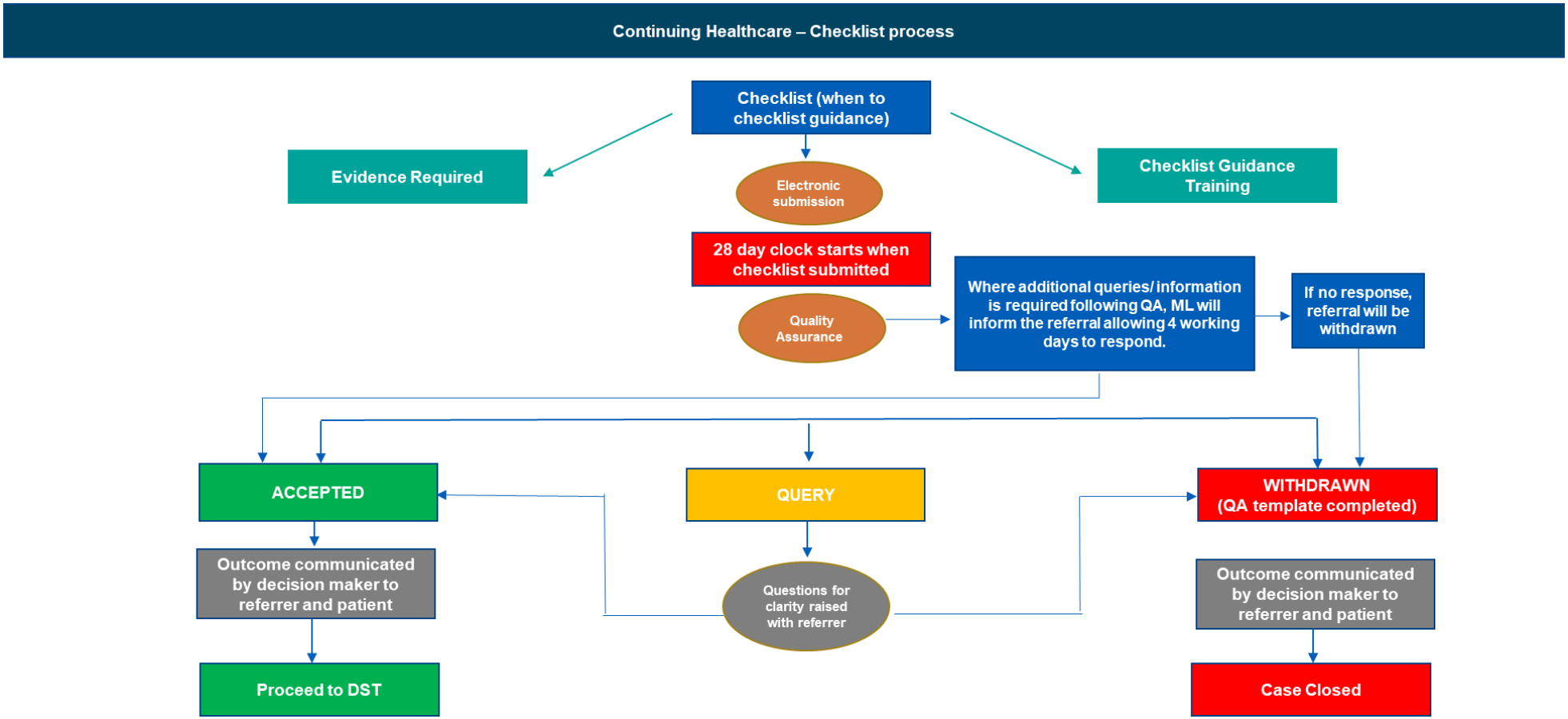
Mental Capacity Act - Code of practice
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

NHS-funded Nursing Care Practice Guidance - published (2022)
https://www.gov.uk/government/publications/nhs-funded-nursing-care-practice

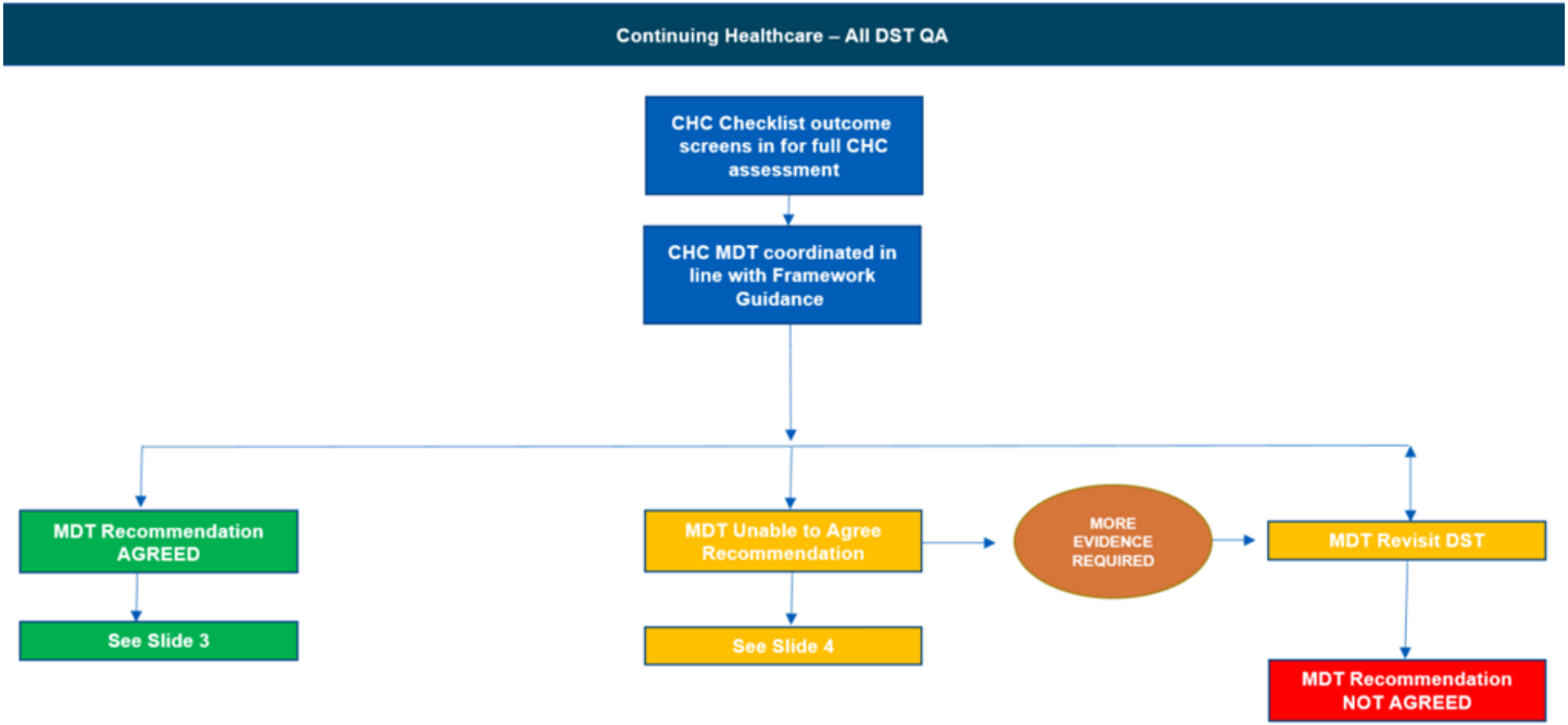
NHS Who Pays (August 2020)
https://www.england.nhs.uk/publication/who-pays-determining-responsibility-for-nhs-payments-to-providers/

Contact Addresses
CHC Referrals: aaccinitialreferral@StaffsStoke.ICB.nhs.uk
CHC Enquiries: aaccspa@StaffsStoke.ICB.nhs.uk
CHC DST Submission for Verification: aaccpanel@StaffsStoke.ICB.nhs.uk

26. Appendix 1 – Checklist Process Flow

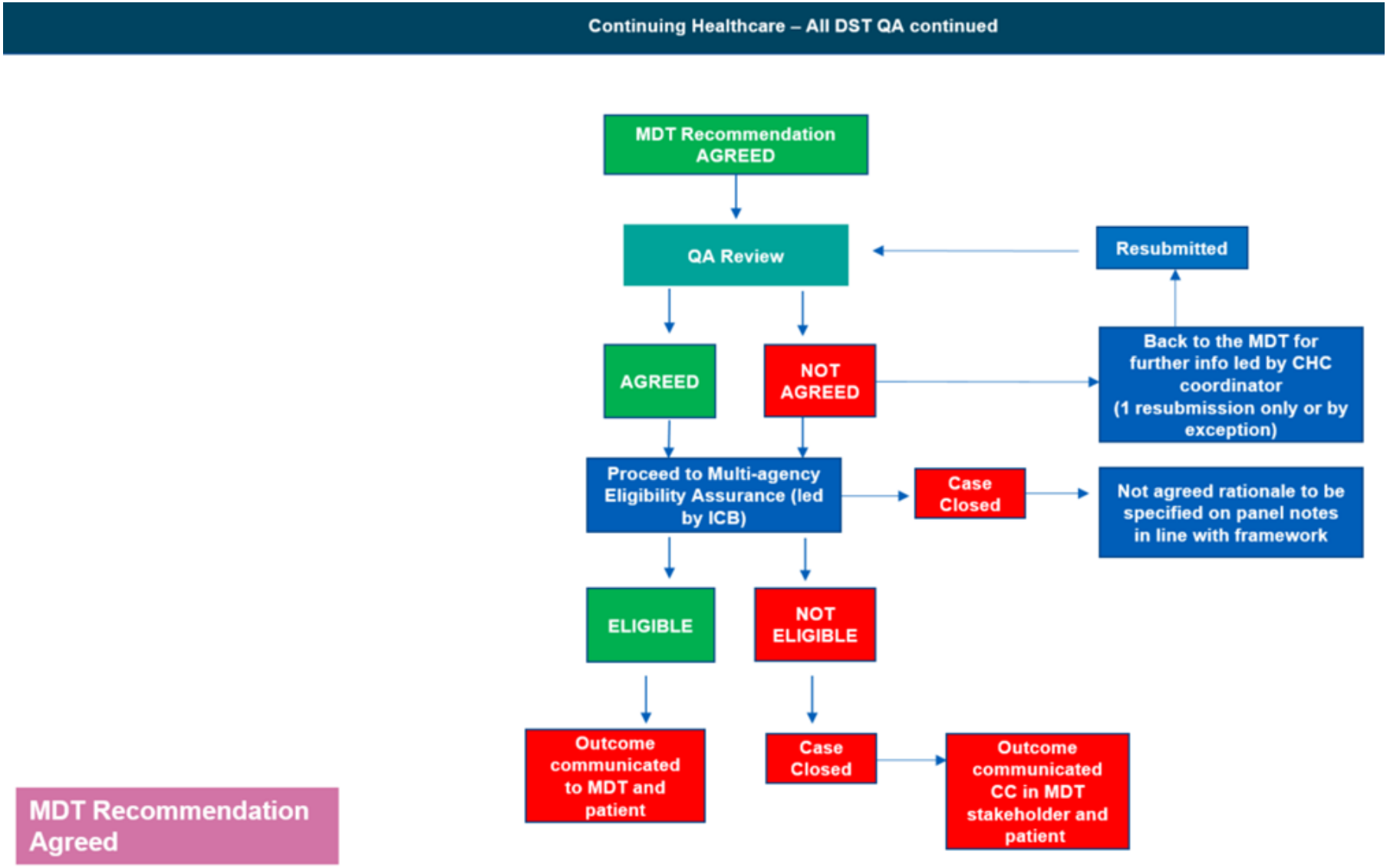


27. Appendix 2 – DST QA process flow

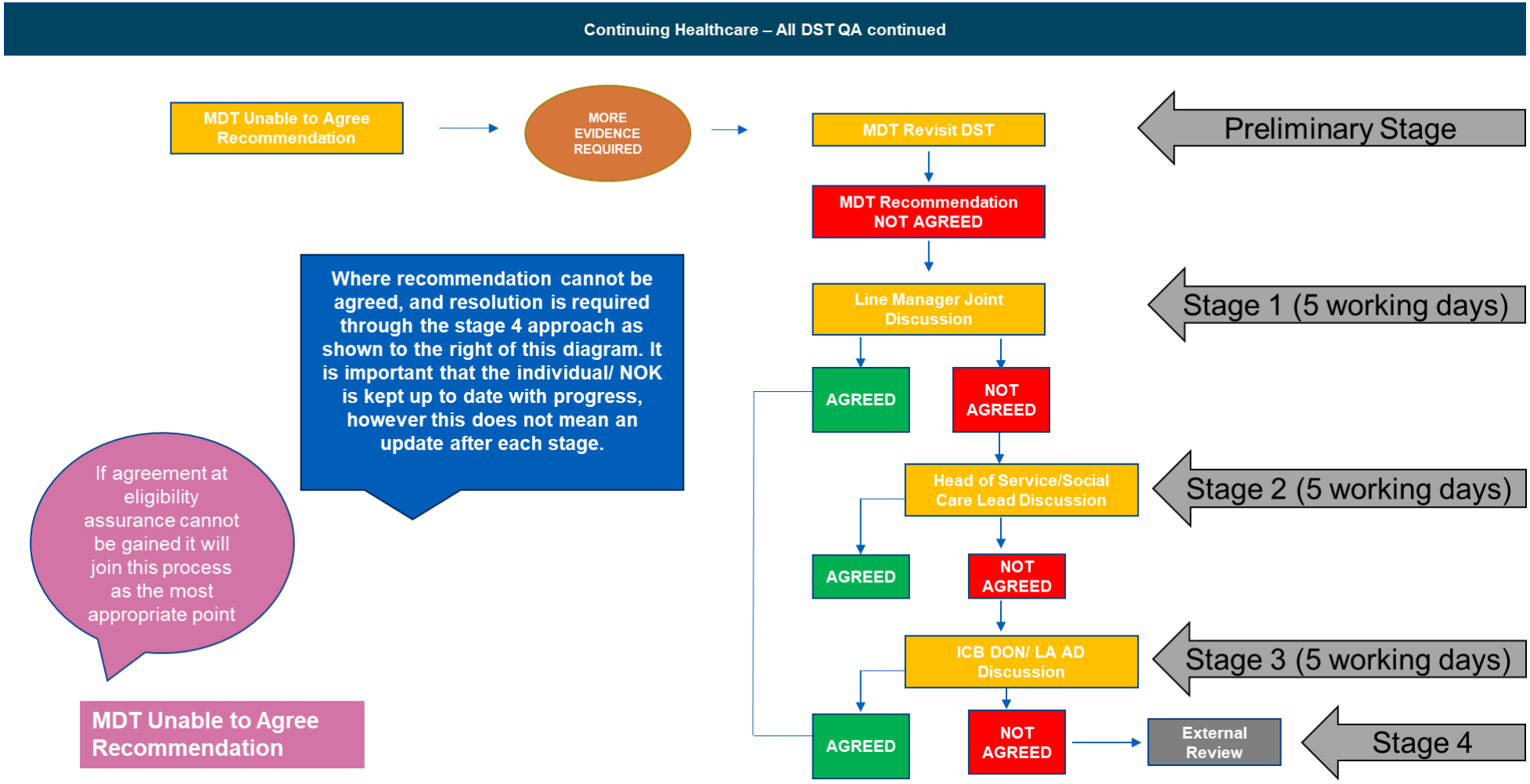


See next slides for continuation

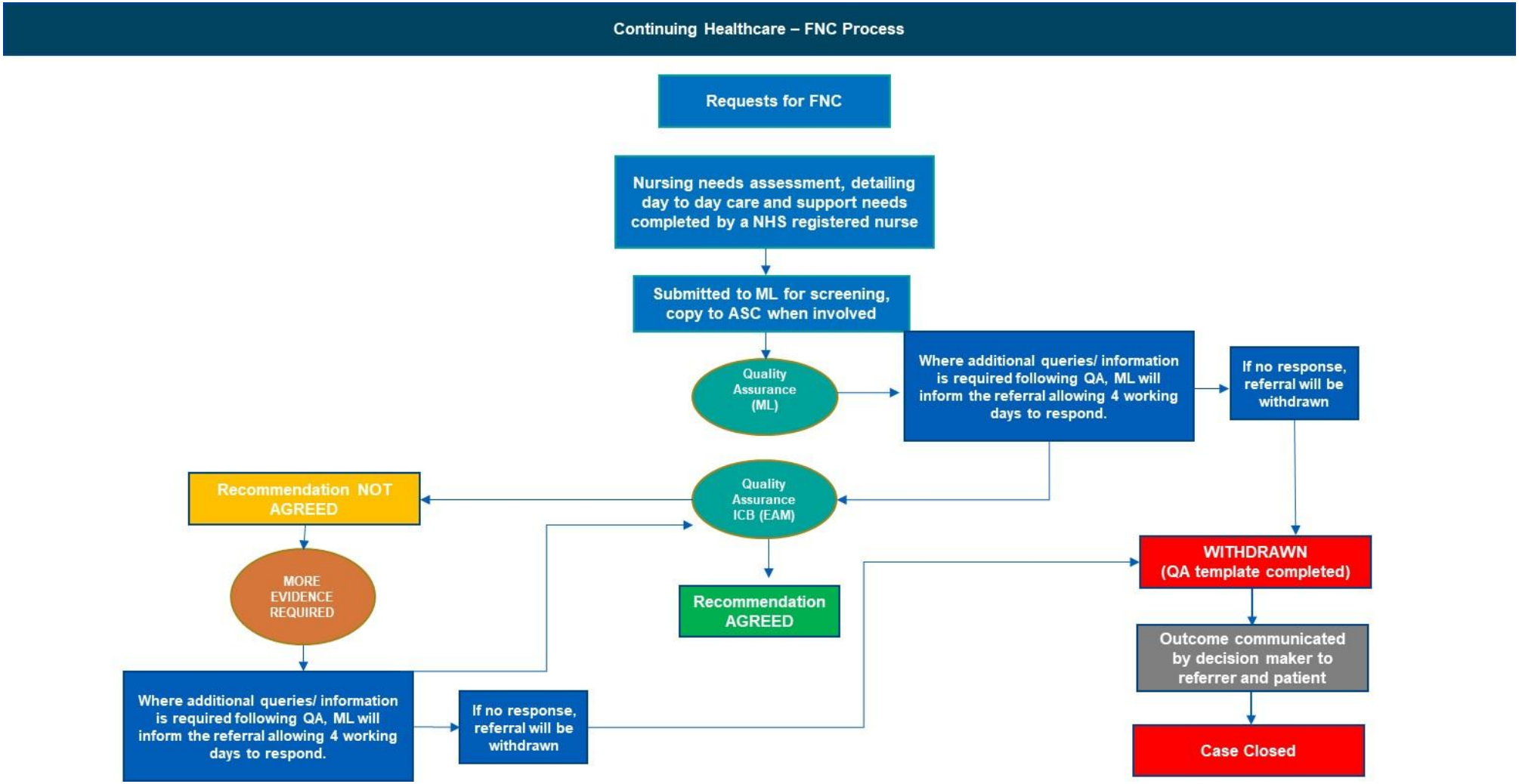
28. Appendix 3 – DST Process Flow



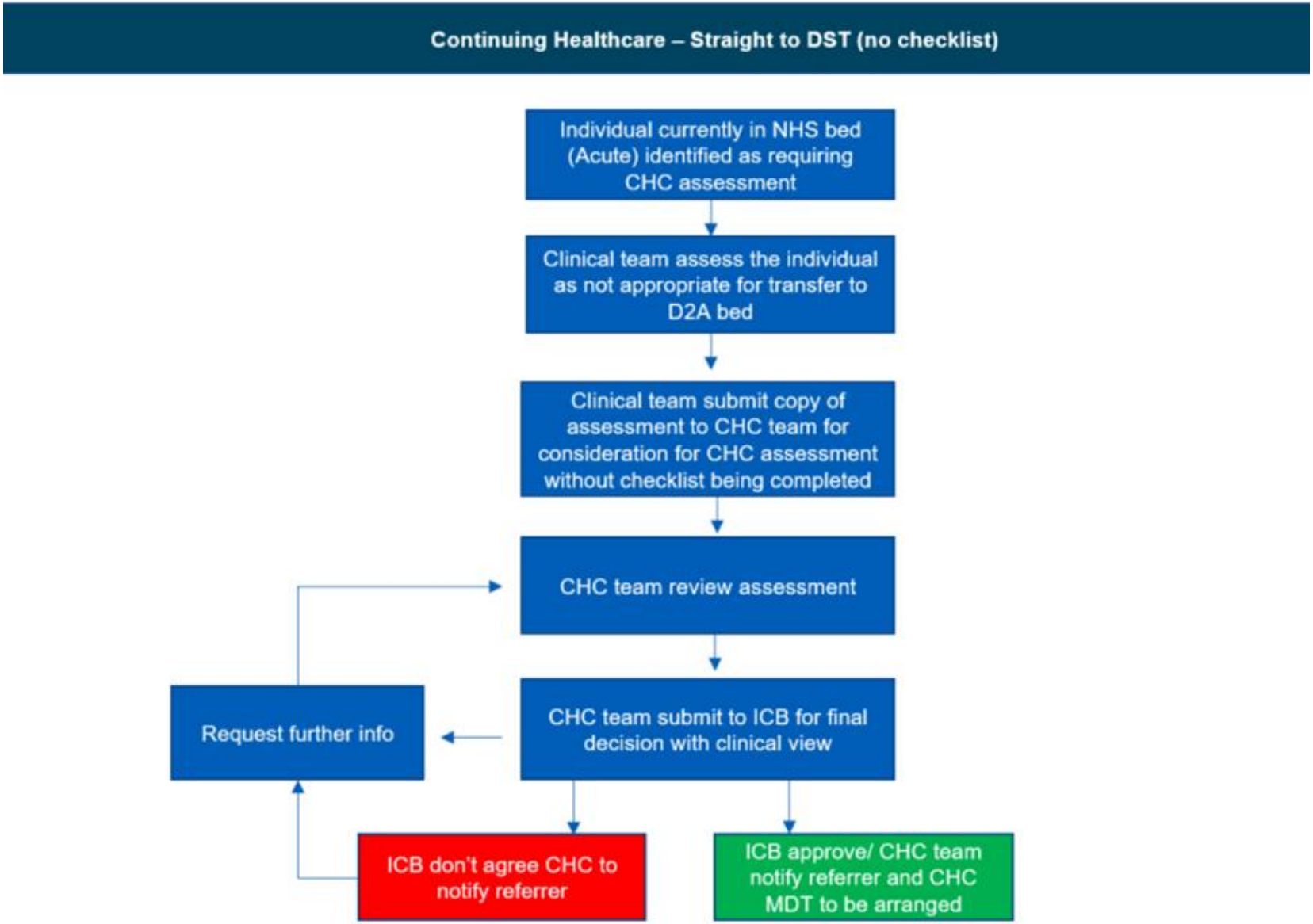
29. Appendix 4 – DST QA Process Flow



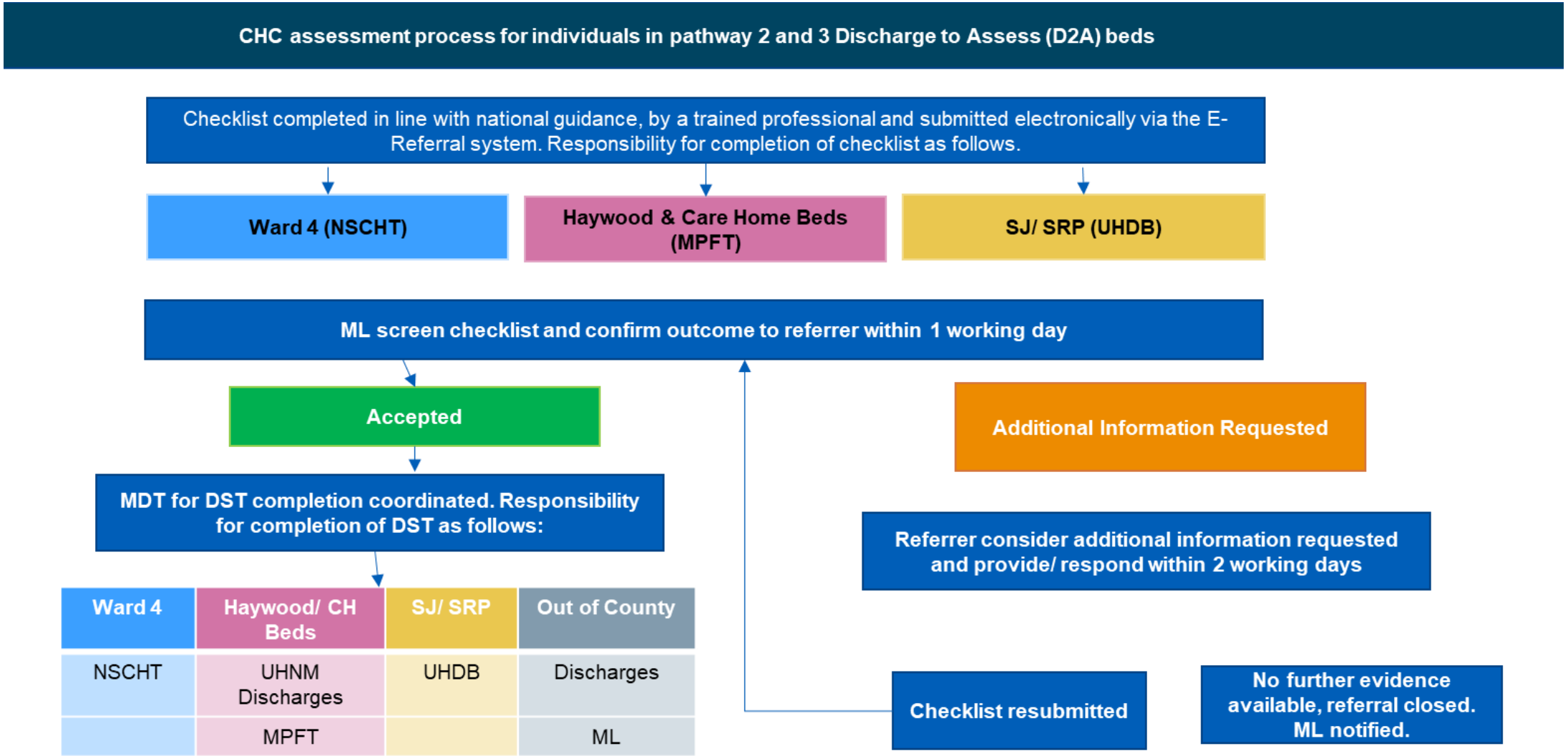
30. Appendix 5 – FNC process flow



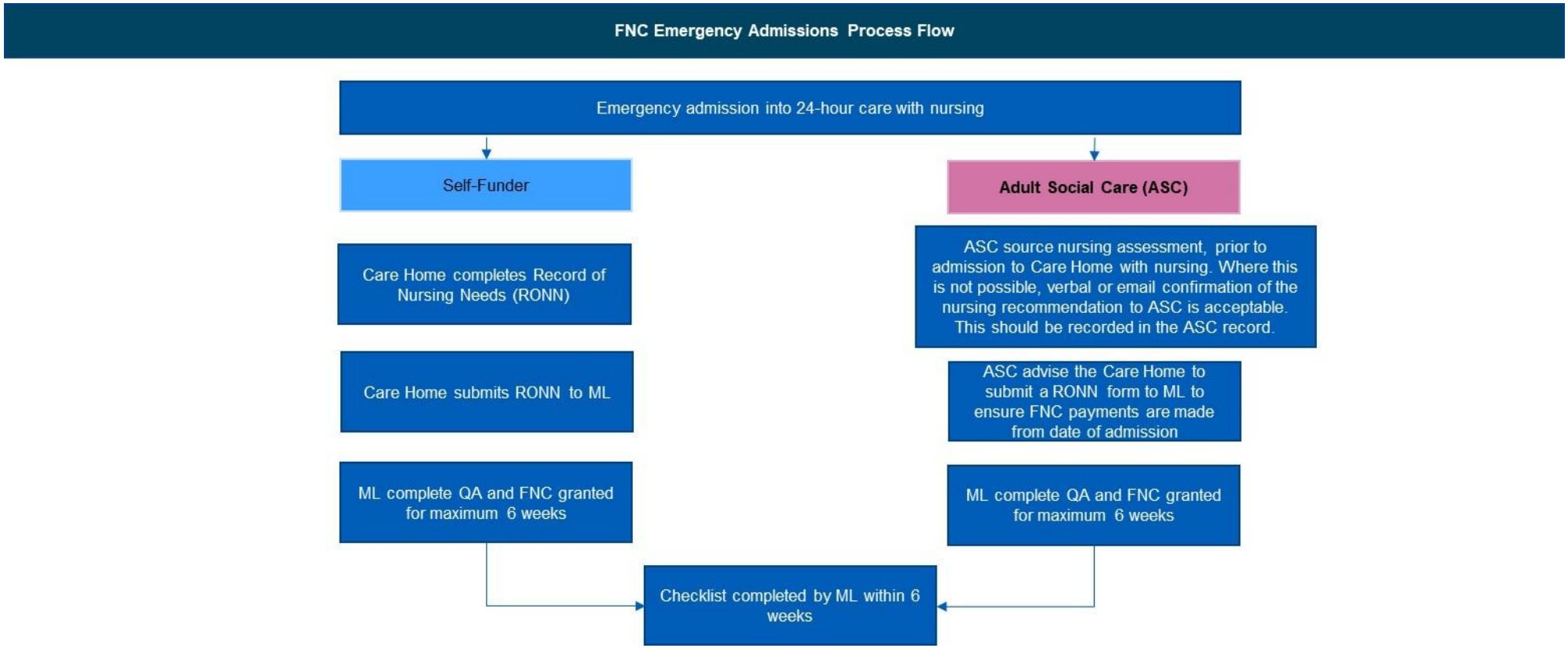
31. Appendix 6 – Straight to DST process flow



32. Appendix 7 – D2A Checklist/ DST process flow



33. Appendix 8 – FNC emergency admissions process flow



34. Appendix 9 – Complaints/ Dispute/ Appeal Process

Continuing Healthcare – Complaint/Disagreement Resolution/Appeals Process

Complaint process

- Negative Checklist completed
- Individual/Patient Representative disagrees with outcome
- Individual completing checklist to revisit for accuracy
- Individual/Patient Representative remains unhappy with outcome
- Complaint via ICB

Disagreement Resolution

- CHC DST MDT completed
- MDT members do not agree recommendation
- Case moves to early resolution process
- See slide 4 for process

Appeal

- CHC DST MDT completed
- ICB verification process supports recommendation
- Individual/Patient Representative disagrees with outcome
- Individual/Patient Representative contacts appeals team
- Appeals team obtain necessary documentation to commence appeal process
- See appeals process