NHS
Derby and Derbyshire
Clinical Commissioning Group

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Continuing Healthcare for Adults Commissioning Policy

KEY POLICY MESSAGES	
1.	Details the CCG's commitments in relation to individual choice and resource allocation.
2.	Describes the way in which the CCG plans and commissions services for people eligible for fully funded NHS Continuing Healthcare and a Personal Health Budget.
3.	Sets out the CCG's principles for joint funded packages of health and social care.

VERSION CONTROL

Title:	NHS Derby and Derbyshire CCG Continuing Healthcare for Adults Commissioning Policy
Supersedes:	Continuing Healthcare for Adults Commissioning Policy for Derbyshire CCGs
Description of Amendment(s):	February 2020, Version 1.0 – initial draft for NHS Derby and Derbyshire CCG August 2021, Version 2.0 – annual review November 2021, Version 3.0 – full review by Chairs of the Panel • Scope extended to include that the Principles of the Policy are applied to Commissioning for Individuals decisions (non-CHC Complex cases) • Funding threshold for home care changed from 25% to 15% • Recording when patients are paying for additional care • Rate paid for 1: 1 care amended to reflect different complexities • Include reference to Enhanced Observation Policy • Added CCG may withdraw CHC funding or offer alternative setting for care if care staff are subject to physical or emotional abuse or if client/ family behaviours result in multiple failed care packages and the CCG has made all reasonable effort to provide CHC care
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Author:	Assistant Director of Quality (CHC, Care Homes, End of Life & Personalisation)
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1. POLICY STATEMENT

1.1 This policy applies to NHS Derby and Derbyshire Clinical Commissioning Group (the "CCG").

1.2 This policy describes the way in which the CCG will plan and commission services for people who have been assessed as eligible for an episode of fully funded NHS Continuing Healthcare (CHC), and patients who are eligible for CHC who wish to have a Personal Health Budget (PHB). It also sets out CCG principles for joint funded packages of health and social care.

1.3 The policy describes the ways in which the CCG will procure and provide care in a timely manner that reflects the choice and preferences of individuals and balances the need for commissioners to procure care that is safe and effective and makes best use of available resources across the system, while taking into consideration the wishes of clients and their families.

1.4 NHS Continuing Healthcare means a package of continuing care arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in the National CHC Framework (2018). The actual services provided as part of that package should be seen in the wider context of best practice and service development for each client group. Eligibility places no limits on the settings in which the package of support can be offered or on the type of service delivery.

1.5 Individuals receiving CHC have some of the most clinically complex and severe health needs within the local population. Some are receiving end of life care and in other cases, people's needs may change to the extent that they are no longer eligible for CHC funding. In the delivery of CHC, the CCG must ensure consistency in the application of the National Framework whilst, implementing and maintaining good practice, ensuring quality standards are met and sustained.

1.6 This policy ensures that individuals who are in receipt of CHC in Derby and Derbyshire will receive care in line with the principles listed below:

1.6.1 the CCG has the duty to consider the best use of resources for the population of Derby and Derbyshire whilst meeting the assessed health needs of an individual. Therefore, options will always be considered to meet the identified health needs of an individual who is eligible for CHC, and the CCG will always consider the most cost-effective option to meet the patient's needs;

1.6.2 equality of individuals will be upheld, and any agreements will not be discriminatory;

1.6.3 the CCG has a prime responsibility to ensure that services it procures are clinically appropriate and meet agreed quality standards. The safety, welfare and potential risks to the individual are considered in care purchased.

Personalisation of support and care for an individual, are central to decision making, once the other principles above have been assured

1.7 The CCG has developed this policy to help provide a common and shared understanding of the CCG's commitments in relation to individual choice and resource allocation.

1.8 Once an eligibility decision has been made NHS CHC packages of care are subject to a cost effectiveness test in the same way as all other NHS services. Whilst agreeing a package of care for eligible individuals that meet their assessed needs, the CCG has a statutory duty to consider the available resource. In coming to a decision on a package of care to be commissioned for a patient the CCG must balance the need to commission safe, effective and clinically appropriate care that makes the best use of available resources and in a manner that reflects the choice and preferences of individuals.

2. SCOPE OF THE POLICY

2.1 The scope of this policy applies to guide decision making by all staff employed by or contracted to the CCG, who are required to make decisions about the care packages for individuals that are eligible for an episode of Continuing Healthcare (for the avoidance of doubt this includes PHBs) and for joint funded packages of health and social care. The purpose, aims and commissioning principles outlined in this policy will also be applied to other Commissioning for Individuals decisions (non-CHC complex cases) where the CCG has a responsibility to fund to meet assessed care needs.

2.2 This policy applies to all adults aged 18 years and over who are eligible for CHC.

3. LEGAL COMPLIANCE

3.1 The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (Revised 2018) sets out the principles and processes for CCGs to adopt. It concentrates mainly on the process for establishing eligibility for CHC and the principles of care planning.

3.2 The established NHS values and principles of equality and fairness are set out in The NHS Constitution for England, Department of Health (2013) and the laws under the Equality Act 2010 together with the European Convention on Human Rights.

3.3 The Care Act 2014 is a comprehensive piece of legislation that sets out clear principles on how Adult Social Care should work with people. It is founded on the statutory principle of 'promoting wellbeing' and underpinned by the principle of 'personalisation'.

3.4 In all cases the CCG will follow safeguarding policy and the Mental Capacity Act (2005) to ensure the best interests of the individual are maintained. All staff are

responsible for adhering to staff guidance and are expected to understand the legal framework that governs health care.

3.5 In drawing up this policy, the CCG has had regard to the Human Rights Act 1998 and the implications of placement for individuals in relation to their Article 8 rights.

3.6 Section 14v of the National Health Service Act 2006 places a procedural statutory duty on CCGs to take account of patient choices when making commissioning decisions. It provides:

> "Each clinical commissioning group must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them."

Subject to the terms of this policy, the CCG will seek to commission services in accordance with choices made by individuals including as to their preferred setting of care. However, there is a need to balance personal choice alongside safety and effective use of finite resources in the provision of CHC services. There should also be consistency and equitable decisions around the provision of care regardless of the person's age, condition, or disability. All procurement decisions need to provide transparency and fairness in the allocation of resources.

4. PURPOSE, AIMS AND COMMISSIONING PRINCIPLES

4.1 The purpose of this policy is to:

4.1.1 define how and when the CCG will support choice of care setting for individuals in relation to safe, effective and clinically appropriate care which makes the best use of available resources and to ensure that care is provided equitably across the CCG; and

4.1.2 ensure that the reasonable assessed needs of eligible individuals are met in a manner which supports consistent and equitable decisions about the provision of that care regardless of the person's condition or disability.

4.2 It is the intention that application of this policy will ensure that decisions about care will:

4.2.1 be robust, fair, consistent, and transparent;

4.2.2 be based on the objective assessment of the person's clinical need, safety, and best interests;

4.2.3 have regard for the safety and appropriateness of care to the individual and staff involved in the delivery;

4.2.4 involve the person and their family/representatives' views wherever possible;

4.2.5 consider the need for the CCG to allocate its financial resources in the most cost-effective way;

4.2.6 facilitate effective partnership working between healthcare providers, NHS bodies and the Local Authorities in the area;

4.2.7 support individual choice to the greatest extent possible in view of the above factors.

For these reasons there may be occasions where the CCG cannot offer to commission services which are the individual's preferred option. If this is the case reasons will be explained to the individual.

4.3 This policy aims to assist the CCG to:

4.3.1 understand the legal requirements, CCG responsibilities and agreed course of action in commissioning care that meets the assessed needs of the individual;

4.3.2 meet the responsibilities under the sources of guidance listed in section 20 of the Policy;

4.3.3 make decisions about clinically appropriate care provision in a robust way, within the available financial envelope;

4.3.4 provide guidance for those staff who are designing the package of care with the eligible individual to ensure the cost of care provided is proportionate for the same level of need regardless of the setting the care that is provided, and to meet all of the individual's assessed health and associated social care needs;

4.3.5 take account of the wishes expressed by individuals and their representatives when making decisions as to the location or locations of care packages to be offered to individuals;

4.3.6 promote the individual's independence and to support individuals to take reasonable risks whilst ensuring that care provided is clinically safe, including through the use of a PHB subject to the factors set out below:

(a) the individual's safety;

(b) the individual's choice and preference;

(c) ensuring services are of sufficient quality;

(d) the individual's right to family life;

(e) ensuring services are culturally sensitive;

(f) ensuring services are personalised to meet individual need and clinical outcomes ;

(g) best use of resources for the population of the CCG (reference to break even reference 4.4.2)

4.4 Commissioning Principles

4.4.1 In balancing the use, and distribution of limited NHS resources, the CCG fully respects equality and diversity, and fully embrace the established NHS values and principles on equality and fairness, as set out in The NHS Constitution for England, Department of Health (2013) and the laws under the Equality Act 2010 together with the European Convention on Human Rights.

4.4.2 The NHS exists to serve the needs of all its patients but also has a statutory duty financially to break even (National Health Service Act 2006). The CCG has a responsibility to provide health benefit for the whole of their population, whilst commissioning appropriate care to meet the clinical needs of individual patients.

4.4.3 The CCG is obliged to meet the health and care needs of individuals who are eligible for CHC. However, guidance does not prescribe the type of healthcare required to meet the need. CCGs have discretion as to the manner of provision of CHC services and must exercise reasonable judgment to provide the most appropriate care within the resources available, considering overall expenditure

4.4.4 Support will be organised that reflects the choice and preferences of individuals, balanced with the need for the CCG to strategically commission and manage the demand for healthcare for all people in a safe and effective manner.

4.4.5 At all times the CCG will ensure the best use of NHS resources both locally and nationally commissioned, and a level of service which maximizes individual health and wellbeing and is fair to the people of Derby & Derbyshire.

4.4.6 If the support requested is not deemed to be cost effective, the CCG may not agree to a support plan or placement that is preferred by an individual, and instead may require the individual to choose a less expensive alternative that will meet all of their identified needs.

4.4.7 The CCG understands that many individuals with complex medical conditions wish to remain in their own homes and continue to live with their families with a package of support to aid them to do this. Similarly, the CCG accepts that many patients might wish for other care options including other forms of supported living or care homes.

4.4.8 Where this is the case, the CCG will investigate whether it is clinically feasible and affordable to provide a sustainable package of CHC funded care for the individual that is consistent with their preferences and will explore the likely cost of commissioning care in accordance with choices made by patients.

4.4.9 Where there is evidence that a person's outcomes can be met in a more cost-effective way, this must be the level of resource that is offered. This may mean that for some individuals, where complex community based support exceeds the cost of a residential or nursing placement with no measurable improved outcomes over time, the residential or nursing options open to that person should be considered. Exceptional circumstances will be considered for providing funding above the agreed budget. However, equity of provision and the wider community health

needs cannot be ignored. Exceptionality will be considered on a case-by-case basis.

4.4.10 The CCG will not normally fund a registered care placement (care home) at more than 10%(subject to ongoing review) above what it would cost to provide care in a care home on the CCG's approved list – Any Qualified Provider Framework (AQP).

4.4.11 The CCG would not normally fund a package of care at home that is more than 15% (subject to on- going review) above the most cost-effective care package identified by the CCG – i.e. In a care home.

4.4.12 The CCG will only fund packages above this level in exceptional circumstances, taking into account the following considerations:

(a) the individual's wishes;

(b) likely impact on the individual of any potential move, including psychological and emotional impact;

(c) suitability and/or availability of alternative arrangements;

(d) risks involved to the individual and others;

(e) the individual's rights and those of his or her family and other carers;

(f) whether there are any creative alternatives available to enable the best use of resources available and to enable the individual's choice to be realised; and

(g) the CCG's obligation in relation to equality and the Public Sector Equality Duty.

(h) where an individual has been self-funding care prior to becoming eligible for CHC funding the principle in section 12 of this policy will be applied.

4.4.13 If the weekly cost of care increases, the care package will be reviewed and other options (for example, a placement in a care home) will be explored (excluding single periods of cost increase to cover an acute episode, or for end-of-life care where the individual is in the terminal stage and hospital admission can be prevented).

4.4.14 This 10% (care homes) and 15% (home care) threshold will be applied consistently to every case across Derby & Derbyshire CCG unless the CCG decides that the patient demonstrates exceptional circumstances or the patient's circumstances come within paragraph 8.4 of this policy.

5. THE ROLE OF THE CCG

The CCG will seek to take into account any reasonable request from the individual and their representative(s) in making the decision about the care provision subject to the factors set out in this policy; and will endeavour to offer a reasonable choice of available,

preferred providers to the individual. Where the individual wishes to receive their care from an alternative provider, the CCG will consider this, subject to the individual's preferred care setting being considered by the CCG to be safe, and effective and clinically appropriate in relation to the individual's needs as assessed by the CCG; and subject to the principles set out in paragraph 4.4 of this Policy.

6. MENTAL CAPACITY AND REPRESENTATION

6.1 The Mental Capacity Act 2005 states that there should be an assumption of capacity. However, where there is reason to believe that an individual may lack the capacity to make a decision regarding the provision or location (or change to) their care and/or accommodation, a mental capacity assessment must be undertaken. If the assessment confirms that the individual lacks capacity to make the relevant decision, a 'best interest decision' should be undertaken in accordance with the Mental Capacity Act and its Code of Practice. Where necessary the CCG will appoint an Independent Mental Capacity Advocate (IMCA) to support the individual in decision making in accordance with the Act.

6.2 Where a personal welfare deputy has been appointed by the Court of Protection under the Mental Capacity Act (2005) or a Lasting Power of Attorney with powers extending to healthcare decisions has been appointed, the CCG will consult with that person and obtain a decision from that appointed person on the preferred care option.

6.3 Where there is no health and welfare deputy or attorney the CCG will be the best interest decision maker.

6.4 In all cases there is an expectation that the decision maker will consult with relevant professionals, family members and / or carers. The CCG will make this decision in accordance with the Mental Capacity Act guidance referenced in Appendix B.

6.5 Commissioning option decisions will be taken first and then a best interest decision can be made from the options that the CCG are prepared to fund.

7. IDENTIFICATION OF CARE PROVISION

Where an individual is eligible for CHC, the CCG will commission the care which meets the individual's assessed care needs giving effect to the patient's choices to the extent defined by this policy.

8. EXCEPTIONAL CIRCUMSTANCES

8.1 The CCG has resolved that, where the patient is able to demonstrate exceptional circumstances, it will be prepared to support a safe, cost-effective, clinically appropriate and sustainable package of care, which keeps a person in their chosen setting. Even where the patient shows that he or she has exceptional circumstances, the CCG retains a discretion to decide the extent to which, if at all,

it is prepared to fund the care package for the patient to be delivered in an alternative appropriate location which costs more than 10% (care homes) and 15% (home care) over the cost of delivering on the CCG's duties to the client in a cheaper location.

8.2 The CCG will decide as to whether the patient is able to demonstrate exceptional circumstances and if so, what package should be funded based on the precise facts of each case. This may involve reviewing the complexity of the individual's condition and the level of clinical risk associated with any proposed placement, which would prevent adequate and timely care provision. The rationale for decision making will be shared with the patient and their family/ carers.

8.3 Exceptionality will be determined on a case-by-case basis, considered at the Commissioning for Individuals Panel (CHC Section) . In urgent cases a decision can be made outside of the panel by joint agreement of a CCG Director, or their Deputy. Authorisation outside of panel would be determined by the CCG's Standing Rules and Financial instructions.

8.4 In addition to the exceptionality provision outlined at paragraphs 8.1 to 8.3, a care package costing more than 10% (care homes) and 15% (home care) over the cost of an alternative care package may be funded for an individual who is deemed, by an appropriate clinician, to have a rapidly deteriorating condition that may be entering a terminal phase. This is in line with The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (Revised 2018). In these situations, individuals will be assessed and offered packages of care to meet needs on a case-by-case basis.

9. REGISTERED CARE SETTINGS

9.1 Where care is to be provided in a registered care setting (i.e. one that provides accommodation, such as a nursing home, residential home, independent hospital and some supporting living schemes), the CCG will only place individuals with providers which are:

9.1.1 located in Derby or Derbyshire (except in exceptional circumstances e.g. lack of suitable or available of local provision);

9.1.2 registered with the Care Quality Commission (or any successor);

9.1.3 not subject to commissioning restrictions placed by the CCG or Local Authorities in the CCG's area as a result of quality and safety concerns, including the host CCG or Local Authority if the provider is not located in the CCG's area; and

9.1.4 prepared to contract with the CCG to provide care at the locally agreed rate unless there are exceptional circumstances.

9.2 The CCG will, subject to the other provisions of this policy, consider providing a placement in a registered care setting not already contracted to the CCG as long

as the requested care provision is clinically appropriate and meets the conditions in paragraphs 9.1.1 to 9.1.4 above.

10. PREFERRED PROVIDER PLACEMENTS

10.1 Subject to the provisions of this policy, and to assist the CCG in achieving consistent, equitable care, the CCG will endeavour to offer and place individuals with providers that have undergone procurement exercise with the CCG and have secured a place on the CCG's approved list – Any Qualified Provider Framework (AQP).

10.2 Where a preferred provider is not available to meet the individual's assessed needs or the patient has expressed a wish to be provided with care by a provider who does come within paragraph 10.1, the CCG may make a specific purchase and place the individual with a care provider who is able to demonstrate that the provider meets the individual's needs.

10.2.1 Where such an arrangement has been agreed on a temporary basis, the CCG reserve the right to offer to move the individual to a suitable preferred provider when capacity becomes available if a move of placement will provide substantially better value for money to the CCG. For example, if an individual has a specific care need which cannot be met in the available preferred accommodation, the CCG will need to specifically commission accommodation for the individual, potentially through an individually negotiated agreement.

10.2.2 The CCG should notify the individual and/or their representative that they may be moved should a preferred provider subsequently have availability. In such circumstances, the CCG will give a minimum of seven days' notice to the individual and / or their representative; and will devise a transition plan with the individual and / or their representative to ensure safe transition within a period of 28 days from date of notice. This is unless the health and safety of the individual warrants transition to the alternative provider sooner.

10.3 Where a CCG deems that a provider is not providing care of an acceptable standard, the CCG reserves the right to terminate a placement and will offer to move the individual to an alternative provider.

10.4 Where an individual's needs change, a CCG may offer a package of care with a different provider.

11. ADDITIONAL SERVICES ('TOP UPS')

11.1 Whilst the NHS is responsible for funding care services to meet the assessed needs of eligible Individuals, individuals or their family may decide that they wish to supplement the care being commissioned by directly funding additional services. The individual or their representative(s) has the right to enter into discussions with any provider to supplement the care provision, over and above that required to meet the individual's assessed needs. Any such costs arising out of any such

agreement must be funded by the individual or through third party funding. These costs may relate to additional non-healthcare services to the individual (for example hairdressing, provision of a larger room, en-suite, or enhanced TV packages).

11.2 Healthcare services normally provided by the CCG shall not form part of these additional services. The exception to this shall be that additional healthcare services outside of the services the CCG has agreed to provide within the CHC package. These types of services may include things such as chiropractor appointments or additional physiotherapy sessions. The CCG will satisfy itself that these services do not constitute any part of the CHC identified need. The CCG will not fund, through CHC, private provision of therapies which are already provided by the CCG as part of their mainstream contracts e.g., physiotherapy/OT where the needs can or are being met by core NHS services.

11.3 The decision to purchase additional services to supplement a CHC package must be entirely voluntary for the individual. The provision of the CHC package must not be contingent on or dependent on the individual or their representative(s) agreeing to fund any additional services. This means that the care home must be willing and able to deliver the assessed CHC needs to the individual, without the package being supplemented by other services.

11.4 Any funding provided by the individual for private services should not contribute towards costs of the assessed need that the CCG has agreed to fund. Similarly, CHC funding should not in any way subsidise any private service that an individual chooses outside of the identified personalised care and support plan

11.5 Where additional services to supplement a CHC package are being purchased by the individual or their representative(s) this should clearly be recorded in care records to provide assurance that these services relate to additional non-healthcare services and not the assessed care needs of the individual .

12. ADDITIONAL ONE TO ONE CARE IN A CARE HOME

12.1 In exceptional cases the CCG may consider funding additional one to one (1:1) care for an individual. This will be included in considerations about the cost of the package and the value for money that it provides where the 1:1 care is required for longer than 2 weeks. This 2-week window acknowledges that there may be brief periods of time where additional support is required, but for any longer period the appropriateness of the package in place will need to be reviewed.

12.2 Where additional 1:1 care is commissioned the following principles apply:

12.2.1 the rate paid for 1:1 care will reflect care needs, complexity, and the rationale for 1:1 care.

12.2.2 1:1 care should be reviewed regularly and only agreed short term.

12.2.3 a small amount of 1:1 care is expected to be included in the package where a higher-level care home tariff has been agreed based upon complexity of need/speciality (e.g., challenging behaviour unit) - it is assumed that the first 2 hours of 1:1 is included in the base fee these homes;

12.2.4 opportunities to investigate more efficient routes to provide the care needed, such as cohort nursing and use of technology, should be considered where possible;

12.2.5 rotas and evidence of care provision relating to 1:1 are required for invoices for 1:1 to be paid; and

12.2.6 1:1 care should be invoiced or itemised separately from core care packages to ensure these costs are clearer.

12.2.7 any 1:1 care agreed and the management of 1:1 care should reflect the CCG Enhanced Observations Policy

12.2.8 Any requests for base fee uplifts will be considered separately from 1:1 funding

13. JOINTLY FUNDED PACKAGES

13.1 In some cases where a person does not demonstrate a primary health need, the CCG may still commission a package with the local authority in which the CCG accepts responsibility for meeting the identified health needs/outcomes in that package. In those cases, the general principles outlined in this policy continue to apply to the health element of that funding and should be considered alongside the Joint Funding Policy (joint policy with Derby City Council and Derbyshire County Council – *to be formally approved*) .

13.2 If a jointly funded package has been agreed for a care home placement in a nursing home, clear evidence is needed about what health input is being provided beyond the funded nursing care (FNC) element of the package (especially if it's a standard placement rate) and any agreement will include the cost of FNC. Funded nursing care will not be provided in residential packages where there is no evidence of nursing oversight provided by the home.

13.3 A jointly funded package will be agreed based on the care input commissioned and the CCG will fund the tasks/interventions which are beyond the powers of the local authority to provide.

As previously noted, the CCG will not fund therapies available in a care home e.g. Physiotherapy/OT at additional charges that would otherwise be accessed core NHS services.

14. DOMICILIARY CARE AND DOMICILIARY CARE PROVIDERS

14.1 The CCG and the CHC team do not have the resources or facilities to provide a hospital at home service. The CCG indicates that packages which require a high level of input may be more appropriately and safely met in another care setting.

The CCG's duty to fund services does not extend to funding for the wide variety of different, non-health and non-personal care related services that may be necessary to maintain a person in their home environment. The NHS is not obligated to provide a home care package if it is more expensive than providing care in a nursing / care home setting. If the clinical need is for registered nurse direct supervision or intervention throughout 24 hours, it may be necessary for this to be provided within a nursing home placement.

14.2 There are specific conditions or interventions that it may not be appropriate to manage in a 'care at home' setting. These would include (but are not limited to): the requirement for sub-cutaneous fluids, intravenous fluids, total parenteral nutrition (TPN), continual invasive or non-invasive ventilation or the management of grade 4 pressure injury. In each case a comprehensive risk assessment would be completed to determine the most appropriate place for care to be provided.

14.3 Many individuals with complex healthcare needs wish to remain in their own homes, with support provided in that environment. Where an individual or their representative(s) express such a desire, the CCG will investigate to determine whether safe, effective, clinically appropriate, and sustainable care can be provided for an individual in their own home. The CCG will only consider commissioning packages of care at home providing care can be delivered safely without undue risk to the individual, the staff or other members of the household (including children), and the level of risk that is acceptable to the individual. If this care option is discounted, the reasons for decision should be clearly documented and communicated to the individual.

14.4 The CCG will also consider if domiciliary care for an individual is likely to be more costly than for an individual whose equivalent care is provided in a residential or nursing home placement as outlined at paragraph 4.4 of this policy.

14.5 Where domiciliary care is to be provided, the CCG will use approved domiciliary care agencies to provide such care. Where the CCG is assured through a procurement process that domiciliary care will be provided by agencies suitably qualified to deliver the care that meets an individual's assessed needs they will ask family members if they are willing and able to supplement support. If they agree the relevant CCG will assume that family members will provide the agreed level of support when designing any domiciliary care package.

14.6 There will be occasions where there is a clear commitment by family members or others (whether paid or unpaid) to provide some elements of the patient's care needs that may reduce the assessed needs of the patient that the NHS is required to provide; thus reducing the services that the CCG is obliged to fund for the patient. In such cases, care by family members or others may have the effect of making a package of care at home a cost effective option having regard to the terms of paragraph 4.4 of this policy when, without those commitments, the home care package would be outside the terms of this policy.

14.7 CCG staff should ensure that no pressure is applied to family members or others to offer and provide such support. The CCG recognises that family members are

under no legal obligation to offer care but equally recognises that family members can often be expert and reliable carers and that patients may wish to continue to be supported by their family members. When deciding about whether to make an offer of a domiciliary care package, the CCG will take account of any voluntary offers from family members or other commitments to provide care to a patient when applying paragraph 4.4 of this policy in comparing the cost of any such package with the cost of a suitable package of care in a registered care setting.

14.8 Where the CCG decide to offer domiciliary care to an individual, the individual's home becomes the member of staff's place of work. Employee safety is an important consideration in domiciliary care packages. The individual's home must be a reasonably safe environment to work and deliver care to the individual. This includes cleanliness and safety of the environment, and interactions between the individual, family/carer, and the employee. The CCG reserves the right to terminate any domiciliary care package if it appears that the patient's home is not an appropriate place of work for care staff for any reason.

14.9 Eligible Individuals in receipt of Domiciliary Care are entitled to Respite Care in a residential setting for not more than 4 weeks per year. The setting chosen may be selected by the Eligible Individual or their family but the CCG retains the right to offer an alternative setting/placement where deemed appropriate by the CCG and in line with the commissioning of Residential Care above.

14.10 Unless for End of Life care, the CCG will not normally commission 24/7 care outside of a residential setting. Where such care is requested by family choice the CCG will consider the reasons for this choice and any exceptional circumstances presented.

15. PERSONAL HEALTH BUDGETS

15.1 Any adult eligible for CHC receiving a package of care at home will have a Personal Health Budget (PHB.) The funds made available via the PHB are for use to meet the individual's agreed health and well-being outcomes as identified in their Personalised Care & Support plan. The support plan is the tool by which the health outcomes of the individual are identified and options for meeting these identified. The setting of the indicative budget for calculating the value of a PHB must apply the principles set out in this policy. The cost of a PHB will, if is not being taken as a notional PHB include any directly incurred additional expenditure, including but not limited to:

15.1.1 administering managed accounts;

15.1.2 recruiting a Personal Assistant including any training and employment checks;

15.1.3 tax, national insurance, and any other costs associated with directly employing staff;

15.1.4 costs associated with redundancy;

15.1.5 legal advice, financial advice, including accountancy.

15.2 Where the individual receives a PHB via a direct payment and they directly employ staff they assume responsibility for all of the obligations that apply to any employer. The CCG will not accept any vicarious liability arising out of an individual's decisions to employ staff, funded by a direct payment.

15.3 The requirements for PHBs are laid down in the CCG's PHB Policy.

16. AVAILABILITY OF CARE PROVISION

16.1 To enable individuals to receive the correct care promptly, they must be offered care as soon as possible. If an individual's agreed provider and placement does not have the capacity to provide the care at the point required, the individual will be offered another CCG preferred provider in the interim to ensure care is provided as soon as possible preventing any delays.

16.2 If the individual requests care from one of the CCG's preferred providers which is currently unavailable, there are several options available to the CCG:

16.2.1 temporary placement of the individual with alternative care provision until the care from the individual's preferred care is available. For example, alternative home care provider, alternative care home, respite care or a community bed;

16.2.2 if the temporary placement is refused the individual may choose to go to their own or a relative's home without receiving the assessed care provision that has been offered by the CCG until the preferred care is available. The individual will retain the right subsequently to change their mind and elect to accept the care provision offered by the CCG. If the individual does not have mental capacity to make this decision, the CCG will exercise its duties under the Mental Capacity Act;

16.2.3 if it has been agreed with the individual that the assessed needs can best be met through a care home placement, the CCG may choose to provide a package of care at home to cover the assessed care needs of the individual until the preferred care home is available. This must be considered in light of paragraph 4.4 (c) of this policy.

16.3 If there is a delay in the CCG being able to secure a placement in a care home due to non-availability of a preferred home, and the individual does not have the mental capacity to make this decision themselves, the CCG will follow due process in applying the Safeguarding Children and Adults Policy and the Mental Capacity Act 2005 as appropriate.

16.4 If the individual is in an acute healthcare setting, they must move to the most appropriate care setting as soon as they are medically optimised for discharge, even if their first choice of care provision is not available. The individual's preference must be considered, in line with this policy, when the CCG is deciding which package of care to offer to them. Where the individual's preferred choice is not available, but alternative provision which will meet their assessed needs is

available, they must move and cannot remain in an acute healthcare setting once they are medically fit for discharge.

17. REFUSAL OF CARE PROVISION

17.1 An individual has the right to decline/refuse NHS services and funding and make their own private arrangements. If an individual refuses care packages offered by the CCG he or she will not be prejudiced should they wish to take up an offer of NHS services at a later date and this policy will be applied to such individuals in the same way as to all those newly eligible for CHC.

17.2 The NHS discharges its duty to individuals by taking account of its legal obligations including those outlined in Section 4 and makes an offer of a package of care to meet an individual's assessed care needs. It is an individual's decision whether they choose to accept the offer of care made by the CCG. This includes situations in which the individual has requested a particular package of care and the CCG has taken a decision that the package will not be commissioned but offered an alternative package of care. Where an individual chooses not to accept the CHC package, the CCG will take reasonable steps to work with the individual to help them understand their available options and facilitate access to appropriate advocacy support if necessary.

17.3 An individual can refuse to accept the CCG's offer of care. In these circumstances the NHS will not be responsible for arranging and paying for a care package for that patient.

17.4 Where there appears to be a refusal, the CCG will write to the individual with a final offer setting out the care packages that the CCG is willing to consider, and the consequences of declining a package of care or placement. In this letter the CCG will provide a period of no less than 14 days for confirmation of acceptance of a package. The CCG will ask the individual or their representative(s) to sign a written statement confirming that they are choosing not to accept the offer of care provision.

17.5 If the individual does not respond within the stated time period, the CCG will provide a written notice confirming that NHS funding will cease on a specified date, which will be no earlier than 28 days from the date of the notice.

17.6 If the individual is considered to be vulnerable, appropriate Safeguarding Adult policies will be applied.

17.7 Decisions regarding individuals without capacity will be taken in accordance with the Mental Capacity Act and the CCG will make an application to the Court of Protection as necessary.

18. CONTINUING HEALTHCARE REVIEW

18.1 A care needs review should be undertaken no later than three months after the initial eligibility decision, in order to review the individual's clinical care needs and to ensure that the Individual's assessed needs are being met in current care setting. Reviews should thereafter take place annually, as a minimum or more frequently if an individual's care needs have changed. The CHC care needs review may identify an adjusted, decreased, or increased care need, or no further health care needs. Any change in need should initiate a refresh of the DST and MDT meeting.

18.2 Where change of need has been identified and the individual is accommodated in a care home, the CCG will ensure that the care home is able to meet any changed care needs of the individual

18.3 Where the care home is unable to meet this adjusted care need, the CCG will offer to fund an alternative package of care for the individual in accordance with this policy.

18.4 Where change of need has been identified and the individual currently has a home care package provided the CCG will, in accordance with section 14 of this policy, consider whether the clinical needs of the individual may be more appropriately and safely met in another care setting. The NHS is not obligated to provide a home care package if it is more expensive than providing care in a nursing / care home setting.

18.5 After full discussion with the individual or their carer where an individual does not have capacity, any decision about a future setting of care will need to take into account whether a package of care is being and/or will in the future be delivered in an individual's preferred choice safely. Keeping an individual safe must take priority, however this must be balanced with an individual accepting responsibility for their choices where they have capacity to make the decision about their care.

18.6 Where a review identifies a decreased need but eligibility to fully funded NHS care is indicated following completion of the DST the CCG will consider the cost effectiveness of the package to be delivered in the current care home, and may move the individual to a suitable alternative provider in accordance with this policy.

18.7 If the review demonstrates that the individual's condition has improved to an extent that the individual may no longer meet the eligibility criteria for CHC funded care provision, the CCG is obliged to cease funding accommodation and social care for the individual. This includes home care and care home provision. In these cases, the CCG will carry out a joint refreshed DST eligibility assessment and MDT meeting with the relevant Local Authority. At this point the Local Authority has 28 days to review the individual's requirements and the individual will be notified they are no longer eligible for CHC. CCG funding for an individual's care may be continued for up to 28 days where a Local Authority is undertaking such a review.

19. WITHDRAWAL OR REFUSAL OF CARE PROVISION

19.1 The CCG has a duty to ensure that all staff providing care are not subject to violence, abuse (physical or emotional) or harassment in any form. The CCG and care provider will work to ensure that positive behaviour support – from patient or family is reflected in an individual's care package where necessary. However, under extreme circumstances, it may be appropriate for the CCG to remove CHC services where the situation presents a risk of danger, violence, emotional distress to or harassment of care staff who are delivering the package and/or all attempts of positive behaviour support have failed.

19.2 Where the CCG considers that it has made every reasonable attempt to provide care but the behaviours of the individual or family members has resulted in a number of care package breakdowns the CCG may withdraw the offer of CHC funded support in the home environment. In these circumstances the CCG may offer CHC services in an alternative care setting.

19.3 The CCG may also withdraw the offer of CHC funded support in a home care environment where the clinical risks become too high. This can be identified through, or independently of, the review process. Where the clinical risk has become too high in a home care setting, the CCG may choose to offer CHC in a care home setting.

20. DISPUTES RESOLUTION AND APPEALS

20.1 Where an individual is not satisfied with the choices offered to them, or believes that because of exceptional circumstances the principles in this policy are not applicable in their case they may request in writing that the CCG reconsiders, providing any additional information for consideration. The CCG are only required to provide services that meet reasonable requirements. Exceptionality is determined on a case by case basis and will require a clear clinical rationale and agreement by a CCG Panel with executive decision-making ability. If the care package offer proposed by the CHC Team is upheld, the individual will be advised of their right to complain through the CCG's complaints process in line with local and national policy, or if the complaint cannot be resolved locally, the individual can be referred to the Parliamentary and Health Service Ombudsman.

20.2 Interim arrangements - where the CCG, having applied the criteria set out in this policy, decides to place an individual in a care home as opposed to providing a home care package and the individual makes an appeal against this decision, the CCG will offer an appropriate interim placement taking account of the individual's safety as the over-riding factor. For these purposes, 'interim' refers to the time between the appeal being lodged and then considered by the CCG. Depending on the outcome of the appeal, such 'interim' placements may become permanent. The CCG decision will be effective until the outcome of the appeal. If the appeal is successful arrangements will then be made to revise the care package provided in consultation with the individual. If, during the interim, the individual refuses the CCG's offer of an interim placement, they may arrange and fund their own package

of care or placement within their chosen care home. If the CCG's original decision is upheld, it will again offer the individual an appropriate care package in a care home that meets the criteria set out in this policy. If the care home placement is still not acceptable to the individual, they may continue to arrange and fund their own package of care or placement.

21. SELF-FUNDERS WHO BECOME ELIGIBLE FOR NHS CONTINUING HEALTHCARE

21.1 If an individual who is currently self-funding a home care or care home placement becomes eligible for CHC, and the care home fee is in excess of what the CCG would expect to fund, the individual must be informed that the CCG would only continue to fund at the higher rate based on evidence of exceptional clinical reasons why the individual's needs could only be met in that specific placement (for example, if there is potential for significant detriment to the individual's health if moved).

21.2 If the individual is deemed to lack capacity to make a decision about provision of care, the principles of the Mental Capacity Act (2005) will be applied regarding a best interest decision.

21.3 If an individual is found eligible for CHC and there is no evidence of exceptional clinical need the CCG will:

21.3.1 renegotiate fees with the current provider, however, if this is unsuccessful;

21.3.2 consider an alternative placement which can meet the individual's assessed needs.

21.4 If alternative placements are offered and declined, the CCG will consider that funding has been refused and the individual wishes to continue with his or her existing private arrangement with the care provider. From the date of rejection, the CCG will give the individual and the existing care provider 28 days' notice that NHS funding will not be provided for the existing placement.

22. FUNDING ARRANGEMENT FOR INDIVIDUALS RECEIVING SERVICES OUTSIDE THE CCG AREA.

For individuals who are to receive services outside the local CCG area, but where the CCG are the responsible commissioner the principles outlined in this policy will continue to apply.

23. MONITORING AND REVIEW OF THE POLICY

23.1 Performance against key performance indicators will be reviewed on an annual basis and used to inform the development of future procedural documents.

23.2 This policy will be reviewed on an annual basis, and in accordance with the following on an as and when required basis:

23.2.1 legislative changes;

23.2.2 good practice guidance;

23.2.3 case law;

23.2.4 significant incidents reported;

23.2.5 new vulnerabilities; and

23.2.6 changes to organisational infrastructure.

23.3 The policy will be reviewed once every three years or sooner where relevant changes occur in regard to the law, national policy, or guidance.

Appendix 1 – Definitions

"Accommodation"

in the context of CHC, accommodation relates to an appropriately registered care setting or the individual's own home;

"Care provision"

care provision takes two main forms:

- care provided in an individual's own home and referred to in this document as 'home care' or 'domiciliary care';
- care provided in an appropriately registered care setting (such as a nursing home, a residential home, or an independent hospital) and referred to in this document as 'registered care setting' or 'care home';

"Individual"

means the service user that has been assessed for and offered continuing healthcare, often referred to as the individual;

"Local Authority / Authorities"

refers to Derby County Council and / or Derby City Council;

"Preferred providers"

means the providers who have been assessed and accepted onto the Any Qualified Provider framework by the CCG as being able to fulfil the continuing healthcare requirements of defined categories of individuals at an agreed cost;

"Provider"

means the organisation that provides CHC on behalf of the CCG;

"Representative(s)"

means the people or person that liaises between individuals and the CCG. The individual receiving healthcare may elect to have representative(s) act with them or on their behalf, or there may be representative(s) where the individual does not have the mental capacity to make independent decisions. Representatives may be legal representatives, individual advocates, family, or other people who are interested in the individual's wellbeing. Where the individual has capacity, they must give consent for any representative to act on their behalf. A person who has formally been appointed as an Attorney or Deputy has defined responsibilities for the individual. The extent of these responsibilities will vary according to the nature of their appointment.

Appendix 2 – Sources of Guidance

- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (revised)
- Mental Capacity Act 2005 Code of Practice
- Human Rights Act 1998
- National Assistance Act 1948 (Choice of Accommodation) Directions 1992 (as amended)
- Guidance on: National Assistance Act 1948 (Choice of Accommodation) Directions 1992. National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendment) (England) Regulations 2001
- Updated guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1992: Consultation outcome (14 October 2004)
- National Health Service Income Generation - Best practice: Revised guidance on income generation in the NHS (1 February 2006)
- National Health Service Act 2006
- Who Pays? Establishing the Responsible Commissioner (December 2012)
- Guidance on NHS patients who wish to pay for additional private care (May 2009)
- Legal guidance Relevant case law, notably:
    - Gunter v South Western Staffordshire Primary Care Trust (2005).
    - St Helens Borough Council v Manchester Primary Care Trust (2008)
    - McDonald v Royal Borough of Kensington and Chelsea (2010).

Appendix 3 – Approval/Panel Checklist

To be developed