CONTINUING HEALTHCARE (CHC) AND FUNDED NURSING CARE (FNC)

CHOICE & EQUITY POLICY

Version 7

Subject and version number of document:	Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Choice and Equity Policy Version 7
Serial number:	CLIN/006/V7.01 N.B. This is a Hampshire policy, however, the serial number applies to West Hampshire CCG document register only.
Operative date:	This policy has been in operation since 2010. It was reviewed in 2013 to take into account the changes in NHS Commissioning and reviewed in 2015 to ensure it remains current.
Author:	Diane Wilson, Associate Director. Reviewed by Paul Turner, Associate Director in 2015.
Review date:	April 2017
For action by:	The Choice and Equity Policy is aimed at the Hampshire CHC team
Policy statement:	This policy describes the way in which the Hampshire Continuing Healthcare Team (CHC) on behalf of CCG's will provide care for people who have been assessed as eligible for fully funded NHS Continuing Healthcare. The policy describes the way in which the CHC team will commission care in a manner which reflects the choice and preferences of individuals but balances the need for the Clinical Commissioning Groups (CCG's) to commission care that is safe and effective and makes the best use of available resources.
Responsibility for dissemination to new staff:	Line managers within the CHC / FNC team.
Methods for dissemination:	All new and updated policies are published on the CCG website and are promoted to staff through the CCG's internal staff newsletter.
Training implications:	All new staff to the team are provided with training
Resource implications:	There are no resource implications in relation to implementation of this policy.
Further details and additional copies available from:	Paul Turner, Associate Director: Vulnerable Adults. http://www.westhampshireccg.nhs.uk/downloads/categories/policies-and-guidelines

Equality Analysis Completed?	Yes
Consultation Process	This policy has been in operation since 2010 and was developed in partnership with Hampshire County Council.
Approved by:	West Hampshire CCG Clinical Governance Committee (January 2015) and Hampshire Five CCG Commissioning Group
Date approved:	22 April 2015

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2				
3				
4				
5				

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Name of Reviewer	Ratification Process	Notes
	September 2013	Paul Turner	Reviewed as requested by March WHCCG Corporate Governance Committee. No changes Required.	
7	Nov 2014, further reviewed Apr 2015	Paul Turner	Reviewed in accordance with the WHCCG Policy for the Management of Policies	

CONTINUING HEALTHCARE (CHC) AND FUNDED NURSING CARE (FNC) CHOICE AND EQUITY POLICY

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FOREWORD

The five Hampshire based Clinical Commissioning Groups (CCG's) assumed statutory responsibility for NHS Continuing Healthcare from 1 April 2013. The Continuing Healthcare Team (CHC) is hosted by the West Hampshire CCG with a collaborative risk sharing agreement with all of the Hampshire CCG's. This policy will be ratified by all of the Hampshire based CCG's.

1. INTRODUCTION

1.1 This policy describes the way in which the Hampshire Continuing Healthcare Team (CHC) on behalf of the CCG's will provide care for people who have been assessed as eligible for NHS Continuing Healthcare. The policy describes the way in which the CHC team will commission care in a manner which reflects the choice and preferences of individuals but balances the need for the Clinical Commissioning Groups (CCG's) to commission care that is safe and effective and makes the best use of available resources.

2. THE NATIONAL FRAMEWORK FOR NHS CONTINUING HEALTHCARE AND NHS FUNDED NURSING CARE NOVEMBER 2012 (REVISED)

2.1 The National Framework says:

"Where an individual is eligible for NHS continuing healthcare, the CCG is responsible for care planning, commissioning services and for case management. It is the responsibility of the CCG to plan strategically, specify outcomes and procure services, to manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS continuing healthcare, and for the healthcare part of a joint care package. The services commissioned must include ongoing case management for all those entitled to NHS continuing healthcare, as well as for the NHS elements of joint packages, including review and/or reassessment of the individual's needs." (para 108)

''Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is appropriate for the individual's needs. Although the CCG is not bound by the views of the LA on what services the individual needs, the Local Authority's (LA) assessment under Section 47 of the National Health Service and Community Care Act 1990, or its contribution to a joint assessment, will be important in identifying the individual's needs and, in some cases, the options available for meeting them'' (paragraph 167)

3. CONTEXT

3.1 "NHS Continuing Healthcare" means a package of continuing care arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in the National Framework. The actual services provided as part of that package should be seen in the wider context of best practice and service development for each client group. Eligibility places no limits on the settings in which the package of support can be offered or on the type of service delivery.

3.2 The Secretary of State has developed the concept of a 'primary health need'. Where a person's primary need is a health need, the NHS is regarded as responsible for providing for all their needs, including accommodation, if that is part of the overall assessed need, and so they are eligible for NHS Continuing Healthcare.

4. THE PROVISION OF SERVICES FOR PEOPLE WHO ARE ELIGIBLE FOR NHS CONTINUING HEALTHCARE

4.1 The CHC team has developed this policy in light of the need to balance personal choice alongside safety, clinical effectiveness and appropriate use of finite resources. It is also necessary to have a policy which supports decisions that are consistent, equitable and compliant with the CCG's obligations under equality legislation. These decisions need to provide transparency and fairness in the allocation of resources.

4.2 Application of this policy will ensure that decisions about care will:

- Be robust, fair, consistent and transparent
- Be based on the objective assessment of the person's clinical need, safety and (where a person lacks mental capacity to make decisions about their care) their best interests
- Have regard for the safety and appropriateness of care to the individual and staff involved in the delivery
- Involve the person and their family/representative wherever possible
- Take into account the need for the CCG's to allocate its financial resources in the most cost effective way;
- Support choice to the greatest extent possible in view of the above factors.

4.3 The CCG's have a duty to provide care to a person with continuing healthcare needs in order to meet those assessed needs. An individual or their family/representative cannot make a financial contribution to the cost of the care identified by the CHC team as required to meet the individual's needs. An individual however, has the right to decline NHS services and make their own private arrangements. The level of need is determined based upon the comprehensive, multi-disciplinary assessment of the full range of health and

social care needs that contribute to the decision-making process of eligibility for NHS funded healthcare.

4.4 Access to NHS services depends upon clinical need, not ability to pay. The CCG's will not charge a fee or require a co-payment from any NHS patient in relation to the assessed needs. The principle that NHS services remain free at the point of delivery has not changed and remains the statutory position under the NHS Act 2006. The CCG's are not able to allow personal top up payments into the package of healthcare services under NHS CHC, where the additional payment relates to core services assessed as meeting the needs of the individual and covered by the fee negotiated with the service provider (for example, the care home) as part of its contract with the CCG.

4.5 However, where service providers offer additional services which are unrelated to the person's needs as assessed under the NHS CHC framework, the person may choose to use personal funds to take advantage of these services.

4.6 Examples of such services which will in most cases fall outside NHS provision as they are unrelated to the person's primary healthcare needs include hairdressing, a bigger room or a nicer view. Any such additional services will not be funded by the CCG's as these are services over and above those which the service user has been assessed as requiring, and the NHS could not therefore reasonably be expected to fund those elements.

4.7 In instances where more than one suitable care option is available (such as a nursing home placement and a domiciliary care package) the total cost of each package will be identified and assessed for the overall cost effectiveness. While there is no set upper limit on the cost of care, the expectation is that the most cost effective option will be commissioned that meets the individual's needs.

4.8 Any assessment of a care option will include the psychological and social care needs and the impact on the home and family life as well as the individual's care needs. The outcome of this assessment will be taken into account in arriving at a decision.

4.9 The setting in which CHC is commissioned is ultimately a matter for a decision by the CCG's. However the CCG's will carefully consider the views of the individual, their family or others as appropriate and act on all reasonable requests to the best of their ability

5. CONTINUING HEALTHCARE FUNDED CARE HOME PLACEMENTS

5.1 Where a person has been assessed as needing placement within a care home, the CHC team operates a preferred provider list and the expectation is that individuals requiring placement will have their needs met in one of these homes.

5.2 The person may wish to move into a home outside of the preferred provider list or their family/representative may wish to place the individual in a home outside of the preferred provider list. As long as the fee for the bed is comparable to the fee agreed with the preferred provider and the home can meet the patient's care needs the CHC team will consider this option.

5.3 If the fee is higher than the fee charged by a care home on the preferred provider list the CHC team would anticipate subject to clarification that the extra fees are for services or facilities unrelated to the person's primary health care need. The provider will only be able to invoice the CCG's for the care costs and reasonable accommodation costs associated with the person's primary healthcare needs and will have to invoice the client separately for any services unrelated to those needs. The invoices will detail what the CCG and client is being charged for.

5.4 If the provider refuses to do this the CCG will not be able to purchase the care at this home and the client or their family as appropriate will be advised that they will need to consider other homes, including those on the preferred provider list.

6. CONTINUING HEALTHCARE FUNDED PACKAGES OF CARE AT HOME

6.1 People who are eligible for continuing healthcare funding have a complexity, intensity, frequency and unpredictability in their health needs which can present challenges to the safe delivery of care in their homes. The CHC team does not have the resources or facilities to provide a hospital at home service where the cost of providing those services safely and effectively significantly exceeds the equivalent costs of a residential placement.

6.2 The CHC team will take account of the following issues when considering whether or not to commission a care package at home:

- The psychological, social and physical impact on the person
- Care can be delivered safely and without undue risk to the person, the staff or other members of the household (including children)
- Safety will be determined by a written assessment of risk undertaken by an appropriately qualified professional in consultation with the person or their family. The risk assessment will include the availability of equipment, the appropriateness of the physical environment and the availability of appropriately trained care staff and/or other staff to deliver the care at the intensity and frequency required
- The acceptance by the CHC team and each person involved in the person's care of any identified risks in providing care and the person's acceptance of the risks and potential consequences of receiving care at home
- Where an identified risk to the care providers or the person can be minimised through actions by the person or their family and carers, those

individuals agree to comply and confirm in writing their agreement with the steps required to minimise such identified risk.

- The person's GP agrees to provide primary care medical support
- The suitability and availability of alternative care options
- The cost of providing the care at home in the context of cost effectiveness
- The relative costs of providing the package of choice considered against the relative benefit to the person
- The willingness and ability of family, friends or informal carers to provide elements of care where this is part of the care plan and the agreement of those persons to the care plan.

6.3 Many persons wish to be cared for in their own homes rather than in residential care, especially people who are in the terminal stages of illness. The CCG's will carefully consider a person's preference about their care setting but it cannot be guaranteed that the CCG's will commission a package of care at home. The option of a package of care at home should be considered, even if discounted, with documented reasons.

6.4 When a person is discharged into the community the CHC team as commissioner takes on the responsibility for the care.

6.5 Home care packages in excess of eight hours per day would indicate a high level of need which may be more appropriately met within a residential placement. These cases would be carefully considered and a full risk assessment undertaken.

6.6 It is likely to be easier to provide waking night care to a person in a residential placement. The need for waking night care indicates a high level of support day and night.

6.7 Residential placements may be more appropriate for persons who have complex and high levels of need. Residential placements benefit from direct oversight by registered professionals and the 24 hour monitoring of persons.

6.8 If the clinical need is for registered nurse direct supervision or intervention throughout the 24 hours the care would often be expected to be provided within a nursing home placement. This would include the requirement for 1-2 hourly intervention/monitoring for turning, continence management, medication, feeding, manual handling or for the management of significant cognitive impairment.

6.9 There are specific conditions or interventions that it would not generally be appropriate to manage in a home care setting. These would include but are not restricted to: the requirement for sub-cutaneous fluids, continual invasive or non-invasive ventilation or the management of grade 4 pressure areas.

6.10 Each assessment will consider the appropriateness of a home based package of care, taking into account the range of factors in paragraph 6.2 and underpinned by the principles in 4.2.

7. EXCEPTIONAL CIRCUMSTANCES

7.1 The CHC team will seek to take account of the wishes expressed by persons and their families when making decisions as to the location(s) of care packages and residential placements to be offered to satisfy the obligations of the CCG's to provide continuing healthcare. The CCG's accept that many persons with complex medical conditions wish to remain in their own homes and to continue to live with their families, with a package of support provided to the person in their own homes. Where a person or their family expresses such a desire the CHC team will investigate to determine whether it is clinically feasible and cost effective to provide a sustainable package of continuing care for a person in their own home.

7.2 Packages of care in a person's own home are bespoke in nature and thus can often be considerably more expensive for the CCG's than delivery of an equivalent package of services for a person in a care home. Such packages have the benefit of keeping a person in familiar surroundings and / or enabling a family to stay together. However the CCG needs to act fairly to balance the resources spent on an individual person with those available to fund services to other persons.

7.3 The CCG's have resolved that, in an exceptional case and in an attempt to balance these different interests it will be prepared to support a clinically sustainable package of care which keeps a person in their own home provided the anticipated cost to the CCG's does not significantly exceed the anticipated cost of a care package delivered in an alternative appropriate location such as a care home. The CCG's will generally not fund a home care package where its costs are more than 10% higher than care in an alternative appropriate location such as a care home.

7.4 Exceptionality would be determined on a case by case basis. Decisions will be made by a director and will be documented with reasons.

8. CAPACITY

8.1 If a person does not have the mental capacity to make a decision about the location of their commissioned care package and suitable placement, the CHC team will commission the most cost effective, safe care available based on an assessment of the person's best interests. This will be carried out in consultation with the following so far as is reasonably practicable:-

(i) Any appointed advocate

(ii) Any attorney under a Lasting Power of Attorney which does not authorise the attorney to make a decision by themselves as to where the person should live (see further 8.3 below)

(iii) A Court Appointed Deputy whose terms of appointment do not authorise them to make a decision by themselves as to where the person should live (see further 8.3 below)

(iv) Family members

(v) Any other person who should be consulted under the terms of the Mental Capacity Act 2005.

8.2 If there is a significant dispute between any of those referred to in the preceding paragraph about where the person should live, the CCG's should take advice as to whether the matter should be referred to the Court of Protection.

8.3 Alternatively, if the terms of a Lasting Power of Attorney or Deputyship grant authority for the Attorney/Deputy to make decisions about where a person lives, the CCG's will advise the Attorney/Deputy as to what they consider to be the most appropriate placement. The Attorney/Deputy will then decide whether to accept that placement as being in the person's best interests.

9. AGREEMENT TO FUND

9.1 The authorisation for the commissioning and funding of packages of care at home lies with the CCG's. There will be a process for the authorisation of eligibility and the authorisation of care packages and placements.

9.2 Individuals eligible for NHS CHC were given the 'right to have' a Personal Health Budget from October 2014. Clinical Commissioning groups (CCGs) can also offer a Personal Budget (joint health and social care budget) to others that they feel may benefit from the additional flexibility and control.

9.3. Once the level of need of the individual has been identified and agreed by the CHC team the person may be given a notional weekly personal health budget. Persons and their families will be able to have some flexibility in the delivery of the care (for example, times) as long as the person's assessed care needs are being met.

10. REVIEW

10.1 Individuals and their families need to be aware that there may be times where it will no longer be appropriate to provide care at home. For example, deterioration in the person's condition may result in the need for clinical oversight and 24 hour monitoring that can only be provided in a residential setting.

10.2 The care package will be reviewed three monthly and then annually as a minimum requirement alongside the continuing healthcare review to ensure that it is still meeting the person's needs at that time.

10.3 If the weekly cost of the care increases, apart from a single period of up to two weeks to cover either an acute episode or for end of life care to prevent a hospital admission, the care package will be reviewed and other options (for example a nursing home placement) will be explored following consideration of the issues outlined in paragraph 6.2.

February 2013 (Reviewed November 2014) (Further reviewed April 2015)

APPENDIX 1: ANALYSING THE IMPACT ON EQUALITY

1.	**Title of policy/ programme/ framework being analysed** Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Choice & Equity Policy
2.	**Please state the aims and objectives of this work and the *intended equality outcomes*. How is this proposal linked to the organisation's business plan and strategic equality objectives?** The CHC team has developed this policy in light of the need to balance personal choice alongside safety and effective use of finite resources. It is also necessary to have a policy which supports consistent and equitable decisions about the provision of care regardless of the person's age, condition or disability. These decisions need to provide transparency and fairness in the allocation of resources. Application of this policy will ensure that decisions about care will: • Be robust, fair, consistent and transparent • Be based on the objective assessment of the person's clinical need, safety and best interests • Have regard for the safety and appropriateness of care to the individual and staff involved in the delivery • Involve the person and their family/representative wherever possible • Take into account the need for the CCG's to allocate its financial resources in the most cost effective way • Support choice to the greatest extent possible in view of the above factors.
3.	**Who is likely to be affected? e.g. staff, patients, service users, carers** Service users, carers and providers
4.	**What evidence do you have of the potential impact (positive and negative)?**
4.1	**Disability** (Consider attitudinal, physical and social barriers) – Please see section 2
4.2	**Sex** (Impact on men and women, potential link to carers below) Please see section 2
4.3	**Race** (Consider different ethnic groups, nationalities, Roma Gypsies, Irish Travellers, language barriers, cultural differences). Please see section 2
4.4	**Age** (Consider across age ranges, on old and younger people. This can include safeguarding, consent and child welfare). Please see section 2

4.5	**Gender reassignment** (Consider impact on transgender and transsexual people. This can include issues such as privacy of data and harassment). Please see section 2
4.6	**Sexual orientation** (This will include lesbian, gay and bi-sexual people as well as heterosexual people). Please section 2
4.7	**Religion or belief** (Consider impact on people with different religions, beliefs or no belief) Please section 2
4.8	**Marriage and Civil Partnership** Please see section 2
4.9	**Pregnancy and maternity** (This can include impact on working arrangements, part-time working, infant caring responsibilities). Please section 2
4.10	**Carers** (This can include impact on part-time working, shift-patterns, general caring responsibilities, access to health services, 'by association' protection under equality legislation)**.** Please section 2
4.11	**Additional significant evidence** This policy has been reviewed in line with the National Framework for NHS Continuing Health Care and NHS-funded Nursing Care 2012 (Revised) (referred to as the 'Framework') and Part 6 of The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012
5	**Action planning for improvement** N/A

Sign off
Name and signature of person who carried out this analysis Diane Wilson
Date analysis completed 13 February 2013