

Devon Primary Care Trust and Devon Adult and Community  
Services

NHS Continuing Health Care Agreement and Operational  
Protocols for NHS Continuing Healthcare

Author: Jennie Stephens Assistant Director Joint Strategic Commissioning

Date: February 09

Version No: V 2.2

Document Status: Agreed by Devon Primary Care Trust and Devon Adult and Community Services

Document History

Version	Date	Author	Description of Change
Version 1.0	3.10.08	Jennie Stephens	First approved document
Version 2.0	02.01.09	Jennie Stephens	Updated in light of operational workshops
Version 2.1	11.02.09		Incorporates comments from Bevan Brittan
Version 2.2	20.02.09		Incorporates required changes by NHS SWest NHSCHC lead Ross Weatherburn

<b>Purpose</b>	<p>Devon PCT intends to exercise its legal duties in relation to NHS Continuing Health Care (“NHS CHC”) through its contractual framework with service providers. This Protocol applies to all service providers setting out the requirements of those organisations in relation to NHS CHC. It has been agreed with Devon Adult and Community Services.</p> <p>This Protocol relates to individuals of 18 years and over who may be eligible for NHS CHC. It addresses:</p> <ul style="list-style-type: none"> <li>• The processes for determining eligibility for NHS CHC in Devon</li> <li>• The roles and responsibilities of key health and social care staff</li> <li>• How Devon PCT will arrange and fund care in a way that reflects the choices and preferences of individuals and balances the need for the PCT to commission safe and effective care that makes best use of its resources.</li> </ul> <p>The application of this protocol will provide transparency and consistency in decision making in order to ensure that decisions taken:</p> <ul style="list-style-type: none"> <li>• Are robust, fair, consistent and transparent</li> <li>• Are based on the objective assessment of the individual’s clinical need, safety and best interests</li> <li>• Have regard for the safety and appropriateness of care packages to those involved in care delivery</li> <li>• Involve the individual and their family wherever this is possible</li> <li>• Have regard to the PCT’s responsibility to fund (“Responsible Commissioner”)</li> <li>• Take into account the need for the PCT to allocate its financial resources in the most cost effective way</li> <li>• Support choice to the extent possible in the light of the above factors</li> </ul> <p>This revised agreement will be effective from 1<sup>st</sup> January 2009. It must be used within the context of the principles and guidance in the National Health Service Continuing Healthcare (NHS CHC) National Framework implemented on 1<sup>st</sup> October 2007.</p> <p>This protocol has been agreed by Devon PCT and Devon ACS. It will be jointly review in December 09 by the Joint Strategic Commissioning Team</p> <p><b><i>Devon Primary Care Trust</i></b>  <b><i>Devon County Council</i></b></p>
----------------	---

## INDEX

No		PAGE
1	<b>Context</b> <ul style="list-style-type: none"><li>• Definition for NHS CHC</li><li>• Key national documents</li><li>• Web address links</li></ul>	<b>6</b>
2	<b>Legal context</b> <ul style="list-style-type: none"><li>• Joint Duties</li><li>• NHS Duties</li><li>• Responsible Commissioner</li><li>• Acute Trust Duties</li><li>• LA Duties</li><li>• Fair Access to Care Services</li><li>• Primary health need concept</li><li>• Consents</li><li>• Mental Capacity Act</li><li>• What to do if individual cannot make informed choice</li><li>• Section 17 and Section 117</li><li>• Joint or transferred arrangements</li></ul>	<b>7</b>
3	<b>Individual Choice Preferences and Patient Safety</b> <ul style="list-style-type: none"><li>• General considerations for decision making</li><li>• NHS Obligations regarding Choice</li><li>• Considerations for arranging care in a person's own home</li><li>• Making Use of Directly provided services</li><li>• Considerations for arranging care in a care home</li><li>• Top Up fees and Optional extras</li><li>• Right of Appeal</li></ul>	<b>11</b>
4	<b>Referrals and Assessments</b> <ul style="list-style-type: none"><li>• What is the MDT?</li><li>• How to refer for a MDT HNA</li><li>• Integrated teams</li><li>• Deciding on the case manager</li></ul>	<b>14</b>
5	<b>Care Plan and Procurement</b> <ul style="list-style-type: none"><li>• What is the Health Needs Assessment – HNA?</li><li>• What are the outcomes of the assessment/review?</li><li>• Who is responsible for arranging and procuring services?</li><li>• Care Planning responsibilities</li><li>• Broker Service</li><li>• Respite Care</li><li>• NHS Direct Provider Services</li><li>• Costing Care Package Guidelines</li><li>• Arranging services with Block providers/pre agreement providers</li></ul>	<b>15</b>

	<ul style="list-style-type: none"> <li>• Arranging Community based packages</li> <li>• Roles and Responsibilities</li> </ul>	
6	<b>Review Process</b> <ul style="list-style-type: none"> <li>• What are the Review arrangements?</li> <li>• What are the outcomes of a review?</li> <li>• Withdrawal of care</li> </ul>	21
7	<b>End of Life Care</b> <ul style="list-style-type: none"> <li>• When to use the End of Life process</li> <li>• Who can raise a Fast Track situation?</li> <li>• What should be the outcome of the Fast Track Assessment?</li> <li>• Who can agree funding for these cases?</li> </ul>	22
8	<b>NHS CHC Needs Checklist</b> <ul style="list-style-type: none"> <li>• What is the Checklist?</li> <li>• Who/When should it be completed?</li> <li>• What are the outcomes of completing the Checklist?</li> </ul>	23
9	<b>Decision Support Tool</b> <ul style="list-style-type: none"> <li>• What is the Decision Support Tool?</li> <li>• Who completes the Decision Support Tool?</li> <li>• Outcome of Decision Support Tool</li> <li>• Who Checks this?</li> <li>• What happens to the form?</li> </ul>	24
10	<b>Joint Agency Panel</b> <ul style="list-style-type: none"> <li>• The decision making process</li> <li>• Generic, Area Joint Agency Panel</li> <li>• County NHN CHC Panel</li> </ul>	26
11	<b>Disputes</b> <ul style="list-style-type: none"> <li>• Dispute resolution process between NHS and ACS</li> <li>• Dispute resolution process between NHS and individuals</li> <li>• Funding Arrangements for disputed cases</li> <li>• Living in own home</li> <li>• In hospital/funded by PCT</li> </ul>	27
12	<b>Timeframes</b> <ul style="list-style-type: none"> <li>• What is the timeframe for completing the assessment and decision making?</li> <li>• Performance Framework</li> </ul>	28

## **GLOSSARY OF TERMS**

ACS	Adult and Community Services
CPA	Care Programme Approach
DCC	Devon County Council
DH	Department of Health
DPT	Devon Partnership Trust
DST	Decision Support Tool
HDT	Hospital Discharge Team
HNA	Health Needs Assessment
IPP	Independent Placement Panel
LA	Local Authority
LD	Learning Disability
LTC	Long Term Conditions
MDT	Multi Disciplinary Team
MH	Mental Health
NHS	National Health Service
NHS CHC	National Health Services Continuing Health Care
OP	Older People
OPMH	Older People Mental Health
PCT	Primary Care Trust
PD	Physical Disability
SAP	Single Assessment Process





The legal framework relating to secondary care commissioning responsibilities for Primary Care Trusts (PCTs) is set out in regulations 3(7) to (10) of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (S.I. 2002/2375) as amended by S.I. 2002/2548, 2003/1497, 2006/359 and 2007/559 (“the Functions Regulations”).

This document is intended to provide guidance on the application of that legal framework to particular situations.

[Download Who Pays? Establishing the responsible commissioner \(PDF, 253K\)](#)

Since 1 April 2006, out of area placements for individuals assessed as eligible for CHC remain the commissioning responsibility of the placing PCT. Therefore, if Devon PCT decides to place one of its CHC patients in a facility outside of Devon, it cannot transfer responsibility for that package to the receiving PCT. This is the case even if the patient registers with a non-Devon PCT GP.

However, this principle only applies to placements that are made by the PCT. It does not include circumstances where an individual eligible for CHC and currently being funded by Devon PCT decides, of their own free will, to move out of the area. In these circumstances, commissioning responsibility will transfer to the out of area PCT. Devon PCT would, however, be expected to fund all costs associated with the CHC package up until the date that the patient moves to his or her new location. The only exception to this would be if the patient remained registered with a Devon PCT but this is only likely to be relevant where they choose to move to care home in the area of a neighbouring PCT.

A Devon summary paper is attached for guidance (Appendix 2]). Where there are concerns about who is the responsible commissioner, the full national guidance and, where appropriate, legal advice must be sought by managers/Panels before agreeing to fund any cases.

#### Acute Trust Duties

Acute Trusts must consider whether a person may be eligible for NHS CHC and, if it considers there is a need for such care, take all reasonable steps to ensure that an assessment is carried out before making a referral to the Local Authority under s2 Community Care (Delayed Discharges etc) Act 2003.

#### LA Duties

The National Framework sets out the legal duties for the LA and is an important source of information. Each LA will:

- Assess a person who appears to be in need of community care services (community care services include residential accommodation, domiciliary and community-based services for persons who by reason of age, illness or disability are in need of care and attention *which is not otherwise available to them*)
- Decide if a person's needs require provision of community care services
- Notify the relevant PCT if it becomes apparent that the person has needs which may fall under the National Health Service Act 2006, and invite them to assist in the making of the assessment (see section

47(3)(a) of the National Health Service and Community Care Act 1990

**Fair Access to Care Services**

Fair Access to care services guidance can be accessed via :  
<http://www.devon.gov.uk/index/socialcare/assessment-and-eligibility/facs-policy-adults.htm>

**Primary health need concept**

To assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the National Health Service Act 2006, and to distinguish between those and the services which LA's may provide under section 21 of the National Assistance Act 1948, the Secretary of State has developed the concept of "a primary health need". Where a person's primary need is a health need they are eligible for NHS Continuing Healthcare.

There should be no gap in the provision of care, such that people might be in a situation where neither the NHS nor (subject to the person meeting the relevant means test) the relevant LA, separately or together, will fund care.

Therefore, the "primary health need" test should be applied so that a decision of ineligibility for NHS Continuing Healthcare is possible only where, taken as a whole, the *nursing or other health services* required by the individual are:

- i. no more than incidental or ancillary to the provision of accommodation which LA Social Services are under a duty to provide; and
- ii. are not of a nature beyond which a LA whose primary responsibility is to provide Social Services could be expected to provide.

There are however certain limitations to this test: neither the PCT nor the LA can unilaterally dictate what the other agency should provide, and the Coughlan judgment itself focused only on general and registered nursing needs.

Instead, a practical approach to eligibility is necessary, which will apply to a range of different circumstances, including situations in which the "incidental or ancillary" test is not applicable. This will include, for example, cases where people are cared for at home, or currently fund their own care in a care home.

Certain characteristics of need, and their impact on the care required to manage them, may help determine whether the "quality" or "quantity" of care required exceeds the legal limits and powers of LAs' responsibilities.

The decision as to whether this is the case should look at the totality of the relevant needs. The following characteristics of need and their impact on care are set out in the national framework to assist with the determination of whether an individual may have a primary health need:

- Nature: the type of needs, and the overall effect of those needs on the individual, including the type ("quality") of interventions required to manage them
- Intensity: both the extent ("quantity") and severity (degree) of the needs, including the need for sustained care ("continuity")

<b>Consents</b>	<ul style="list-style-type: none"> <li>• Complexity: how the needs arise and interact to increase the skill needed to monitor and manage the care</li> <li>• Unpredictability: the degree to which needs fluctuate, creating difficulty in managing needs, and the level of risk to the person's health if adequate and timely care is not provided</li> </ul> <p>Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs.</p> <p>Consent should be obtained from the individual being assessed including confirming whether they are willing for other family members or representatives to be involved. Asking about consent, and recording the outcome, is embedded in the Devon health and social care assessment documentation and processes. Staff, managers and the public should also be aware of the requirements of the Data Protection Act and the Freedom of Information requests.</p>
<b>Mental Capacity Act</b>	<p>Guidance in relation to persons who lack capacity to consent can be found in the National Framework. The Mental Capacity Act (MCA) 2005 is now in force, requiring full involvement of individuals in the decisions that affect them, whether or not they have the mental capacity to make the decisions themselves. Further details of the MCA and MCA code of practice are available via this link: <a href="http://www.devon.gov.uk/mentalcapacityact.htm">http://www.devon.gov.uk/mentalcapacityact.htm</a></p>
<b>What to do if individual cannot make informed choice?</b>	<p>If an individual does not have the capacity to make an informed choice the most cost effective, safe care available will be delivered based on an assessment of best interests and in conjunction with any advocate, close family member or other person who should be consulted under the terms of the Mental Capacity Act 2005.</p>
<b>Section 17 and Section 117</b>	<p>Patients who have been detained under Section 3 of the Mental Health Act 1983 will be eligible for Section 117 aftercare until they are discharged from their aftercare. They are entitled to an assessment to determine their primary need in the same way and with the same priority as individuals not subject to those arrangements. The Decision Support Tool may be considered relevant as a means of guiding decisions about whether the aftercare provided should be funded by the PCT, the LA or jointly.</p> <p>Section 117 is a freestanding duty that is distinct from the PCT's obligations to provide NHS CHC. Budget accountability and the budget for S117 remains as it is currently. The process has been broadened to include older people and people with disabilities as set out in Appendix 2 attached to this document.</p> <p><a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003622">http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003622</a></p>
<b>Joint or transferred arrangements</b>	<p>Section 17 guidance and process will be appended to this document.</p> <p>Individuals subject to joint or transferred arrangements e.g. S75 NHS Act 2006 (previously S31 Health Act 1999) or S256 NHS Act 2006 (previously S28a NHS Act 1977) are entitled to an assessment to determine their</p>



<p><b>NHS Obligations Re choice</b></p>	<p>require the PCT to take into account the individual's assessed needs, the acceptable standards of living, the nature and extent of the needs and the relative cost balanced against the relative benefit and relative need for that benefit when deciding on care options.</p>
<p><b>“Reasonable” requirements Care Homes</b></p>	<p>The consideration of the needs of the individual must be a consideration of that individual's total needs. In addition to a person's healthcare needs this must include a review of the psychological and social needs and the impact on the home and family life</p>
<p><b>“Reasonable” requirements Own Home</b></p>	<p>Cost alone cannot be used in the first instance to deny community based care packages. Cost parameters may be used as a guide but must <i>not</i> be applied rigidly.</p>
<p><b>Considerations for arranging care in a person’s own home</b></p>	<p>The NHS does not have an absolute obligation to meet individual choice and preferences and is not subject to specific directions on Choice of Accommodation in the same way as the Local Authority. The Choice Directive on accommodation is not binding on the PCT in the same way as the Local Authority but does represent good practice (see below).</p>
	<p>The PCT is obliged to arrange or provide services that it considers necessary to meet all <i>reasonable</i> requirements. In the context of <i>care homes</i> for NHS CHC the PCT is obliged to provide for the cost of providing accommodation, care and support necessary to meet the assessed needs of the individual.</p>
	<p>The PCT is not obliged to provide for the cost of providing accommodation if the individual is living in their own home but it should fund services that are required directly as a result of the individual's health need. This could include domiciliary care services.</p>
	<p>The PCT is not obliged to fund services of a domestic or family nature e.g. cleaning, gardening, cooking, childcare simply because, due to the patient’s health need, the patient is no longer able to fulfil those requirements themselves. The NHS will fund costs that arise directly as a consequence of an individual's health care needs (or associated care) e.g. increased laundry costs, water or other utility bills.</p>
	<p>Devon PCT will take account of the following issues when considering a request to deliver a complex care package in a person’s own home:</p>
	<ul style="list-style-type: none"> <li>• A full range of options for care must be considered in partnership with the individual and their family / carer as appropriate. This should include clear, written evidence that individual choices, safety and risks have been fully discussed and differences of view recorded.</li> <li>• Care can be delivered safely to the individual. This will take account of risks to the individual, the staff or other people living in the house. A formal risk assessment will be undertaken by a trained person to determine risk and safety issues. The risk assessment will include: <ul style="list-style-type: none"> <li>- The availability of equipment including telehealth, telecare and</li> </ul> </li> </ul>

home adaptations

- The appropriateness of the physical environment;
- The availability of appropriately trained carers and/or staff to deliver care when it is required.

- The acceptance by the PCT and those involved in providing the individual's care of any identified risks
- The individual's acceptance of the risks and potential consequences of receiving care
- The individual or his/her family and/or carers agreement to comply with the steps required to minimise such identified risks to those involved
- The individual's General Practitioner agrees to provide primary medical support
- The individual's preferred choice
- The suitability and availability of alternative arrangements
- The extent of an individual's needs
- The cost of providing the care at home in the context of best value and the costs of usual care
- The cost effectiveness, clinical effectiveness and quality of care that can be provided
- The relative cost of providing the package of choice considered against the relative benefit
- The psychological, social and physical impact on the individual
- The individual's human rights and the rights of their family and/or carers including the right of respect for home and family life
- The willingness and ability of family members or friends to provide elements of care where this is a necessary/desirable part of the care plan and the agreement of those persons to the plan
- How care and support is arranged to address individuals needs relating to age, gender, ethnic group, religion, disability, culture, disability and/or personal relationships

### **Making Use of Directly provided services**

*Note:* NHS directly provided services may be used as part of a home care package *Devon PCT may use NHS directly provided services such as PC T provider, NDHT or DPT where this is the most efficient way of meeting some, or all, of an individual's needs safely.* The case manager will arrange these services and refer to the Broker Service to arrange the independent and third sector services as appropriate.

### **Considerations for arranging care in a care home**

Whilst the Choice Directive is not binding on the NHS, the emphasis on individual choice is good and reasonable practice. When considering whether a less expensive care home is a genuine alternative to a more expensive placement the same considerations must be undertaken as set out in the section, 'Considerations for arranging care in a Person's Own Home'. In addition the following must be addressed:

- The individual's wishes and/or that of their family/carer
- The psychological, social and physical impact on the individual
- The availability of alternative care home placements
- The suitability of the option of choice and the proposed alternatives
- The location of the alternative care home – proximity to individual's home, family and other support networks

<b>Top Up fees and Optional extras</b>	<ul style="list-style-type: none"> <li>• Potential risk to the individual’s health if changes are made to current arrangements</li> <li>• Practical and legal issues resulting if a person refuses to move</li> </ul>
<b>Right of Appeal</b>	<p>All NHS Health Care is free at the point of delivery; where an individual has been assessed as eligible for NHS CHC there is no provision for “top-up” fees for individual contributions to fund assessed needs. However, a person does have the right to decline NHS services and make their own private arrangements if they wish to do so. Where a person has been assessed as eligible for NHS CHC they cannot chose not to accept the decision and return to “:L:A funded care with or without NHS funded nursing care”</p> <p>Individuals can choose to pay a first party or third party top up but only for <i>optional extras</i>. Optional extras include non essential services which a care home resident has chosen but was not obliged to include in their care package to meet their assessed needs and risks. The NHS must assure itself that these services are non essential to the care and support of the individual and that they do not fall within its statutory responsibilities given the circumstances of the individual case.</p> <p>The appeal process set out in the National Framework and local policy is applicable if the patient wishes to dispute a decision about eligibility.</p>
<b>4. Referrals and Assessment</b>	<p><i>This section sets out the overall, generic process for NHS CHC. It will provide an ‘at a glance’ overview and is not intended to provide detailed operational guidance for all circumstances. Frequently Asked Questions and Answers alongside detailed process mapping will be used to augment this high level guidance.</i></p>
<b>What is the MDT?</b>	<p>Where, following assessment or review, health or social care staff consider an individual may have a primary health need the following process should be followed.</p> <p>This section should be read alongside SAP/CPA guidance.</p> <p>In this context integrated teams are Complex Care Teams (Older People/ Older People Mental Health/Long Term Conditions/Physical Disability/Sensory), Network Teams (Adult Mental Health), Integrated Joint Teams (Learning Disability).</p> <p>A “multi-disciplinary team” (MDT) is defined in the Directions as consisting of at least two professionals from different healthcare or social care backgrounds. Typically this will be a nurse and a case manager, but should extend to those professionals involved in the care of the individual and must include the views of the individual and or their family / appointed representative where appropriate.</p>
<b>How to refer for a MDT HNA</b>	<p>All normal referral routes apply for both assessments and reviews. For example where an individual is actively case managed by an integrated team member this first step may not be needed.</p>

<p><b>Integrated teams</b></p> <p><b>Deciding on the case manager</b></p>	<p>What follows is a generic overview of the key processes and issues that will need to be addressed in relation to an individual's circumstances. Service providers may wish to provide detail for staff in specific situations to support staff in using this guidance.</p> <p>Where following the completion of a contact assessment and NHS CHC Needs Checklist it is considered that a MDT HNA is required to ascertain whether an individual has a primary health need, a referral should be made to the relevant integrated MDT. The referral should include as a minimum:</p> <ul style="list-style-type: none"> <li>• Contact assessment</li> <li>• NHS CHC Needs Checklist</li> <li>• A request for a MDT assessment to ascertain whether the individual has a primary health need</li> <li>• Confirmation of whether a fast track assessment is required</li> <li>• Confirmation that the referring team has communicated with the individual/family the outcome of the initial assessment and the decision to refer the individual to the MDT.</li> <li>• Referring staff must ensure that individuals and their families fully understand that the referral for an MDT assessment does not mean a person will be found eligible for NHS CHC.</li> </ul> <p>Where other SAP /CPA or other specialist assessments have been completed these should be shared with the relevant integrated team.</p> <p>Staff working in an integrated health and social care team should nominate one member of the team to lead and co-ordinate on behalf of the MDT team, the assessment, monitoring and review processes. This person will also ensure timely and clear communication with the individual and their family/carer and involve care providers in care homes and persons own home in the assessment and review process.</p> <p>This team member will be referred to as the <i>case manager</i> and should be chosen on the basis of being the most appropriate person to undertake this role – not on the basis of organisational or professional boundaries. It is a requirement that:</p> <ul style="list-style-type: none"> <li>• Everyone being assessed/reviewed for CHC has a case manager</li> <li>• The case manager may be employed by the NHS or ACS</li> <li>• Where ACS staff undertake this role there MUST be a named health worker in place to contribute to the assessment, monitor and review as required by the case manager</li> </ul>
<p><b>5. Care Plan and Procurement</b></p>	
<p><b>What is the Health Needs Assessment - HNA?</b></p>	<p>The HNA <i>is not a</i> decision making tool to determine eligibility for NHS CHC – it is part of the MDT assessment which comprehensively evidences an individual's total health and social care needs.</p> <p>The HNA should detail:</p>

<p><b>What are the outcomes of the assessment / review ?</b></p>	<ul style="list-style-type: none"> <li>• The physical and psychological needs</li> <li>• The specific interventions needed to meet them</li> <li>• Whether these interventions should be carried out by a professional, a formal carer or an informal carer</li> <li>• Be signed and dated by the practitioner(s) completing it.</li> <li>• Accurate, comprehensive and clear recording – regardless of which form it is recorded on</li> </ul> <p>The assessment may be recorded on the Health Needs Assessment (HNA), relevant SAP or CPA documentation or a combination of these. To ensure proportionate assessment / review practice and to avoid duplication for users / patients, staff should use the HNA to build on the overview / CPA / specialist assessments. If the information is already recorded, that information should be cross referenced and not repeated within the HNA domains. Alternatively staff may record the HNA on the SAP overview and specialist assessments if this is more appropriate in the individual case.</p> <p>The Practice Manager and Community Nurse Team Manager (Older People/Physical Disability) and the Team Leaders (Adult Mental Health and Learning Disability) are responsible for assuring both the quality of assessment / review recording and of the practice of the MDT members within their management.</p> <p>The outcomes of an assessment / review will support Area Panel decision making regarding eligibility.</p> <ul style="list-style-type: none"> <li>• The individual has a primary health need and is, or remains, eligible for NHS CHC.</li> <li>• The individual does not meet the criteria for NHS CHC. The PCT may still have a responsibility to effectively contribute to that person's health needs and should assess (i) whether the individual is eligible for NHS-Funded Nursing Care in accordance with the NHS-Funded Nursing Care Practice Guide (DoH, 2007). (ii) what other health needs exist and how they can be met through locally provided services.</li> <li>• The needs are within the power of the Local Authority. In these circumstances they may be offered social care services, subject to Fair Access to Care services, which may result in means-tested charges being applied, or they may self-fund</li> <li>• The person may self fund</li> <li>• Other care needs identified and either the LA or the NHS or a contribution from both organisations is required.</li> </ul> <p>All NHS CHC cases will be authorised via the Panel Process (see Section 10). Panel will look at the assessment and DST in detail. Where there are sufficient details to inform Panel decision making Panel will make that decision and this will normally follow the MDT recommendation. In the unusual circumstances where Panel does not support the MDT recommendation and there is sufficient information available Panel will have to give a very detailed explanation and justification to the Case Manager and MDT. A Panel member –normally the lead nurse - must be identified to undertake this role on behalf of Panel.</p>
--	--

	<p>Where Panel has insufficient information to support the MDT recommendation they will require additional information to ensure the recommendation is safe and consistent. In these circumstances Panel will not make a decision regarding eligibility for NHS CHC but it will not unduly delay this decision. Panel will refer the case back to the case manager and MDT within 1 working day of the Panel meeting and require the more detailed assessment and DST to be presented to the following weeks Panel. It will specify areas that require particular attention.</p> <p>Panel will require the case manager to communicate with the individual and their family/ representatives to ensure they are clear that Panel has not made a decision about eligibility for NHS CHC, what is required to be undertaken by Panel and the time scales for when the decision will be made.</p> <p>Lead nurses will also work with case managers where cases have been returned by Panel to support and improve the standard and quality of the assessment recording and DST analysis presented to Panel.</p> <p><b>End of Life Fast Track cases are the only exception to this as set out in Section 7.</b></p> <p>The Devon NHS CHC lead nurses will moderate random selected review cases and quality assure selected cases</p> <p>Please refer to the section 10 in this guidance on details regarding Area Joint Agency Panels.</p>
<p><b>Who is responsible for arranging and procuring services?</b></p> <p><b>Care planning responsibilities</b></p> <p><b>Broker Service</b></p>	<p>When a person is assessed as eligible for NHS CHC the PCT is responsible for arranging appropriate care and ensuring case management support is provided to the individual. This will be undertaken by the case manager. See Section 4 for who can be a case manager.</p> <p>The care plan must establish the review date and be shared with the individual, service providers and others as required. It must be signed and dated by the case manager.</p> <p>Devon PCT is putting in place arrangements with Devon County Council for a broker service to arrange and procure services to meet the needs of individuals eligible for NHS CHC (the "Broker Service").</p> <p>Devon PCT and ACS have agreed:</p> <ul style="list-style-type: none"> <li>• The Broker Service will be used to procure and arrange services from the 3<sup>rd</sup> and independent sectors on behalf of the PCT</li> <li>• There will be a standard broker service and a personal broker service</li> <li>• The Broker will enter into contracts with the service providers using the PCT agreed contract format unless otherwise agreed</li> <li>• The Broker will send all relevant details to the service provider including a copy of the care plan and assessments</li> <li>• Relevant case details and review dates are input to and held on Care First 6</li> <li>• Invoices and Payment to providers will be made through the LA</li> </ul>

payment system

Note: the Broker Service will not arrange NHS directly provided services. This is the responsibility of the case manager.

There are two types of brokerage support within the Broker Service.

The *standard* Broker Service will arrange care where this is a call off a block contract or a pre placement agreement. This can be for community based or care home services.

The *personal* Broker Service will arrange services where there is no block contract or pre placement agreement. This may be community based or care home services.

**What details are sent to Broker Service?**

The assessment and care plan must be sent by the case manager to the Broker service for services to be procured on behalf of the PCT. These forms will be shared with the service provider.

**When to use the Broker Service**

When fully operational, care from the independent and / or third sector service providers will be arranged through the Broker Service – not clinical or case management staff. The exception is Fast Track End of Life situations which due to the urgency may require immediate action by the case manager. See Section 7 for details of fast track situations.

Where the individual becomes eligible for NHS CHC having previously self-funded or been funded by ACS and is already receiving a package of care at a price already being paid, the process set out in this guidance must be applied. *It must not be assumed that Devon PCT will continue to pay the same fee levels.* Equally where the person has been funded by NHS CHC and is assessed as no longer eligible for this it must not be assumed that the Devon ACS will continue to pay the same fee levels.

**Respite care**

Where an individual is in receipt of respite care to support a carer to continue caring please refer to the guidance set out in Appendix 1. Respite care will generally be the provision of care directly to an individual as a result of their primary health need and in these circumstances will generally be an NHS responsibility. Where the service being provided or arranged is a direct service to a carer, in most circumstances, this will be a LA responsibility as there is unlikely to be a primary health need for the carer. Where a person is eligible for Continuing NHS Health Care (“CHC”), a PCT must provide services that meet all reasonable requirements in relation to that person's health needs. The services that a PCT must secure and fund as part of a CHC package are those services necessary to meet the physical or mental needs that have arisen as a result of illness.

In the context of a home care package, this does not mean that a person has the right to receive NHS funding for the wide variety of different, non-health and non-personal care related services that may be necessary to maintain the patient in their home environment. For example, the PCT is not obliged to fund services of a domestic or family nature e.g. cleaning, gardening, cooking, childcare simply because, due to the patient's health need, the patient is no longer able to fulfil those requirements themselves. It is only where all or part of those needs arise directly as a result of the

	<p>patient's health need that they should NHS funded e.g. if as a result of their health need, the usual level of domestic chores etc is increased, the PCT should make provision for this additional requirement (e.g. increased laundry or cleaning requirements due to soiling or the need for a sterile environment or increased utility bills due to healthcare equipment etc being used).</p>
	<p>Respite care will generally be the provision of care directly as a result of the health need. Therefore, where respite care is required then for people eligible for Continuing Healthcare, this will generally be an NHS responsibility.</p>
<p><b>NHS Direct Provider Services</b></p>	<p>Where there is a mix of care between the NHS directly provided services such as PCT provider, NDHT or DPT, the case manager will arrange the NHS directly provided services and refer to the Broker Service to arrange the independent and third sector services.</p>
	<p>End of life care will be arranged in the most timely manner taking account of the individual's circumstances.</p>
<p><b>Costing Care Packages Guidance</b></p>	<p><i>The following is a guide only for staff and not to be rigidly applied.</i> Each case must be assessed on the basis of its individual needs, risks, patient safety and expressed choices/preferences (see above).</p>
<p><b>Arranging services with Block providers/ pre agreement providers</b></p>	<p>For services (care homes and domiciliary care) where there is a block or pre placement agreement the local authority banding system will be used to guide cost packages of care and negotiate fee levels with service providers.</p>
<p><b>Arranging community based packages</b></p>	<p>As a guide, the maximum weekly cost for a community based care packages should not exceed the weekly cost of a care home per week. However, decision making must be based on a combination of needs, safety and risks rather than on set cost caps. Reference Section 3 for considerations regarding needs, safety and risks.</p>
	<p>Where community based care packages are above this guide this cannot be used to deny community based support in the first instance. Case managers will need to discuss all such cases with their manager</p>
	<p>Any care packages that are beyond the delegated financial accountability of the area panel will require County NHS CHC Panel approval before care services can be arranged. Any care packages that are beyond the delegated financial accountability of County Panel will be referred to the DPCT CEX.</p>
	<p><b>Clinical staff, case managers or the Broker Service must not accept or input cases to CF6 without the agreement of the relevant panel with delegated financial accountability.</b></p>
	<p>The cost of care arranged by the personal Broker Service will be determined on a case by case basis using the agreed process for this service.</p>

## Roles and Responsibilities

### ***The case manager will ensure:***

- The HNA is completed as part of the MDT assessment / review - building on assessment /review information that is already recorded to avoid duplication and ensure proportionate practice. The health worker will play a key role in the assessment, monitoring and review of individuals
- The Decision Support Tool (DST) is completed / updated by the health care worker
- Co-ordination of specialist assessments as identified by the MDT
- Involve, negotiate and agree with the individual and their family about issues of choice, safety and preferences in terms of where and how care is arranged. This is not a function of the Broker Service
- Ensure individuals and families are fully aware that NHS CHC is not for life and some individuals may not meet NHS CHC criteria at subsequent reviews
- Record outcomes of assessments, decisions and negotiations with family including recording any differences of view
- Liaise closely with the lead health worker and ensure the assessment risks are shared with them
- Involve care home managers in the assessment and review process where someone is in a care home and involve domiciliary care managers where they are caring extensively for a person in their own home.
- A recommendation is made to the relevant manager
- NHS directly provided services are arranged where this is the agreed plan
- The service user/ representative is informed of their right to make a complaint/ appeal if they remain unhappy with the decision
- Set a review date
- Ensure the appropriate process for authorisation of spend is followed
- Provide the Broker Service with care plan, assessment details , panel requirements which should clearly set out where (care home/ community based) and how care is to be arranged, any special assessed needs or risks to individual or service provider that require consideration – without this, care cannot be arranged or costs agreed
- Undertake reviews – use *Devon NHS and Adult and Community Services Operational Protocols for NHS Continuing Healthcare*
- Enter all case details and assessment on to CareFirst 6 in a timely and accurate manner following agreed procedures
- Ensure individuals and families are aware of the outcome of panel including in writing as well as verbally where this is the agreed approach with them

### ***The Broker Service will:***

- Receive the care plan from the case manager
- Negotiate and arrange the care with service providers
- Use the personal Broker Service where relevant
- Notify case manager of service providers or send options to case manager of potential service providers for personal brokered services
- Input relevant details of the care package / contract to Care First 6



<p><b>Withdrawal of Care</b></p>	<p>If it is agreed that the person is no longer eligible for NHS CHC best practice will be to have completed the review jointly to ensure timely responses for individual and their families as to whether the person is eligible for NHS-funded Nursing Care and / or community care assessment. Where this is not the case such assessments will be required to inform decision making.</p> <p>The case manager should complete the DST and send to the area joint panel for final decision making. The Devon NHS CHC lead nurses will moderate random selected review cases and quality assures selected cases.</p> <p>Please refer to the section 10 in this guidance on Joint Agency Panels for further details.</p> <p>Where a review is carried out on an individual receiving NHS CHC in their own home and the review determines that the package of care is no longer feasible then an alternative package will be discussed and agreed.</p> <p>There may occasionally be circumstances where the individual declines to accept alternative suitable provision and a suitable package acceptable to the individual and the PCT cannot be identified. This may result in the PCT issuing a <i>Withdrawal of Care Notice</i> where safety of the individual and/or those people involved in providing care is likely to be compromised without such action or a material increase in support is required and, as a result of this increase, the PCT considers that the cost of providing the care in the individual's home is no longer appropriate.</p> <p>Where the assessment or review identifies, or the PCT otherwise becomes aware that an action to reduce risks to the service provider or the individual has not been observed and such failure may put those individuals providing care at risk or may significantly increase the cost of the package, then the PCT will take the necessary steps to protect the individual and staff involved with a view to ensuring the safety of all concerned. This may result in the PCT issuing a <i>Withdrawal of Care Notice</i> where safety is likely to be compromised without such action.</p>
<p><b>7. End of Life Care</b></p>	<p>Appendix 1 provides detailed operational guidance on this issue.</p>
<p><b>When to use the End of life process?</b></p>	<p>The End of Life process should be used for those individuals who have a rapidly deteriorating condition with an increasing level of dependency. This will normally be an individual at the end of life and regardless of the setting they are in. It is for use within the guidance of the National Framework for NHS Continuing Healthcare.</p>
<p><b>Who can raise a fast track situation?</b></p>	<p>A senior clinician such as a Ward Sister, Consultant or GP, the relevant Consultant or Nurse Specialist/Consultant must outline the reasons for fast tracking an individual's situation. This may be supported by a prognosis if available, but strict time limits are not relevant for end-of- life cases and the responsibility rests with the assessor to make a decision based on the relevant facts of the case.</p>

	<p>They must identify that the person’s condition is rapidly deteriorating with an increasing level of dependency which meets the criteria for NHS CHC.</p> <p>The expectation is to use existing funded healthcare provision in first instance where this is agreed with the individual and / or family (i.e. community nursing, community hospital, rapid response, Marie Curie, Hospicare ) without any recharging to CHC budget.</p> <p>See below for authorisation of NHS CHC funding in these circumstances.</p> <p><i>NB. Clinicians and their immediate line managers are not authorised to agree these situations.</i></p>
<p><b>What should be the outcome of the Fast Track Assessment?</b></p> <p><b>Who can agreed Funding for these cases</b></p>	<p>Correctly identified individuals who meet the Fast Track requirements should receive the care they need without delay. They may need NHS Continuing Healthcare funding to enable their needs to be urgently met (e.g. to allow them to go home to die or to allow appropriate end of life support to be put in place). The provider will require an appropriate level of information to ensure safe and effective patient care and support when packages are first set up. The clinician must ensure this is in place.</p> <p>A full assessment should follow as appropriate. In most cases the PCT will fast track these individuals care, however if there is disagreement between the statutory agencies please refer to the “<b>Without Prejudice</b>” section.</p> <p>People whose primary health care needs meet NHS CHC criteria and who are at the end of life require swift authorisation of care. The Assistant Director or their nominated deputies and cluster managers can authorise care packages for up to 7 days in these circumstances and up to £1,000 per week. Such cases must then be referred for authorisation at next area / county panel as appropriate.</p> <p>Reference appendix 3 for detailed operational process guidance.</p>
<p><b>8. NHS CHC Needs Checklist</b></p>	
<p><b>What is the Checklist?</b></p> <p><b>Who/when should it be completed?</b></p>	<p>The Checklist is a DH tool to help health and social care staff identify individuals who may be eligible for NHS CHC and to decide whether there is a need for a comprehensive MDT and HNA.</p> <p>It can be used by a variety of people in a variety of settings. The checklist can be used by hospital discharge, a nurse in an individual’s home, and Adult Social Services workers carrying out a Community Care Assessment.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>• Where an individual has been assessed, or is being funded by ACS either in a care home or their own home</li> <li>• Where the NHS currently funds an individual and a review of their needs indicates that they may no longer be entitled to NHS funding</li> <li>• When planning hospital discharge</li> </ul>



<p><b>Outcome of Decision Support Tool</b></p>	<p>the assessment.</p> <p>Once completed the form is sent to the Area Panel along with the relevant assessment documentation to support Panel decision making.</p> <p>The Professional Lead Nurses within the PCT NHS Continuing Care team will offer advice and guidance on the most complex cases. They will also provide mentoring for those who are using this tool for the first time and will set up moderation approach to assure consistency of approach.</p> <p>The completed Decision Support Tool should result in the following:</p> <ul style="list-style-type: none"> <li>• A Primary Health Need <b>is</b> established and the recommendation is for NHS Continuing Healthcare</li> <li>• A Primary health need <b>is not</b> established, however, NHS funded nursing care and other health and social care needs are established – that is the person’s needs are within the powers of the LA ( Section 2)</li> <li>• Other Care needs identified and either the local authority or NHS or contribution from both organisations is required</li> <li>• The person does not have a primary health and is not eligible for LA funded support and will self fund their care. This individual may still have health needs that are met through locally provided services.</li> </ul>
<p><b>Who checks this?</b></p>	<p>The national guidance for the Decision Support Tool advises that eligibility for NHS Continuing Healthcare would be <i>expected</i> for anyone found to have:</p> <ul style="list-style-type: none"> <li>• 1 Priority need in any domain, or</li> <li>• 2 or more Severe needs.</li> </ul> <p>People <i>may</i> have a primary health need if they are found to have either:</p> <ul style="list-style-type: none"> <li>• 1 Severe need together with needs in a number of other domains, or</li> <li>• A number of domains with high and/or moderate needs.</li> </ul> <p>People with needs falling entirely in Low needs or No Needs are likely to be ineligible for NHS Continuing Healthcare but each case must be decided on its individual facts and merits in order to determine whether or not a primary health need still exists.</p>
<p><b>What happens to the form?</b></p>	<p>This is a guide for clinicians only and should not be used to substitute for professional decision making about whether an individual has a primary health need or is within the legal limits of the LA (See Section 2).</p> <p>The manager of the integrated team should check all the documentation to ensure:</p> <ul style="list-style-type: none"> <li>• The agreed processes have been followed</li> <li>• Involvement of individuals, family, carers and key practitioners and clinicians is evidenced</li> <li>• The assessment is sufficiently detailed to support the decision making process</li> <li>• All legal processes such as MCA assessments have been addressed</li> </ul>



<p><b>County NHS CHC Panel</b></p>	<ul style="list-style-type: none"> <li>• Eligible for NHS CHC fully funded by PCT</li> <li>• Within the legal limits of the LA – ACS or self funder</li> <li>• Not eligible for full NHS CHC but for NHS Funded Nursing Care and either refer for ACS funding or self funder</li> <li>• Eligibility not agreed – refer to disputes resolution (See Section 11)</li> </ul> <p>A series of standardised letters has been produced to inform patients, their families and providers about CHC reviews and decisions. These letters can be personalised by adding in additional information if staff wish, but no part of the letters should be removed as they cover all our obligations to offer appropriate advice and information to people. Templates for the letters can be sourced from Karen Morrison, Business Support Manager for CHC at <a href="mailto:karen.morrison@nhs.net">karen.morrison@nhs.net</a>.</p> <p>There will be one county panel for NHS CHC decision making about funding for cases which are beyond the financial authorised levels of the Area Panels.</p> <p>This Panel will be chaired by a senior manager of the PCT.</p> <p>The purpose of the panel will be:</p> <ul style="list-style-type: none"> <li>• To agree funding for all NHS CHC funded cases within the financial authorised level of Area Panel</li> <li>• To resolve disputes in conjunction with the Director of ACS</li> </ul> <p>Note: For cases to come to this level it is a requirement that managers have fully addressed and confirmed the eligibility for NHS CHC and sought the most effective, safe and efficient package of care. This panel will focus on funding requirements only.</p> <p>Both County and Joint Agency Area Panels are attending by a range of clinical leads for the service areas of Learning disability, mental health, older people, older people mental health, physical disability and long term conditions.</p>
<p><b>11. Disputes</b></p>	
<p><b>Dispute resolution process between NHS and ACS</b></p>	<p>Devon PCT and ACS are committed to avoiding disputes wherever possible. Experience shows that commissioning additional assessments and carrying out, or reviewing the assessments jointly, through our integrated teams can resolve most differences.</p> <p>For cases where there is a dispute between NHS bodies or between LA and PCT about responsibility there should not be a delay in the provision of the care package. The protocol below sets out how funding will be handled during the dispute.</p> <p>Where the locality joint-agency Panel is unable to reach a decision or agreement in a case, the information should be referred to another Area Panel for review and decision making. If this fails to reach agreement the</p>

<p><b>Dispute Resolution Process between NHS and individuals</b></p> <p><b>Funding Arrangements for disputed cases</b></p> <p><b>Living in own home</b></p> <p><b>In hospital/funded by PCT</b></p>	<p>Chief Executive and Director of ACS will reach a conclusion about responsibility.</p> <p>Devon PCT will deal promptly with any request to review decisions about eligibility for either NHS Continuing Healthcare or NHS-funded Nursing Care.</p> <p>The PCT should continue to fund anyone whose care is being funded by the NHS (e.g. in hospital, at home or in a care home) at the point at which the original decision is made. Funding should continue until the Strategic Health Authority (SHA) Independent Review Panel (IRP) level. If an individual not in NHS care disputes a decision the PCT does not need to pick up funding until the issue is resolved.</p> <p>The local resolution process will be to set up a PCT review panel.</p> <p>Once local procedures have been exhausted, the case should be referred to the SHA for consideration by their Independent Review Panel.</p> <p>Devon PCT and ACS have agreed there should be no delay in the provision of services to individuals due to disagreements on the assessment recommendation or outcome of the decision on eligibility. There will be no unilateral withdrawal of existing funding arrangements without the agreement of the other party.</p> <p>Anyone in their own home, or care home funded by the local authority must continue to be financially assisted by the Council until the dispute is resolved.</p> <p>Similarly, anyone in hospital, or otherwise funded by the PCT (e.g. at home or in a care home) must remain funded by the PCT until the dispute is resolved.</p> <p>Devon PCT and Devon ACS agree to adopt a <b>“Without Prejudice”</b> approach to such situations whereby the final outcome of the dispute will be backdated to the time of the original funding request. This means that if the Council has continued to fund an arrangement that subsequently is decided to be NHS Continuing Healthcare, the PCT funding should be backdated to the date that the Council gave notification to the PCT and the individual should be reimbursed any charges that they have paid during this interim period.</p> <p>Similarly, where a PCT has continued to fund an arrangement that subsequently is decided to have been a local authority responsibility, the Council will reimburse the relevant PCT to the date of notification.</p> <p>Placements in care homes will be made within the current Local Authority banding levels.</p>
<p><b>12. Timeframes</b></p>	
<p><b>What is the timeframe</b></p>	<p>The National Framework requires ‘<i>most decisions regarding eligibility for</i></p>



## **Appendix 1**

### **End of Life: policy and procedure**

Policy Extract from **DH Continuing Care – Core Values and Principles**

“Palliative care is considered to be the model for quality and compassionate care for people facing an illness or injury. It involves a team-oriented approach to expert medical care, emotional and spiritual support and pain management, if required; all expressly tailored to the person’s needs and wishes.

Palliative care may be required for many years, but end-of-life care, which often includes specialist palliative care, is generally required for a relatively short period.

Where a person has needs that require the input of specialist palliative care services they should be referred to the specialist services for an assessment. The specialist service will assess both immediate needs and continuing care needs, in the light of the person’s prognosis. Where the person’s health needs are increasing rapidly and a delay in assessment is anticipated, the specialist service in consultation with the care manager should consider referring the person for NHS Continuing Healthcare through a fast track process to avoid delays in discharge from hospital or hospice to home.

Individuals with a rapidly deteriorating condition and short-term life expectancy will immediately qualify for NHS Continuing Healthcare. For the purposes of determining eligibility to NHS funding, ‘short-term’ should not to be defined prescriptively or restrictively, but should be based on an assessment of the person’s care needs and considered as a period of time which can be expressed in days and weeks. Strict time limits are not relevant for end of life cases and should not be imposed – it is the responsibility of the assessor to make a decision based on the relevant facts of the case.

#### **Procedure**

1. Assistant Directors for North, Eastern and South Devon are accountable for decision-making about eligibility for EOL fast track CHC funding for up to 7 days. The role of Professional Lead Nurses within the CHC Team and specialist palliative care staff is advisory.
2. No services should be purchased for fast-track cases until all in-house options, including existing contracted services, have been explored and fully utilized wherever possible. Thereafter the delegated limit for purchased services is £1000. Any figure above this must be personally authorized by an Assistant Director.
3. Practitioners across the health and social care economy need to be clear that End of Life applies only to a person with a rapidly deteriorating condition and short-term life expectancy.
4. The CHC Manager should be informed by e-mail of all fast-track authorisations. All patients authorised under these arrangements must be entered on to CareFirst 6.
5. Each Area Panel should review cases authorised for 7 calendar days fast track funding and require submission of a full HNA and DST for any individual case that remains as EOL fast-track funded beyond one week, including those whose life has ended before the Panel review date.
6. The numbers of fast track cases and their associated costs should be identified and monitored separately via Panel processes.

**Continuing Health Care: Who is the “Responsible Commissioner”?**

**APPENDIX 2**

Situation	Devon PCT	Another PCT	Responsible Commissioner
Person lives in Devon PCT and is registered with a GP in Devon PCT	Patient resident and registered in Devon		Devon
Person lives in Devon PCT but is not registered with a GP	Patient resident in Devon		Devon (provided that their residence in Devon is their “usual residence”)
Patient has no fixed address (or refuses to provide one) and no GP	Patient ‘presents’ to the service in Devon (eg A & E)		Devon but note if a person is of no fixed abode and not registered with a GP, responsibility must be determined by reference to “usual residence” which is where that person considers themselves to be usually resident e.g. a hostel. It is only if they are unable to give an address that responsibility would be determined by the PCT in whose area he/she is present. The guidance does state that ever effort should be made to establish an address.

Situation	Devon PCT	Another PCT	Responsible Commissioner
As above, but patient is an asylum seeker			Probably Devon. Seek advice. [See comments above, would need to consider where they are “usually resident” whilst in the UK. NB, for individuals detained on the grounds of their immigration status the responsible commissioner is the PCT in which the detention facility is located]
Patient intends to move house but hasn't yet and is currently resident in Devon and registered with Devon GP	Patient resident and registered in Devon currently		Devon
Patient has moved house (own choice) but remains registered with a Devon GP (exclusion cross border moves – see below)	Patient registered with Devon GP	Patient resident in Another PCT	Devon (Patient to be encouraged to register with GP in Another PCT asap!)

Situation	Devon PCT	Another PCT	Responsible Commissioner
Patient has moved house (own choice)	Patient not registered with Devon GP	Patient resident in Another PCT but has not yet registered with GP	Another PCT
Patient has moved house (own choice)	Not registered and not resident	Registered and resident	Another PCT
Patient lives in Care Home in Devon having been placed here originally by Another Adult Services Authority and becomes eligible for CHC after the placement was made	Patient registered with Devon GP	Resident in Devon	Devon (NB it is also Devon's responsibility to do the assessment in partnership with the placing Local Authority)
Patient is eligible for CHC lives in a Care Home in Devon having been placed here by Another PCT	Registered and resident		Another PCT (provided the patient was eligible for CHC as at the date of the placement and the placement was made on or after 1 April 2006)  (guidance allows them to request Devon to provide the services on their behalf but for which they pay - seek advice).

Situation	Devon PCT	Another PCT	Responsible Commissioner
Patient lives in a care home outside Devon having been placed there by Devon Adult Services and becomes CHC eligible after the placement was made.	Not registered, not resident	Registered and resident	Another PCT  (transfer from Devon ACS funding to CHC to be done in co-operation with Another PCT)
Patient eligible for CHC lives in a care home outside Devon having been placed there by Devon PCT	Not registered, not resident	Registered and resident	Devon (provided the patient was eligible for CHC as at the date of the placement and the placement was made on or after 1 April 2006))
Patient is a Member of the Armed Forces	Patients should be de-registered on enlistment		For primary medical services: MOD (although in some circumstances military personnel can be registered as a temporary resident with a GP).  Secondary medical services will be the responsibility of the PCT (determined in accordance with the usual principles) if appropriate military healthcare provision is not available.

Situation	Devon PCT	Another PCT	Responsible Commissioner
Patient has moved, or intends to move, to Scotland, Wales or Ireland	Patient registered in Devon		Complicated. Seek advice.
<b>Mental Health Act</b>			
Patient in receipt of s117 After Care	Patient registered and/or resident in Devon		This is dependant on where the patient was “usually resident” as at the date of admission to hospital under section (i.e. and not by reference to the area in which they are resident whilst in receipt of S117 aftercare, even if they register with a GP in the new area).
Patient on s17 leave	Patient registered and/or resident in Devon		Devon Partnership Trust for people under 65 (from IPP budget); CHC funding for over 65s For individuals detained under the MHA 1983, responsible commissioner is determined in accordance with the usual principles i.e. GP registration or, if not GP, usual residence]

Situation	Devon PCT	Another PCT	Responsible Commissioner

The above guidance applies from April 2006. For situations arising prior to that date, the same principles broadly apply but if in doubt, seek advice.

## **Continuing Care**

Means care provided over an extended period to a person 18 or over to meet the physical and mental health needs which have arisen as a result of disability, accident or illness. An individual who needs continuing care may require services from NHS bodies and/or local authorities. If a person does not qualify for NHS Continuing Healthcare the NHS may still have responsibility for contribute to that person's health needs. A "joint package" of continuing cares. One way in which the NHS does this is by means of the NHS - Funded Nursing Care contribution.

## **NHS Continuing Healthcare**

A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need. It can be provided in any setting. In a person's own home, it means that the NHS funds all the care that is required to meet their assessed health needs. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the person's accommodation as well as all their care.

## **NHS – Funded Nursing Care**

NHS Funded Nursing Care is the contribution paid by the NHS to individuals for their registered nursing care who are resident in care home with nursing care. This replaces the current three tier banding of Registered Nursing Care Contribution, which remains in place until the 30<sup>th</sup> September 2007. Directions will be issued which will cancel the current system and introduce a single band from October 1<sup>st</sup> 2007. The determination of eligibility for NHS – funded Nursing Care will be integrated into the same framework as eligibility determination and care planning for NHS Continuing Care.