NHS Continuing Healthcare

Frequently Asked Questions

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NHS Continuing Healthcare

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Frequently Asked Questions

Contents

1. ABOUT THIS DOCUMENT

1.1 What is this document?

This is a response to some of the most frequently asked questions (FAQs) about NHS Continuing Healthcare and NHS-funded Nursing Care. In many cases, hyperlinks are provided that will direct you to the published Directions and Guidance where you will find authoritative information.

1.2 Will you update this? When?

We will update from time-to-time, depending on what further questions come in to us. We will, highlight new questions and answers the first time they are published, so that you will be able to quickly identify the changes.

1.3 What do I need to read, and where can I find it?

The key documents are all available from the DH website, they are

Directions

- NHS Continuing Healthcare (Responsibilities) Directions 2007
- NHS Continuing Healthcare (Responsibilities) Directions 2009
- NHS (Nursing Care in Residential Accommodation) Directions 2007
- Delayed Discharges (Continuing Care) Directions 2009

Guidance

- National Framework for Continuing Healthcare 2009
- CHS Continuing Healthcare Checklist 2009
- Decision Support Tool 2009
- Fast Track Pathway Tool 2009
- Practice Guidance 2010
- Refunds Guidance 2010
- NHS – Funded Nursing Care Practice Guide 2009
- NHS Continuing Healthcare and NHS-funded nursing care - public information leaflet
- Who Pays?: Establishing a Responsible Commissioner

1.4 Is there any other Guidance available to help me?
Any other guidance relevant to this topic is published on the Department of Health website.
1.5 What do I do if the answer to my question is not here?
Each PCT has a lead officer for NHS CHC and this person should be contacted in the first instance for clarification on any policy issues. Where necessary they may discuss the matter with the relevant SHA Continuing Healthcare Lead. If a query arises that raises a wider policy issue the SHA may decide to raise the matter with other SHAs or with the DH for clarification.

2. POLICY

2.1 What is the status of the Framework and Practice Guidance?

The Department has published Directions on Continuing Healthcare and NHS-funded nursing care that the NHS and local authorities must follow. More detailed information is given in guidance that the NHS and local authorities should follow.

2.2 Is there any diagnosis or prognosis that guarantees an automatic right to NHS Continuing Healthcare?

No. Eligibility for NHS Continuing Healthcare is based on needs, not any specific diagnosis

2.3 Does the Framework apply retrospectively? Should it be used in retrospective review cases?

The original National Framework applied from 1st October 2007, and the updated Framework applied from 1st October 2009.

Paragraph 145 of the 2009 National Framework reminds PCTs that, when reviewing decisions made before implementation of the original Framework, they should use the most relevant, lawful criteria for the period under consideration. These may, therefore, be pre-National Framework criteria, so long as they are compliant with the *Coughlan* and *Grogan* judgments (see National Framework). The same approach should be taken by Independent Review Panels (IRPs)

2.4 Is there an authoritative definition of "beyond the responsibility of the local authority"

This is a complex area of law and there is no simple authoritative definition. The powers and duties of local authorities are a matter of Statute and Case law (including the Coughlan Judgment). Whilst there is no legal lower limit to what the NHS can provide, there is a legal upper limit to nursing and healthcare that can be provided by local authorities (see para 22 of the National Framework).

Generally, local authorities have a duty to carry out an assessment of needs where someone appears to be in need of community care services, and a duty to provide services or support to meet assessed eligible needs. However local authorities cannot lawfully commission services that are clearly the responsibility of the NHS (e.g. care provided by registered nurses and services that the NHS has to provide because the individual has a

'primary health need').

However, local authorities can and do commission care in care homes (with or without nursing) where needs to be met include elements of 'general nursing' provided by 'auxiliary' nurses or care assistants. A local authority can fund this 'nursing care' provided it is both incidental and ancillary to the individual's accommodation and of a nature that a local authority can be expected to provide.

2.5 If a person is in receipt of NHS Continuing Healthcare are they entitled to any local authority funding for social care?

Local authorities may not provide community care services to anyone in a care home who gets NHS Continuing Healthcare, although they have a role in relation their wider responsibilities such as safeguarding vulnerable adults and the Deprivation of Liberty Safeguards. Where an individual is in receipt of NHS Continuing Healthcare but is living in their own home the NHS is still responsible for meeting all nursing and personal care needs and associated social care needs but there may be other needs that the local authority can help with. For full details see paragraph 11.8 of the Practice Guidance.

2.6 If someone receiving NHS Continuing Healthcare also receives some services from the local authority, will they be means tested and charged for these services?

The individual should not be charged for any NHS Continuing Healthcare service funded by the NHS. If a local authority is providing additional services it may use its powers to charge the individual subject to the person's financial circumstances and the local authority's Fairer Charging policy.

2.7 Can a local authority act as a 3rd party to administer direct payments to someone who has been deemed eligible for NHS Continuing Healthcare?

Where a PCT has been authorised by the Secretary of State to have powers to make NHS Direct Payments they can reach a formal agreement (under Section 75 of the NHS Act 2006) to transfer these powers (and funding) to the relevant local authority. This would enable the local authority to make direct payments to individuals receiving NHS CHC.

Where an individual is not entitled to NHS CHC but is receiving a joint package of care between the LA and PCT, they can reach agreement for the local authority to make a direct payment for the elements of the care package that are within local authority powers. The remaining elements of the care package (beyond local authority powers) should be arranged by the PCT in a manner that, as far as possible, is compatible with the direct payment arrangements.

Where the PCT has not been given powers to offer direct payments, there is currently no provision to allow a local authority to make direct payments for NHS CHC on their behalf.

However, PCTs should always consider the other models of personal health budget that are available for all PCTs to use, including a) notional personal health budget held by the PCT and used in partnership with the individual; and b) a real personal health budget held by a 3rd party such as a brokerage organisation, who should agree with the individual how it is to be spent.

PCTs should commission services using models that maximise personalisation and individual control and that reflect the individual's preferences, as far as possible. It is particularly important that this approach should be taken when an individual who was previously in receipt of an LA direct payment begins to receive NHS continuing healthcare; otherwise they may experience a loss of the control they had previously exercised over their care.

2.8 Is there any additional guidance on the relationship between NHS CHC and the Mental Health Act?

Paragraphs 112 to 116 of the National Framework and para 4.13 of the Practice Guidance explain the relationship between NHS CHC and the Mental Health Act.

Arrangements under the Mental Health Act are separate and different from NHS Continuing Healthcare and the two should not be confused.

The above guidance particularly deals with Section 117, however the same principles apply where an individual is subject to Section 17 leave or to a Section17a Supervised Community Treatment Order.

It is preferable for a PCT to have separate budgets for funding s117 and NHS continuing healthcare. Where they are funded from the same budget they still continue to be distinct and separate legal provisions.

2.9 Do we make NHS-funded Nursing Care payments for §.117 patients placed in nursing homes?

Yes. See The National Health Service (Nursing Care in Residential Accommodation) (England) Directions 2007 para (3) (b)

2.10 How can consistency be assured?

Under the National Framework (para 166) PCTs are responsible for ensuring consistency in the application of the NHS CHC eligibility criteria in their area. PCTs and local authorities are also encouraged to regularly and jointly review patterns of eligibility for NHS Continuing Healthcare in their area, having regard to the demographics of their locality and eligibility levels in other similar localities.

2.11 What information is published on NHS CHC eligibility?

The Department of Health regularly collects and publishes information on the numbers of people currently in receipt of NHS CHC, and provides a calculation of numbers per 50,000 population for each PCT.

2.12 Is there guidance available for the transition from children's to adult continuing healthcare?

See paragraphs 118 to 132 of the Framework, the content of which is reflected in the National Framework for Children and Young People's Continuing Care.

'Who Pays?: Establishing the Responsible Commissioner' also contains guidance on the transfer of Continuing Health Care responsibilities in transitions cases (para 38).

2.13 If someone has NHS Continuing Healthcare at home, does the PCT have for pay rent/mortgage, food and utility bills?

No. The NHS is responsible for funding health and personal care costs, not rent, food and **normal** utility bills. There will be circumstances, however, when a contribution towards a utility bill may be appropriate (because, for example, the individual has increased costs to run specialised equipment).

2.14 How do the policies in "Valuing People/Valuing People Now" fit with the National Framework when considering CHC eligibility for people with learning disabilities?

The National Framework seeks to deliver a consistent approach to assessing eligibility for all people with all conditions using a common set of tools.

The NHS CHC Framework, including the Checklist, DST and Fast Track tools, apply equally to all client groups.

Once it has been determine whether an individual is eligible for NHS CHC then, if they have a learning disability, the principles contained within 'Valuing People' and 'Valuing People Now' should inform care planning arrangements. It is the needs that the individual has, as recorded through the use of the DST, that should inform the recommendation, not whether or not they have a learning disability.

2.15 Is there a combination of highs and moderates that guarantees eligibility for NHS Continuing Healthcare?

There is no specific combination of highs and moderates that would 'guarantee' eligibility. The user notes for the DST state:

- *one domain recorded as severe, together with needs in a number of other domains, or*
- *a number of domains with high and/or moderate needs, **.... may well also indicate a primary health need**. In these cases, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments should be taken into account in deciding whether a recommendation of eligibility for NHS continuing healthcare should be made.*

2.16 In a joint package does the DST define which elements are the responsibility of the NHS and which are the responsibility of social services?

No. The completed DST will help to indicate the nature and levels of need of an individual, but it does not attribute responsibility for individual elements of a care package. Where a person is not entitled to full NHS Continuing Healthcare the cost of a jointly funded support package are a matter of negotiation between PCT and local authority based on the assessed needs of the person and the limits of what a local authority can fund. For further information see paragraph 11.2 of the Practice Guidance.

One approach to identifying respective funding responsibilities is to analyse a 24 hour/48 diary of the tasks and interventions required to meet the individual's needs in order to identify which elements are beyond local authority powers, which are areas where both health and social care have power to provide, and which areas which are clearly social care responsibility.

PCTs and local authorities should agree protocols for dealing with jointly funded packages/placements. Local dispute resolution processes should cover both disputes over joint funding as well as NHS CHC eligibility.

2.17 Does NHS-funded Nursing Care cover the entire cost of a person's nursing needs?

No, it covers a contribution towards the cost of services provided by a registered nurse, involving either the provision of care or the planning, supervision or delegation of the provision of care, but it does not cover services which do not need to be provided or supervised by a registered nurse.

Para 11.2 of the Practice Guidance reminds PCTs that joint funding will be appropriate where someone in a care home with nursing has nursing or other health needs that, whilst not constituting a primary health need, are clearly above the level of needs intended to be

covered by NHS-funded nursing care

Individuals in receipt of either NHS-funded Nursing Care or NHS Continuing Healthcare continue to be eligible for the full range of services available to any other patient of the PCT, including specialist nursing services where required.

2.18 How does the single-band NHS-funded nursing care contribution affect other funding for the care package such as from local authorities?

The fundamental issue here is about how the care home fee is shared between the NHS, the local authority and the individual concerned and how the breakdown of fees for accommodation, nursing and personal care are reflected in the contract governing a given individual's placement in the care home.

The single band NHS-funded Nursing Care enables the NHS to contribute towards the cost of registered nursing in a care home.

Fee levels are agreed in contracts that are the result of negotiations between the relevant parties and are reviewed in accord with the specific contract provisions.

There are broadly four models of contracting for NHS Funded Nursing Care that are used by PCTs, local authorities and care homes;

a) The PCT contracts directly with the care home for the provision of NHS-funded Nursing Care and makes the payments directly to the care home. The local authority's contract with the care home is completely separate and their contribution is not explicitly linked to the amount of the NHS contribution. and any increases in either element are separate matters.

b) The local authority contracts with the care home for the provision of NHS-funded Nursing Care on behalf of the PCT as part of the local authority's overall contract with the care home. The local authority's contract includes a composite fee at a set amount to be paid to the care home for each resident regardless of the level of payment arising from their NHS-Funded Nursing Care banding.
In this model, the total amount paid to the care home stays the same, although the proportions within the fee of the local authority and PCT contributions may change.

c) The local authority contracts with the care home for the provision of NHS-funded Nursing Care on behalf of the PCT as part of the local authority's overall contract with the care home. The local authority's contract specifies a separate amount in respect of the local authority payment, regardless of the level of payment arising from their NHS-Funded Nursing Care banding.
Under such arrangements any increase in the NHS-funded Nursing Care payment is fully reflected in a corresponding increase in the fee paid to the care home.

d) The PCT contracts directly with the care home for the provision of NHS-funded Nursing Care and makes payments directly. The local authority contracts separately with the care home for their contribution towards the overall fee. The overall fee (including the NHS contribution) is referred to but the local authority specifically contracts for an amount

equivalent to the overall fee level less the relevant NHS contribution at the time. In this model, the total amount paid to the care home stays the same, although the proportions within the fee of the local authority and PCT contributions may change.

There may also be other forms of contract used and care will be needed to ensure that local discussions are based on the precise nature of the contractual arrangements between the local authority, PCT and care home.

In each of these models it is the responsibility of the care home and the local authority and/or PCT to negotiate any changes in respective contributions to the overall fee level in accordance with the specific terms of their contract. The Department cannot become involved in individual fee negotiations.

For 'self-funders' the specific arrangements are dependent on the terms in their contract with the care home. Depending on the terms, in some situations the overall fee would increase to reflect the increase in NHS FNC and the residents contribution would remain the same. In other situations the overall fee would remain the same and the resident's contribution would decrease.

If, the contract explicitly stated the overall fee level was made up of a specific contribution by the resident plus the amount of any NHS contribution the residents contribution is a separate matter to any changes in the level of the NHS contribution. The overall fee level payable to the care home would increase/decrease in the level of NHS contribution.

Self-funders should consider seeking independent advice on their position where they have concerns about their contribution to the overall fee level as a result of the Single Band NHS-funded Nursing Care Contribution.

2.19 Is medicines management a health need or a social care need?

The management of medicines is everyone's business, as described in Management of Medicines – a resource to support implementation of the wider aspects of medicines management for the National Service Frameworks for Diabetes Renal Services and Long-Term Conditions (2004).

The lead responsibility for the safe and effective use of medicines rests with the clinician who prescribes, but there are key roles for other NHS professionals such as pharmacists and for staff providing personal care to service-users in their own homes or in residential care.

It is important, however, that no assumption is made that non-clinical staff have the necessary training and skills to undertake or supervise clinical tasks.

3. PROCESS

3.1 Is there a national tool for assessing NHS-funded nursing care?

Annex C of the NHS-funded Nursing Care Practice Guide (revised) 2009 contains a template for recording nursing care needs. This template is for use in those situations where the individual has not already had a full MDT assessment with a DST completed (i.e. the individual has had a Checklist completed but this did not indicate the need for a full assessment for NHS CHC).

Where a full MDT assessment and DST have been completed there should be sufficient information to determine the need for NHS-funded Nursing Care.

3.2 What role do financial considerations have in the decision making process regarding NHS CHC eligibility and the subsequent commissioning and care planning processes?

The Framework makes clear that finance should not be a consideration in deciding eligibility for continuing healthcare. The Framework (para 82) states 'because the final eligibility decision should be independent of budgetary constraints, finance officers should not be part of a decision-making panel.,

Paragraph 11.7 in the Practice Guidance explains the circumstances in which resources can be taken into account in meeting the needs of an individual who has been found eligible for NHS CHC.

3.3 What is a *finance officer?*

The purpose of excluding finance officers is to avoid any perception that eligibility has been influenced by funding considerations.

Being a budget holder does not automatically mean that a person is a finance officer. Almost everyone working in the NHS or in social care has some responsibility for the proper use of public money. This does not make them '*finance officers*'. The term 'finance officer' refers to individuals whose primary role is financial management rather than managing commissioning or providing services. In a PCT, for example, the Director of Finance is a *finance officer* and it is probable that most staff who reports directly or indirectly to that Director are also '*finance officers*'.

3.4 Is use of the checklist mandatory?

Directions state that if a PCT is to use any screening tool that tool must be the NHS Continuing Healthcare Checklist. PCTs may, if they wish, directly move to a full MDT assessment for an individual without using a Checklist. However, PCTs cannot use a different tool or method for screening for NHS CHC.

Directions require PCTs to take reasonable steps to ensure that individuals are assessed for NHS continuing healthcare in all cases where it appears to them that there may be a need for such care.
For more information see para 6.2 of the Practice Guidance.

3.5 How does the checklist fit into the Delayed Discharge arrangements?

The 'delayed discharges' procedures (such as the issuing of section 2 and section 5 notices under the Community Care (Delayed Discharges etc.) Act 2003) are not triggered until the NHS body is satisfied that the relevant individual is not entitled to NHS continuing healthcare.

Therefore, PCTs should have appropriate processes in place to ensure that, where an individual may have a need for support after hospital discharge, either:

a) prior to completing a Checklist in hospital a decision is made to provide interim NHS-funded services to support the individual after discharge (in which case the delayed discharge provisions would not be triggered). Before the interim NHS-funded services come to an end consideration of NHS CHC eligibility should take place through use of the Checklist and where appropriate the full MDT process using the DST.

b) a Checklist is completed which indicates the person may have a need for NHS CHC and interim NHS-funded services are put in place to support the individual after discharge until a full MDT CHC assessment is completed (in which case the delayed discharge provisions would not be triggered); or

c) a Checklist is completed which indicates the person may have a need for NHS CHC and a full MDT CHC assessment takes place. If this results in eligibility for NHS CHC then the delayed discharge procedures do not apply as the NHS continues to have responsibility for the individual's care; or

d) a Checklist is completed which indicates the person may have a need for NHS CHC and a full MDT CHC assessment takes place. If this does not result in eligibility for NHS CHC then the appropriate delayed discharge notices should be issued

e) a Checklist is completed which does not indicate the person may have a need for NHS CHC in which case the appropriate delayed discharges notices should be issued.

If a local area does not use the Checklist either generally or in individual cases then a full

MDT CHC assessment should take place before delayed discharge notices are issued.

For further information regarding how NHS Continuing Healthcare fits with delayed discharge procedures please see section 7.1 of the Practice Guidance.

3.6 In a Fast Track case is it the PCT or the 'appropriate clinician' who decides that the individual has a primary health need?

In Fast Track cases Directions state that it is the 'appropriate clinician' who determines that the individual has a primary health need. The PCT must therefore decide that the individual is entitled to NHS CHC and should respond promptly and positively to ensure that the appropriate funding and care arrangements are in place without delay.

See section 5 of the Practice Guidance for more information.

3.7 Does the Fast Track tool need to be completed if the individual is already receiving a care package which appears could still meet their needs?

Yes. If an individual meets the criteria for the use of the Fast Track Tool this should be used to ensure not only that they receive the care that they require, but also that this care is funded by the appropriate body and end-of-life care arrangements are reviewed.

This is important because the individual may at present be funding their own care or the LA may be funding (and charging) when the NHS should now be funding the care in full.

The setting where an individual wishes to be supported as they approach the end of their life may be different to their current arrangements (e.g. even though they are currently in a care home setting they may wish to be supported in their family environment). PCTs should seek to respond positively to such preferences, having regard to best practice set out in wider 'end of life care' policy.

See section 5 of the Practice Guidance for more information.

3.8 Can an employee of a local authority take on the role of co-ordinator and/or case manager?

Yes, if this has been agreed locally between the local authority and the PCT.

3.9 Can a PCT Panel fill in the DST and make the recommendation?

No. The MDT is responsible for completing the DST and making the recommendation. The PCT is responsible for making the decision based on the MDT recommendation. See Section 9 of the Practice Guidance for more detail regarding the eligibility decision making

process.

3.10 What is the timeframe within which the PCT should make a decision regarding eligibility for NHS Continuing Healthcare?

The National Framework (para 84) makes it clear that 'the time that elapses between the Checklist (or, where no Checklist is used, other notification of potential eligibility) being received by the PCT and the funding decision being made should, in most cases, not exceed 28 days.'

The Refunds Guidance gives further details on this and sets out the implications for PCT funding responsibilities. See also para 6.13 of the Practice Guidance.