



*South of England*

Review of NHS  
Continuing  
Healthcare  
Processes in  
Berkshire

Date: May/June 2012

## South West Strategic Health Authority

### Report on the Review of NHS Continuing Healthcare Processes and Procedures in Berkshire

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|--|---|
| Paper of the findings of the review undertaken by Eileen Roberts, Jill Smith and Jo Dexter |   |
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| Main Aim of Review   | To report on the review of processes and practice relating to NHS Continuing Healthcare in Berkshire with suggestions for improvement   |

## Executive Summary

The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care was launched in 2007 and revised in October 2009. This external review of processes and procedures in Berkshire was requested by both the Primary Care Trusts and the six Local Authorities as some difficulties with regard to processes and procedures between the authorities had arisen.

The report analyses activity and cost data against national benchmarking figures which provides a context for the review, appraises the processes and procedures in Berkshire against the standards of the National Framework, summarises the findings and makes recommendations for change.

NHS Berkshire and the Local Authorities have worked hard to deliver the requirements of the National Framework for Continuing Healthcare. Whilst areas of good practice exist, the review outlines several areas where improvement should be focused particularly in the first few months following this report. The reviewers accept that there are a large number of recommendations include in this review at a time of major change within the NHS structures and suggest that the main areas requiring urgent attention include:

- The Strategic Health Authority requires assurance that the Primary Care Trust is operating within the legal framework and guidance around the Fast Track Pathway Tool;
- Improvements in Joint working between the NHS and the six local authorities at all levels;
- The approval of an Operational Policy which makes all procedures clear will smooth the whole process and procedure and allow for better working relationships;
- Further work is required on the draft dispute resolution policy between the NHS and Local Authorities to put into place a signed and agreed policy as required in the NHS Continuing Healthcare Responsibilities/Directions;
- Further work is required to resolve the current polarised view on the use of the NHS CHC Checklist Tool and information requirements to accompany the tool, in order to avoid delayed discharges from the acute setting and ensure a patient centred approach.

Regarding the other recommendations contained within this report, priorities need to be agreed at a senior level to ensure a smooth handover to local Clinical Commissioning Groups in the future.

# South West Strategic Health Authority

## Review of the NHS Continuing Healthcare Processes and Procedures in Berkshire

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## **Section 1**

### **Introduction**

This section sets out the key components of the National Framework for NHS Continuing Healthcare and the responsibilities for the Strategic Health Authority, Primary Care Trusts and Local Authorities outlined therein.

## 1. Introduction

### **The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care**

- 1.1 'Continuing care' is care provided over an extended period of time, to a person aged 18 or over, to meet physical or mental health needs that have arisen as a result of disability, accident or illness. 'NHS Continuing Healthcare' is a package of continuing care that is arranged and solely funded by the NHS.
- 1.2 In June 2007, the Department of Health published the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care, after a lengthy formal consultation period. This Framework was supported by national decision-making tools and a standard process of assessment of the needs of individuals, and by a national training programme. The Framework meant that instead of each of the 28 Strategic Health Authorities in England having its own rules, tools and processes for determining eligibility for NHS Continuing Healthcare there was one national approach. The Department of Health committed to review the Framework following its implementation in 2007.
- 1.3 In October 2009, the revised National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care was launched along with revision of the three national tools (Fast Track Pathway, Checklist and Decision Support Tool) and clarification on the expected approaches to the completion of them.
- 1.4 The guidance was underpinned by the NHS Continuing Healthcare (Responsibilities) Directions 2009 laid down by the Secretary of State for Health. These Directions came into force on 1 October 2009 and apply to every Strategic Health Authority, Primary Care Trust and social services authority in England. These set out the:-
  - Duties of Primary Care Trusts – determining eligibility for NHS Continuing Healthcare;
  - Duties of Primary Care Trusts and social services authorities: joint working;
  - Duties of Strategic Health Authorities around reviews of decisions,
- 1.5 Relevant Department of Health policy documents are listed in Appendix 2.
- 1.6 A refresh of the National Framework and associated guidance is currently underway in preparation for the new architecture in the NHS. It should be noted that there will be no change to the eligibility threshold for NHS Continuing Healthcare, the purpose of the refresh is to add more clarity to the processes.

## **Strategic Health Authority responsibilities**

- 1.7 The revised Framework confirmed that Strategic Health Authorities are responsible for the following in relation to NHS Continuing Healthcare:
- co-ordinating the Independent Review process which is instigated when there is an appeal about the procedures followed or decision reached by a Primary Care Trust;
  - strategic leadership, organisational and workforce development;
  - ensuring local systems operate effectively and deliver improved performance;
  - holding Primary Care Trusts accountable for their responsibilities.

### **Primary Care Trust responsibilities**

1.8 The range of Primary Care Trust NHS Continuing Healthcare responsibilities include:

- ensuring consistency in the application of the national policy on eligibility for NHS continuing healthcare;
- promoting awareness of NHS continuing healthcare;
- implementing and maintaining good practice;
- ensuring that quality standards are met and sustained;
- providing training and development opportunities for practitioners;
- identifying and acting on issues arising in the provision of NHS continuing healthcare; and
- commissioning NHS Continuing Healthcare on a strategic and individual basis (within the context of World Class Commissioning).

### **Local Authority responsibilities**

1.9 The range of Local Authority NHS Continuing Healthcare responsibilities include:

- ensuring assessment of eligibility of continuing healthcare takes place in a timely manner;
- notifying the relevant PCT if, in carrying out an assessment it is apparent that a person's needs may fall under the National Health Service Act 2006;
- ensuring a person's needs are not of a nature beyond which a LA could be expected to provide;
- promoting awareness of NHS continuing healthcare;
- implementing and maintaining good practice;
- ensuring that quality standards are met and sustained;
- providing training and development opportunities for practitioners.

### **Operational issues**

1.10 As well as clarifying the roles and responsibilities of Strategic Health Authorities and Primary Care Trusts, the revised Framework (2009) provided clarification and guidance on a number of other issues, listed below:

- The threshold of eligibility for NHS Continuing Healthcare did not change but more detailed guidance (including use of the three tools) was provided. The current refresh of the Framework will not change the threshold of eligibility but provide more clarity;
- Use of the national Fast Track Pathway Tool was made mandatory in the NHS Continuing Healthcare (Responsibilities) Directions 2009. Where the Fast Track Pathway Tool is used, NHS Continuing Healthcare must be awarded until the Primary Care Trust has completed a full assessment of needs;
- An individual must be involved (and given support to do so where needed) throughout the eligibility process. Decisions must be given in writing;
- Consent of the individual to be assessed must be explicitly obtained. The need to apply the Mental Capacity Act throughout has been highlighted in the revised National Framework;
- NHS Continuing Healthcare decision-making should usually take no more than 28 days from receipt of a completed Checklist (or where no checklist is used, other notification of potential eligibility for NHS Continuing Healthcare). The NHS Continuing Healthcare Refunds Guidance was published by the Department of Health in March 2010. The guidance states in 6b “where a Primary Care Trust has unjustifiably taken longer than 28 days to reach a decision, the Primary Care Trust should refund to the individual or the Local Authority the costs of the service from Day 29”;
- Primary Care Trusts are recommended to consider providing interim support (in own home, care home, intermediate care) until the patient has stabilised sufficiently to be able to make an NHS Continuing Healthcare decision on basis of likely long term needs;
- The Framework highlights that those in receipt of NHS Continuing Healthcare continue to be entitled to all services available to other patients of their Primary Care Trust (including community nursing, joint equipment services etc) and all other relevant policies;
- Primary Care Trusts should have protocols explicitly setting out the responsibilities of each relevant local NHS organisation and the Local Authority in relation to NHS continuing healthcare;
- Clarity is provided concerning the children/adult NHS continuing healthcare transition policy;
- Primary Care Trusts are encouraged to commission NHS Continuing Healthcare using models that maximise personalisation and individual control. The role of Personal Health Budgets is highlighted.

## **Health and Social Care Bill 2011**

1.11 The Health and Social Care Bill was introduced into Parliament on 19 January 2011. The Bill is a crucial part of the Government's vision to modernise the NHS so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes.

- As a result of the passage of this Bill, the current Primary Care Trust statutory responsibilities will transfer to Clinical Commissioning Groups and the SHA statutory responsibilities will transfer to the NHS Commissioning Board but the detail of how this will work in practice is yet to be determined.

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## **Section 2**

### **Review of NHS Continuing Healthcare Processes and Procedures in Berkshire**

This section sets out the methodology followed in undertaking the review of NHS Continuing Healthcare Processes and Procedures in Berkshire.

## **2. Approach to the Review**

- 2.1 This external review of processes and procedures in Berkshire was commissioned by the Strategic Health Authority alongside both the Primary Care Trusts and the six Local Authorities as difficulties with regard to processes and procedures between the authorities had arisen together with questions regarding practice arising from the benchmarking data.
- 2.2 The review was divided into four stages:-

### **Planning Stage**

- Initial meeting with the Local Authorities representative;
- Initial meeting with the Primary Care Trust representatives;
- Agreement of the Terms of Reference of the review (Appendix 1);

### **Stocktake of Processes and Procedures**

- Questionnaires were designed, one for the Primary Care Trust and one for the Local Authorities in order to gather information relating to NHS Continuing Healthcare processes and procedures in Berkshire;
- The purpose of the review was to ensure compliance with the National Framework and the Responsibilities/Directions, and to provide assurance on the quality and consistency of practice across the two Primary Care Trusts (East Berkshire and West Berkshire) and the six local authority areas. It also provided a platform for the external reviewers to understand how the whole system worked, its strengths and potential areas for improvement;
- The questionnaire covered the following topics:-
  - \* compliance with the National Framework;
  - \* timescales;
  - \* retrospective cases;
  - \* capacity;
  - \* operational policy;
  - \* patient centred;
  - \* management of appeals, complaints and disputes;
  - \* training;
  - \* quality assurance/ standards;

- \* joint working;
- \* networking / best practice;
- \* information and activity;
- \* transitions.

### **Interviews with Staff and Validation of Files**

- These were undertaken on 30 and 31 May 2012 in order to validate areas of underperformance or dispute as well as areas of good practice. The interviews were undertaken by Eileen Roberts and Jill Smith;
- At the same time Mrs Jo Dexter, registered nurse and former clinical lead for NHS Continuing Healthcare in Gloucestershire, undertook the review of 20 case files;
- The six local authorities prepared two files obtaining an audit of cases relating to NHS Continuing Healthcare from their perspective.

### **Presentation of Initial Findings**

- A meeting with senior staff was planned in order to present the initial findings of the review together with initial recommendations;
- At the time of this report, further actions and timescales are yet to be defined.

2.3 The review also considered the activity and expenditure performance of the organisations in Berkshire in relation to NHS Continuing Healthcare; this report also considers this data in Section 3.

## **Section 3**

### **2012 Benchmarking Position of Berkshire Primary Care Trust for NHS Continuing Healthcare**

This section sets out the activity and financial information relating to NHS Continuing Healthcare in Berkshire for 2011/12.

### **3. NHS Continuing Healthcare 2011/12 Benchmarking Position in Berkshire**

- 3.1 NHS Continuing Healthcare funding must be available to all people who are eligible.
- 3.2 There is significant work that can be done by Primary Care Trusts and Local Authorities to ensure that where eligibility is determined the best quality service is made available to individuals at the most cost effective price for the organisation.
- 3.3 Quarterly benchmarking on NHS Funded Care, which includes NHS Continuing Healthcare, is produced by a nationally funded project team based at NHS North Somerset and has been in place nationally for the past three years.
- 3.4 The data is analysed by weighted population. This is based on the crude populations adjusted according to the relative need (age, health status) for healthcare and the unavoidable geographical differences in the cost of providing healthcare.

#### **Activity**

- 3.5 Before drilling down into the statistics for East and West Berkshire it is helpful to look at the broader context, both nationally and regionally. Table 1 shows the regional activity per 10,000 weighted population by region in 2011/12. It shows the number of people receiving Continuing Healthcare.

**Table 1: Activity per 10,000 weighted population by region**

| <b>Region</b>        | <b>Cumulative Activity 20011/12</b> | <b>Weighted Population</b> | <b>Cases per 10,000 Weighted Population 2011/12</b> |
|----------------------|-------------------------------------|----------------------------|---|
| <b>South Central</b> | <b>5,075</b>                        | <b>3,468,003</b>           | <b>15</b>   |
| South East Coast     | 10,203                              | 4,152,379                  | 25  |
| South West           | 14,910                              | 5,115,860                  | 29  |
| East Midlands        | 12,277                              | 4,483,935                  | 27  |
| Yorkshire & Humber   | 16,755                              | 5,170,212                  | 32  |
| West Midlands        | 14,159                              | 5,624,297                  | 25  |
| North East           | 7,391                               | 2,945,582                  | 25  |
| North West           | 14,752                              | 7,702,579                  | 19  |
| London               | 15,935                              | 8,114,958                  | 19  |
| East of England      | 12494                               | 5,470,707                  | 23  |
| <b>TOTAL</b>         | <b>123951</b>                       | <b>52,248,512</b>          | <b>24</b>   |

- 3.6 This cluster analysis shows that overall South Central have the lowest number of people in receipt of NHS Continuing Healthcare per weighted population.
- 3.7 This could be for a variety of reasons. These may include that the population is not in need, there is insufficient information available to the public and clinicians concerning continuing healthcare, the processes are unclear or difficult, the threshold for eligibility is set too high and / or the Primary Care Trust is not adhering to the National Framework.
- 3.8 However it is necessary to see whether this should be applied to the whole cluster and where NHS Berkshire sits within the cluster which the next table shows.

**Table 2: Cumulative NHS Continuing Healthcare activity in 2011/12 sorted by number of cases per 10,000 weighted population**

| <b>Primary Care Trust</b> | <b>Cumulative Activity YTD 2011/12</b> | <b>Weighted Population</b> | <b>Cases per 10,000 Weighted Population 2011/12</b> |
|---------------------------|--|----------------------------|---|
| Berkshire East            | 363                                    | 349349                     | 10  |
| Berkshire West            | 279                                    | 392859                     | 7   |
| Buckinghamshire           | 866                                    | 432557                     | 20  |
| Hampshire                 | 1694                                   | 1153888                    | 15  |
| Isle of Wight             | 340                                    | 156005                     | 22  |
| Oxfordshire               | 613                                    | 530227                     | 12  |
| Portsmouth                | 566                                    | 206088                     | 27  |
| Southampton City          | 354                                    | 247031                     | 14  |
|                           |  |                            |   |
| <b>TOTAL</b>              | <b>5,075</b>                           | <b>3,468,003</b>           | <b>15</b>   |

- 3.9 Comparing the activity levels within South Central shows that both Berkshire East (10) and Berkshire West (7) have the lowest number of recipients of NHS Continuing Healthcare per 10,000 weighted population in the cluster (15), which is considerably lower than the national average of 24.
- 3.10 Berkshire East ranks 148 out 150 Primary Care Trusts in the country on this indicator and Berkshire West ranks 150 out of 150.
- 3.11 All activity nationally has increased over the last two years, including in Berkshire.

## Expenditure

- 3.12 Activity converts into expenditure having differing impact on Primary Care Trust expenditure. The following table shows costs per 10,000 weighted population by region.

**Table 3: Costs per 10,000 weighted population by region**

| Region               | 2011/12<br>Costs<br>£'000 | Population        | Costs<br>(£'000) per<br>10,000<br>Weighted<br>Population<br>2009/10 |
|----------------------|---------------------------|-------------------|---|
| <b>South Central</b> | <b>179,522</b>            | <b>3,468,003</b>  | <b>518</b>  |
| South East Coast     | 209,371                   | 4,152,379         | 504   |
| South West           | 279,659                   | 5,115,860         | 547   |
| East Midlands        | 203,544                   | 4,483,935         | 454   |
| Yorkshire & Humber   | 299,886                   | 5,170,212         | 580   |
| West Midlands        | 288,264                   | 5,624,297         | 513   |
| North East           | 121,114                   | 2,945,582         | 411   |
| North West           | 270,568                   | 7,702,579         | 351   |
| London               | 358,526                   | 8,114,958         | 442   |
| East of England      | 209,612                   | 5,470,707         | 383   |
| <b>TOTAL</b>         | <b>2,420,066</b>          | <b>52,248,512</b> | <b>463</b>  |

- 3.13 Using the aggregated cluster analysis NHS South Central would be expected to record the lowest expenditure on Continuing Healthcare per 10,000 weighted population nationally, however the above table shows that expenditure in this area is the third highest nationally.

**Table 4: Costs per 10,000 weighted population by organisation**

| <b>Primary Care Trust</b> | <b>Costs<br/>£'000<br/>2011/12</b> | <b>Weighted<br/>Population</b> | <b>Costs<br/>(£'000) per<br/>10,000<br/>Weighted<br/>Population<br/>2011/12</b> |
|---------------------------|------------------------------------|--------------------------------|---|
| <b>Berkshire East</b>     | <b>22,607</b>                      | <b>349349</b>                  | <b>647</b>  |
| <b>Berkshire West</b>     | <b>13,258</b>                      | <b>392859</b>                  | <b>337</b>  |
| Buckinghamshire           | 28,692                             | 432557                         | 663   |
| Hampshire                 | 67444                              | 1153888                        | 584   |
| Isle of Wight             | 8468                               | 156005                         | 543   |
| Oxfordshire               | 14515                              | 530227                         | 274   |
| Portsmouth                | 10641                              | 206088                         | 516   |
| Southampton City          | 13896                              | 247031                         | 563   |
|                           |                                    |                                |   |
| <b>TOTAL</b>              | <b>179522</b>                      | <b>3,468,003</b>               | <b>518</b>  |

3.14 Table 4 shows there is wide variation in the costs per 10,000 weighted population across the organisations in South Central with Berkshire East being the second highest in the region and 22 out of 150 nationally. Berkshire West are second lowest regionally and 107 out of 150 nationally in what it spends on NHS Continuing Healthcare per 10,000 weighted population.

3.15 Table 5 sets out the position on numbers of referrals exceeding 28 days in 2011/12

| <b>No. of Referrals Exceeding<br/>28 Days in Quarter 1112*</b> | <b>Q1</b> | <b>Q2</b> | <b>Q3</b> | <b>Q4</b> | <b>TOTAL<br/>1112</b> |
|--|-----------|-----------|-----------|-----------|-----------------------|
| Berkshire East   | 18        | 17        | 15        | 14        | 64                    |
| Berkshire West   | 8         | 19        | 6         | 17        | 50                    |
| <b>TOTAL</b>   | <b>26</b> | <b>36</b> | <b>21</b> | <b>31</b> | <b>114</b>            |

\*Referrals exceeding 28 days are counted according to the date the deadline is first exceeded (i.e. day 29)

E.g. an application which hits day 29 on 28th June in Q1 and is still not complete by 1 July in Q2 is only counted in Q1 NOT both Q1 & Q2

Following the review, the reviewers noted that from the Q1 benchmarking figures for 2012/13 Berkshire East reported 13 referrals >28 days and Berkshire West had 6 indicating a general improvement in comparison to previous quarters

## **Discussion**

- 3.16 NHS Continuing Healthcare activity and cost is increasing nationally and regionally.
- 3.17 In further considering the Primary Care Trust analysis which takes into account the type of populations served by Primary Care Trusts; both Berkshire Primary Care Trusts are in the bottom three of Primary Care Trusts for numbers of people eligible for NHS Continuing Healthcare. However this is not reflected in the money spent on NHS Continuing Healthcare, particularly in Berkshire East.
- 3.18 NHS Berkshire data quality is judged as good nationally. However, even after accounting for some margin of error in the data quality and analysis, it does seem that NHS Berkshire is dealing with proportionately **less** cases that would be expected and that the costs of these cases are also **more** than would be expected.
- 3.19 It is recommended that more work is done by the Primary Care Trusts to review activity and to control costs relating to NHS Continuing Healthcare. In summary:
- NHS Berkshire does not appear to be achieving best value for money when purchasing care;
  - All care packages, including high cost/value care packages should be regularly reviewed;
  - The relationship with the Local Authority should be fostered to maximise joint working arrangements across health and social care. In particular this should focus on value for money and the cost of care, and providing the best quality of care for the individuals.

## **Number of referrals and conversion rate**

- 3.20 The number of referrals, both Fast Track and non Fast Track, is collected under the benchmarking returns. Similarly, the conversion rate is collected for Fast Track and non Fast Track NHS Continuing Healthcare applications. Either of these factors might influence the variation in performance and further analysis is recommended.

### **Cost of care**

- 3.21 The cost of the care funded under NHS Continuing Healthcare will be influenced by many factors including the nature of the market from which the care is purchased in individual areas. Analysing the type, cost and quality of care provided with NHS Continuing Healthcare funding is recommended. It is suggested that this is undertaken strategically alongside all six Local Authorities.

### **High cost cases**

- 3.22 The benchmarking data shows aggregate costs under NHS Continuing Healthcare and therefore the cost of individual packages of care cannot be determined. However, exploring the position with regard to the level of high cost cases funded by NHS Berkshire could provide useful information.

### **Retrospective cases**

- 3.23 Activity and cost information is collected in the benchmarking data relating to retrospective cases. Further work to better understand the influence of retrospective cases on activity and spend is recommended.

### **Number of appeals to the Primary Care Trust**

- 3.24 The nature of the appeals processes within NHS Berkshire might influence activity. The audit showed that very few appeals take place in NHS Berkshire, possibly related to poor publicity and the fact that letters to applicants do not clearly set out the appeal process. Appeals would be expected to increase as the overall NHS Continuing Healthcare Processes including letters to applicants are improved and information to the public is improved.

### **Relationship between the NHS and the Local Authorities**

- 3.25 The relationship with the Local Authority can have a significant influence on the performance of individual organisations in relation to NHS Continuing Healthcare.
- 3.26 Nationally, some organisations have fully integrated adult health and social care services. Others have very active Local Authorities who engage fully with the NHS Continuing Healthcare agenda putting pressure on the NHS to frequently assess and consider individuals for NHS Continuing Healthcare eligibility.
- 3.27 In NHS Berkshire relationships between the NHS and the Local Authorities appear to vary. There is a willingness to work together, however trust appears to have broken down overall with the NHS and one Local Authority often liaising through legal correspondence and practice emerging such as a Local Authority asking for a checklist to be completed for every hospital discharge.
- 3.28 The NHS and Local Authorities should work together in the best interest of the individual, regardless of funding or care outcome. Once achieved performance should improve for all partners.

## Recommendations

3.29 In relation to the activity and cost information presented in this chapter, it is recommended that:

|     |  |
|-----|--|
| KR1 | Primary Care Trusts and Local Authorities review all possible opportunities to improve activity and outcomes for patients and improve compliance with the National Framework;  |
| KR2 | NHS Berkshire is encouraged to maintain the quality of data returns under the benchmarking project;  |
| KR3 | NHS Berkshire and the six Local Authorities jointly and regularly meet to use the benchmarking data to monitor their performance both regionally and nationally;   |
| KR4 | The NHS Berkshire Board and the Local Authorities review the benchmarking data and consider the factors influencing the local performance on NHS Continuing Healthcare.  |
| KR5 | NHS South Central scrutinises the benchmarking data at a regional level and undertakes further analysis in relation to the issues listed above in support of all its Primary Care Trust areas, and ensures that best practice is shared. |

## **Section 4**

### **Assessment of NHS Continuing Healthcare Processes and Procedures in Berkshire**

This section summarises the findings of the review of NHS Continuing Healthcare practice and process in Berkshire.

## **4. Assessment of NHS Continuing Healthcare Processes and Procedures**

- 4.1 This section provides a summary of the key points derived from the questionnaires and interviews.
- 4.2 The section summarises the common themes identified under the topic areas explored within the questionnaires and interviews and gives key recommendations relating to them. The themes are based on the standards set out within National Framework for NHS Continuing Healthcare.

### **General Findings**

- 4.3 From the evidence available it would appear that the Primary Care Trusts in Berkshire may not be acting within the Responsibilities/Directions as laid down by the Secretary of State for Health in relation to the Fast Track Pathway Tool. The Strategic Health Authority needs assurance that the Primary Care Trusts are complying with the Directions. Further information on this is set out from paragraph 4.29.

### **The key areas for improvement are:**

- 4.4 There is an urgent need for a Local Operational Policy which is clear on all the procedures with regard to implementing the National Framework for NHS Continuing Healthcare. This is key to all areas particularly in ensuring consistency, undertaking training of staff, working relationships with the Local Authorities and transparency of process for the public and stakeholders.
- 4.5 Joint working between the Primary Care Trusts and the Local Authorities needs urgent attention with a patient-centred focus although there are some areas within Berkshire where good practice exists.
- 4.6 Timescales for assessment, decision making and review need to be addressed.
- 4.7 The Fast Track process appears to be misinterpreted and may not therefore always be working to the benefit of patients.
- 4.8 A draft dispute resolution process was received from NHS Berkshire, this urgently needs to be taken forward and agreed with all parties.
- 4.9 Staff training needs addressing at all levels in order to ensure consistency of application of the eligibility criteria and to promote understanding of all Continuing Healthcare processes. A Joint training programme involving the NHS and the Local Authorities needs to be established on a regular basis.

### **Compliance with the National Framework**

#### ***Information for the Public:***

- 4.10 Information regarding NHS Continuing Healthcare is available on the NHS Berkshire website and is conveyed through both health and social care

practitioners. There is a reliance on nationally available information, and there was little evidence of locally adapted materials.

- 4.11 All organisations (NHS and Local Authorities) were found to be using the mandatory Checklist, Decision Support Tool and Fast Track Pathway Tool.

### ***Completion of the Checklist***

- 4.12 Referrals are accepted via the Checklist from a variety of settings including acute sector, nursing homes, community and domiciliary care, including both NHS and Social Care Staff although this process is not used for fast track referrals. This means that Checklists are often completed by and accepted from staff who have not undertaken any recent training.
- 4.13 Checklists which are not accepted by the Primary Care Trust are those completed without sufficient evidence or where the evidence supplied does not support the banding applied. Checklists submitted without appropriate evidence can cause delays. There was some ambiguity regarding the information required with the checklist, and in some cases a lot of information was asked for which appeared unnecessary. Practice Guidance (Paragraph 6.9) states “the checklist is intended to be relatively quick and straightforward to complete.”
- 4.14 Where the checklist is negative it is expected that the professional who had completed it would inform the individual/family of the outcome.
- 4.15 Where the checklist is accepted contact is made with the individual/family and appropriate professionals to confirm the assessment and request reports.
- 4.16 The importance of, and need to include the individual in the eligibility process was recognised by the organisations involved. However, all areas were struggling with achieving an appropriate level of input whilst ensuring the timeliness of decision making.
- 4.17 Consent appeared to be recorded appropriately by the NHS, being well documented and signed by the appropriate person (file audit). However there was some confusion regarding what information could be held by different organisations and what could be shared. The reviewers are aware that this confusion is not specific to Berkshire and clarity on the sharing of information would be welcomed nationally.
- 4.18 There was evidence to show that the Local Authority was not always seeking appropriate consent before completing checklists. There was evidence that the hospital staff involved in completing checklists felt that their professional judgements were ignored by the Local Authority whose staff were completing a second checklist with a different outcome in many cases and that Local Authorities were seeking to have a checklist completed for all individuals being discharged from hospital.
- 4.19 Following completion of the checklist, most organisations were experiencing some degree of problem with achieving high quality, timely multi-disciplinary

assessments. In particular, the engagement of Community Psychiatric Nurses and social workers in assessments were cited as problematic. Local Authorities felt that they were not always invited to the table and that timescales were unnecessarily lengthy.

- 4.20 The Department of Health Frequently Asked Questions published in November 2011 gives further information on checklisting and how it fits into the Delayed Discharge arrangements at 3.4 and 3.5. Organisations should take this into account when agreeing arrangements around checklisting. Section 7.1 of the Practice Guidance is also relevant.
- 4.21 The organisations appear to have a polarised view on when checklisting is required, and need to urgently reach a joint understanding and agreement on this with particular reference to Section 6 of the Practice Guidance and appropriate arrangements when individuals are in hospital

### ***Decision Support Tool***

- 4.22 The review highlighted a range of issues in relation to the completion of the Decision Support Tool.
- 4.23 From the interviews and file audit, the process for completion of the multi disciplinary assessment and Decision Support Tool appeared complex. In some areas the domains on the Decision Support Tool are not completed at this stage, with the professionals completing them separately afterwards. For example, on several files, the social services representative's comments had been written after the multi disciplinary meeting (East Berkshire in particular). Whilst this is acceptable it is not necessarily best practice and organisations should be mindful of the Practice Guidance Section 8.5 in terms of multi-disciplinary team assessments.
- 4.24 However, generally Decision Support Tools were well evidenced within the care domains, each individual's view noted and it was documented that discussion had taken place. From the file audit it seemed that some members of the multi-disciplinary team did not understand what evidence was needed to support the levels in each care domain, which showed a lack of understanding of the National Framework. This lack of knowledge could lead to inconsistency in decision-making, particularly at a local level.
- 4.25 The explanation as to how a recommendation for NHS Continuing Healthcare eligibility was made was not clearly documented in any of the Decision Support Tools. There was insufficient detail about the nature, intensity, unpredictability and complexity of a person's needs to explain why a person did or did not have a primary health need. This was evident in all the processes including lack of explanation in the panel minutes and in the letters to the applicants. This was consistent in the file audit and in the evidence given by the local authorities. See also sections 3.55 and 3.56 under training.
- 4.26 The Practice Guidance reiterates the position that only in exceptional circumstances should the recommendation of the multi disciplinary team provided on the Decision Support Tool not be accepted by the organisation.

In the cases reviewed and in the file audit when a multi disciplinary recommendation for NHS Continuing Healthcare was not accepted by the Primary Care Panel, the reasons for this were not given, either in the minutes of the meeting or the letter to the families, and it was not clear whether cases were referred back to the multi-disciplinary teams for further work if the evidence did not match the recommendation made by the MDT.

- 4.27 From the file audit, the decisions appeared to be based on clinical need; however it was difficult to ascertain if they were consistent across and within the two Primary Care Trust areas. No audit of consistency had taken place.
- 4.28 Panel arrangements were different across the two Primary Care Trust areas, although plans were in place to bring the Panels in line with each other. The same Panels consider multi-disciplinary assessments and decision support tools as well as act as Appeal Panels.

### ***Fast Track Processes***

- 4.29 Fast Track procedures appeared clear in some areas and not so clear in others.
- 4.30 NHS Continuing Healthcare (Responsibilities) Directions 2009 at paragraph 2 and the Practice Guidance paragraph 5.9 make it clear that a Primary Care Trust must accept and action the Fast Track Pathway Tool immediately where the Tool has been properly completed in accordance with the criteria.
- 4.31 Hospital discharge staff appeared clear about the required processes with regard to fast track procedures and stated that it worked well most of the time.
- 4.32 Evidence was found where the Primary Care Trust had not agreed Fast Track Pathway Tools immediately and it was not clear what further information was required by the Primary Care Trust resulting in delay for clients with several cases found where disputes still existed after patients had died.
- 4.33 There was also evidence to show that on completion of the Fast Track Tool where eligibility is determined, patients did not always receive funding until a full assessment had been made. This is not in line with the Directions.
- 4.34 The position is very clear in the Directions and National Framework that the sole requirement for a finding of eligibility under the Fast Track Pathway Tool is for a clinician to have reached a positive decision that (a) the patient has a primary health need arising from rapid deterioration and (b) that it may be entering a terminal phase. Completion of the Fast Track Pathway Tool is the mechanism for the clinician to evidence his/her decision. Once the Primary Care Trust has received an appropriately completed Fast Track Pathway Tool then the Primary Care Trust must put into place Continuing Healthcare funding without delay.
- 4.35 Where the clinician has confirmed in the Fast Track Pathway Tool that the patient has met the two requirements set out above then the Primary Care Trust does not have the discretion to overturn a clinician's decision or turn

down a Fast Track Pathway Tool without a full multi-disciplinary assessment being carried out. Further the Primary Care Trust must not delay putting in place the arrangements in order to carry out a multi-disciplinary assessment.

- 4.36 If there is significant concern by the Primary Care Trust that the clinician is acting inappropriately then the Primary Care Trust should speak immediately to the clinician and ask the clinician to confirm that he/she considers the patient meets the two requirements. Only if the clinician decides to withdraw the application can the Primary Care Trust not approve the eligibility for Continuing Healthcare.
- 4.37 The reviewers are aware that a number of Primary Care Trusts are experiencing significant problems with the use of the Fast Track process by some clinicians, for which there is a training need. However, legislation and guidance clearly confirms that the Primary Care Trust does not have discretion to refuse a Fast Track Pathway Tool where it is fully completed. Further, it cannot require additional documentation to be filled in by the practitioner in order for Continuing Healthcare funding to be awarded.

A Fast-track Pathway Protocol should form part of the overall Operational Policy for Continuing Healthcare.

**3.38 *Appeal/Review Panel arrangements***

NHS Berkshire undertook very few Appeals relating to their eligibility decisions. When an Appeal was requested, it was heard at the same Panel as cases at the first stage. Local Appeal/Review Panel membership should be different to the original decision makers wherever practicable. There was no evidence of cases being reviewed by people who had not been previously involved. There was no evidence of a local resolution policy or processes. The PCTs may wish to consider adopting the local resolution process in place in the South West, a copy of which is attached at Appendix 5.

- 4.39 The Primary Care Trust did have terms of reference in place for both Appeal Panels and other Panels. Whilst adequate these require revising to reflect current guidance. They were unclear as to the role of the Local Authority as well as to the expectations of Panel members and of the Applicants. Letters to applicants informing them that they were not eligible for NHS Continuing Healthcare did not clearly inform the applicant of their right to appeal/apply for a review of the decision and how to do this, and there was no signposting to advocacy services.

**Key recommendations relating to Compliance with the National Framework:**

|     |  |
|-----|--|
| KR6 | All organisations in Berkshire should ensure they have clear arrangements for the timely review of Fast Track applications. This should ensure that the relevant staff are clear on how to complete the fast track tool in line with the National Framework. |
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|------|---|
| KR7  | NHS Continuing Healthcare funding must be available to patients once a positive Fast Track Tool has been completed. This funding should be available until a person is assessed as no longer eligible.  |
| KR8  | All organisations should consider how to engage clients and their representatives appropriately at all stages in the process including information on how to appeal and to agree a local resolution process which could form part of the operational policy.  |
| KR9  | All organisations should ensure consent for assessment is explicitly obtained at the appropriate stages and is clearly recorded.  |
| KR10 | All organisations need to reach an agreed understanding and appropriate use of the checklist tool when individuals are in hospital. They should pay particular attention to this with particular reference to Section 6 of the Practice Guidance and appropriate arrangements when individuals are in hospital<br><br>Clarity is also required regarding information required with checklist is required, keeping this as simple as possible. |
| KR11 | The process for completion of the multi-disciplinary assessment and Decision Support Tool must be consistent, transparent and clear. It should include the views of both NHS and local authority organisations and any dissent should be recorded.  |
| KR12 | When a multi-disciplinary team recommendation is not accepted by the Panel a full rationale and explanation must be given (or the case referred back to the MDT for further work/additional evidence)   |
| KR13 | Decisions regarding a person's eligibility for NHS Continuing Healthcare must be clearly distinct from decisions regarding the approval and funding of care packages and/or Funded Nursing Care.  |
| KR14 | Eligibility decisions should be based on the four key indicators of primary health need which should be supported by the Decision Support Tool. A clear rationale should be given on all the relevant documentation.  |
| KR15 | The right to Appeal and how to do so must be transparent to applicants during each part of the process.   |
| KR16 | It is recommended that Appeals are held as a separate process to regular decision making Panels   |
| KR17 | The Primary Care Trust should set up a resolution process prior to an applicant progressing to Independent Review.  |

## Timescales

- 4.40 The NHS Continuing Healthcare Refunds Guidance (March 2010) places the priority on the NHS to be prompt in its decision making regarding NHS Continuing Healthcare eligibility. When a PCT makes a decision that a person is eligible for NHS Continuing Healthcare and it has unjustifiably taken the PCT longer than 28 days to reach a decision, the PCT should, in appropriate circumstances, refund to the individual or the LA, the costs of the services from Day 29.
- 4.41 The data from the National Benchmarking relating to numbers of referral exceeding 28 days in 2011/12 is set out in Section 3.
- 4.42 At the time of the review, the recent announcement of the cut off dates for retrospective cases did not appear to have been communicated to the public. However this was later confirmed to have taken place.
- 4.43 The Primary Care Trust should also ensure that the new timescales for appeal from 1 April 2012, as published by the Department of Health are now incorporated into their processes and correspondence.
- 4.44 A letter was sent from Olga Senior to all Primary Care Trust cluster Chief Executives and copied to Continuing Healthcare staff across NHS South of England on 29 May 2012 highlighting these two announcements and the requirement for Primary Care Trusts to have arrangements in place to deal with any potential increased workload. Primary Care Trusts will need to demonstrate to the Strategic Health Authority that the exercise has been communicated within their areas and the data on numbers of applications and number of reviews undertaken will be collected and published within the national benchmarking figures.

### Key recommendations relating to achieving timescales:

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|------|--|
| KR18 | The Primary Care Trust must ensure that there are arrangements in place for achieving timely eligibility decisions alongside the six local authorities. This includes ensuring that fast track referrals are dealt with in a timely way.   |
| KR19 | New regulations must be communicated to the public and to staff in a systematic and timely way. The Primary Care Trust must ensure that there is a process in place to achieve this, and that capacity of teams to meet this need is addressed. Numbers of retrospective cases received will be collected in the national benchmarking figures |

### Retrospective cases

- 4.45 Dealing with cases that require the consideration of eligibility for a retrospective period can put significant pressure on organisations both in terms of capacity and financial resources.

- 4.46 All Primary Care Trusts are currently experiencing increasing numbers of requests for retrospective reviews following the announcement by the Department of Health of deadlines for individuals to request such reviews and these need to be factored in to capacity planning.

**Key recommendations relating to Retrospective cases:**

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| KR20 | The backlog of retrospective cases needs to be given clear priority and resources allocated appropriately.  |
| KR21 | It is recommended that the Primary Care Trust assesses the potential for both activity and finance in this area and plans accordingly over the next twelve months.  |
| KR22 | The recent announcement with regard to retrospective cases needs to be communicated effectively to both the public and to staff in all agencies. A national communication toolkit was made available to all Primary Care Trusts together with a comprehensive nationally agreed retrospective review policy for Primary Care Trusts to follow or adapt locally. |

**Capacity**

- 4.47 The capacity and structure of the NHS Continuing Healthcare teams appeared light.
- 4.48 There appeared to be limited capacity to undertake reviews and these were behind schedule. Timely reviews are necessary to ensure best patient care and to ensure appropriate use of resources.
- 4.49 The NHS Berkshire Continuing Healthcare lead has recently suggested a new structure for NHS Continuing Healthcare teams across Berkshire, bringing the two former Primary Care Trust teams together.

**Key recommendations relating to Capacity:**

|      |   |
|------|---|
| KR23 | NHS Continuing Healthcare is a significant risk area for NHS Berkshire. Senior managers need to be assured of the processes and procedures within their organisation. This includes assessing that sufficient capacity at the right level is available to undertake the work required as well as maximising and sharing resources across East and West Berkshire. |
| KR24 | Any new structure in relation to NHS Continuing Healthcare should be based on needs not on the present numbers and grades of staff available. The structure must be fit for the future with particular reference to Clinical Commissioning Groups/Commissioning Support Services.   |

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|------|--|
|      |  |
| KR25 | Evidence suggests that resources in Berkshire are low for both NHC Continuing Healthcare work and Funded Nursing Care. It is suggested that further benchmarking takes place to ensure that assessment teams are adequately resourced to achieve the necessary assessment and review requirements.         |
| KR26 | Local Authorities must ensure that they have sufficient staff to be part of multi disciplinary teams and be available to attend members of Primary Care Trust Panels/joint decision making processes and Appeal Panels. This should be within a co-ordinated approach across all of the Local Authorities. |

### **Operational Policy**

- 4.50 There was no operational policy in place for NHS Continuing Healthcare.
- 4.51 Overall the processes and procedures in place lacked transparency and seemed time consuming.
- 4.52 The reviewers were informed that an operational policy was currently being drafted but were not able to see a draft at the time of review.

### **Key recommendations relating to Operational Policy:**

|      |   |
|------|---|
| KR27 | A clear concise operational policy, taking account of the NHS Continuing Healthcare (Responsibilities) Directions 2009 and the principles laid out in the NHS Continuing Healthcare framework, which is drafted in consultation with relevant partner agencies, and in particular the local authorities is required as a matter of urgency for ratification by the Primary Care Trust Board (suggested timescale within four weeks – to be agreed in action plan).<br><br>This must include terms of reference for relevant Panels. |
| KR28 | A local dispute resolution policy must be agreed with the six local authorities urgently (suggested timescale within two months – to be agreed in action plan).   |
| KR29 | The Primary Care Trust must make the operational policy available on their website.   |

### **Patient Centred**

- 4.53 The Framework makes it clear that the whole process of the assessment and decision making should be “patient centred” (Practice Guidance Para 2.3).

This is necessary in a number of ways including good, clear information, inclusive assessment processes and local resolution opportunities.

- 4.54 There were examples of the client and/or their representatives being present at assessments and the completion of the Decision Support Tool. Applicants did not appear to attend panels, and appeal numbers were unusually low.
- 4.55 Letters to the applicants/their representatives were not clear and did not give good explanations of the rationale for decisions neither did they clearly explain what a person could do next if they were not satisfied with the decision.

**Key recommendations relating to Patient Centred:**

|      |   |
|------|---|
| KR30 | Local and regularly updated information should be available on the website and also in paper format if required.  |
| KR31 | The operational policy should clearly set out how applicants are systematically involved in all processes including assessment, decision making and appeal panels as applicable.  |
| KR32 | Opportunity for local resolution meetings should be offered to patients and families as a way of explaining the processes and reasons for the decisions made.   |
| KR33 | All letters should be revised to ensure that they convey appropriate information, are user friendly in plain English and include the reasons for decisions made as well as identifying the next steps for appeal or complaint. It is suggested that NHS Berkshire contacts one or two other areas for examples of letters used. |

**Management of appeals, complaints and disputes**

- 4.56 NHS Berkshire lacked clearly defined local review processes which included how complaints, appeals and disputes are managed.
- 4.57 Appeals are heard through the regular Primary Care Trust Panels and not separated. There was no evidence to demonstrate that applicants/families were involved with these or how often appeal panels were held. However the reviewers were told that Appeals were not requested frequently.
- 4.58 Local resolution is considered an important aspect in the management of appeals. There was no local resolution policy or process identified.
- 4.59 It is essential that NHS Berkshire had an up to date local dispute policy which is agreed with partner organisations. This has been started but not finalised at present.

**Key recommendations relating to Management of appeals, complaints and disputes:**

|      |   |
|------|---|
| KR34 | NHS Berkshire should ensure all those with the potential to request a review of the decision of eligibility for NHS Continuing Healthcare are made aware of how this can happen and the related timescale. That all applicants must know about their right to appeal.   |
| KR35 | Local Appeal/Review Panel membership should be different to the original decision makers wherever practicable.  |
| KR36 | All decision makers on panels should contribute fully to the decision making processes at Panels with any differences in opinion noted.   |
| KR37 | Letters following the Appeal Panel should be clear and give good explanations for decision made. They should also be clear about the next steps in line with the local resolution process and right to request an independent review of the decision once all local resolution processes have been exhausted. |
| KR38 | All organisations should ensure they agree and have in place an up to date local dispute policy agreed between NHS Berkshire and the six local authorities.   |
| KR39 | Information should be clear regarding what can be appealed and what should be dealt with through local complaint processes.   |

**Training**

- 4.60 Primary Care Trusts and Local Authorities are required under the National Framework to provide training and development opportunities for practitioners. It is also important for organisations to invest in NHS Continuing Healthcare awareness training and in training of any professional who may be required to complete the checklist, Decision Support Tool or Fast Track tool to ensure understanding and that the appropriate quality is achieved.
- 4.61 The training of those completing the Decision Support Tool is implicit in the quality of the recommendation being made by the multi disciplinary team. This includes both NHS and local authority staff.
- 4.62 There were some areas of poor practice with regard to the application of the Decision Support Tool and four key indicators of a primary health need. For example if a person was fed through a “PEG” it was thought that they were automatically eligible for NHS Continuing Healthcare; there was also a view (particularly in the Local Authorities) that if someone had a terminal illness they were automatically entitled to Fast Track funding, and that PCTs should fund all end of life care. There were also examples of misapplication of the

Decision Support Tool domain criteria by staff across the board, except for the NHS Continuing Healthcare Nurses who appeared to have a good grasp of its application.

- 4.63 There were also examples noted on two occasions where a nurse had completed a checklist in the acute sector and there was no need to refer on to the NHS Continuing Healthcare team, the social worker then filled in a further checklist, increased the domain levels and sent it to the team. Good training and joint working and understanding of each other perspectives will help to alleviate such incidents. There was another example, this time from a Local Authority where a Continuing Healthcare Nurse Assessor had agreed an A in the breathing domain, but downgraded other domains already stated by the acute sector so that there was no need to complete a Decision Support Tool, this is outside of the national guidance and legal framework.
- 4.64 Some staff interviewed had had minimal training and many had learnt on the job. At the time of the review there was no ongoing training taking place and no joint training with the local authorities planned.

**Key recommendations relating to Training:**

|      |  |
|------|--|
| KR40 | NHS Berkshire and the six local authorities should invest in a suitable training strategy/programme which covers the training needs of each level of staff i.e. whether they complete the checklist, undertake fast track assessments, represent the local authority or are a continuing healthcare assessor or manager. |
| KR41 | Training should be joint and meet the needs of both the NHS and the six local authorities. Urgent training is required at all levels, and should follow shortly after the agreement of the operational policy. It is suggested that external facilitation and training is procured in the first instance.                |
| KR42 | The training strategy and policy should be explicit within the operational policy or at least referred to within that document.  |

**Quality Assurance/ standards**

- 4.65 NHS Continuing Healthcare is a significant resource commitment for organisations and as such should have a profile at a senior level to ensure appropriate scrutiny and strategic leadership.
- 4.66 The responsibility for NHS Continuing Healthcare sits at Director level in the Primary Care Trust and at senior management / assistant director level within the local authorities.
- 4.67 Evidence of Board level reporting was disappointing, with NHS Continuing Healthcare being mentioned in risk registers only within the Primary Care

Trust although it had been discussed at the occasional local authority scrutiny committee. No formal report on activity, costs or risks was found.

**Key recommendations relating to Quality Assurance/ standards:**

|       |  |
|-------|--|
| KR43  | Executive Directors should be appropriately briefed and engaged across the field of NHS Continuing Healthcare and should provide strategic direction where required.   |
| KR 44 | Appropriate Directors within the local authorities should also be properly briefed regarding NHS Continuing Healthcare and its associated risks.   |
| KR 45 | NHS Continuing Healthcare performance should be presented as a separate item at Board meetings at least annually and also to the local health scrutiny committees. Ideally this should be the same joint report across the area. |

**Joint working**

- 4.68 In some Local Authority areas staff on the ground reported good practical working relationships with Local Authority colleagues to achieve the best possible service for individual patients. However there were concerns that this was not evidenced in all areas and not always supported by efforts to engage at a senior and more strategic level.
- 4.69 Generally there was no evidence of a “can do” culture in either health or social services correspondence, with both resorting to their legal position rather than liaising to plan a way forward.
- 4.70 All eight organisations were aware of the need to have constructive working relationships across the health and social care boundary, although evidence suggested that this had broken down, hence difficulties and disputes arising.
- 4.71 The difficulties reported included:
  - The engagement of some Local Authorities in the assessment and review process;
  - Local Authority staff not feeling an equal part of the decision making processes either in assessments or at panels;
  - One Local Authority insisting that the checklist is completed for all patients being discharged from hospital whether appropriate or not;
  - The lack of an operational policy and dispute resolution process;
  - The number of legal exchanges between the NHS and the local authorities (West Berkshire in particular) has decreased trust between the agencies and exacerbated a breakdown in relationships;

- View from Local Authorities that the Primary Care Trust is delaying discharge and view from the Primary Care Trust that Local Authorities do everything they can to put obstacles in the way;
- Staff from all organisations operating to own organisational pressures rather than being customer/patient centred and applying the National Framework objectively.

The reviewers were made aware that the NHS has made a proposal to the Local Authorities that in order to free up beds and reduce delayed discharges, the Local Authority fund people to go to care homes and that a full assessment can then be undertaken as to who should fund the individual's care. Should the individual meet the CHC criteria the Primary Care Trust will then pick up all the costs from day of discharge and refund the Local Authority. It was not clear to the reviewers why the Local Authority would not accept this proposal and this should be explored further.

**Key recommendations relating to Joint working:**

|      |   |
|------|---|
| KR46 | All organisations should be mindful of their responsibilities in relation to NHS Continuing Healthcare as set out in the introduction to this document – 1.6, 1.7 and 1.8.  |
| KR47 | All organisations should prioritise the building and maintenance of constructive strategic and operational working relationships across Berkshire, particularly between the NHS and the six local authorities. This should be led by appropriate senior individuals. Regular joint meetings should take place on at least a monthly basis in the first instance at both strategic and operational levels. |
| KR48 | Assessment and review is the joint responsibility of health and social care and organisations should work collaboratively to ensure this is achieved.   |
| KR49 | Brokerage and/or advocacy services should be considered, and where possible currently available services used to support patients in their NHS Continuing Healthcare applications.  |
| KR50 | NHS Berkshire should ensure that partner organisations and in particular the mental health trust recognise the importance of NHS Continuing Healthcare assessments and make staff available as required by the National Framework.  |

**Networking / Best Practice**

- 4.72 It was unclear what networking arrangements existed across NHS Berkshire to enable problem solving and sharing good practice and arrangements should tie in with the wider South Central networking arrangements. Ideally this should include NHS and Local Authority representation. Due to a lack of

networking it has been difficult for the teams to learn from best practice, share ideas and innovation.

**Key recommendations relating to Networking / Best Practice:**

|      |   |
|------|---|
| KR51 | NHS Berkshire should look outwardly as well as locally to glean ideas and develop practice.   |
| KR52 | NHS Berkshire and the six local authorities should consider setting up a local operational group that meets regularly to discuss issues relating to NHS Continuing Healthcare processes and procedures. |

**Information and activity**

- 4.73 NHS Berkshire appears to have a sound recording and financial management system.
- 4.74 Section 3 of this report discusses in detail issues relating to the benchmarking data which is collected nationally. NHS Berkshire submits data into this national data collection exercise, however does not appear to have outwardly questioned its position nationally and this does not appear to have been discussed at Board level.
- 4.75 NHS Berkshire was aware of the need to ensure data confidentiality. However some of the systems that they had employed to obtain data were laborious. For example they required original signed copies of assessments and would not accept them by email. The reviewers also noted that the Primary Care Trust did not always take a note of telephone calls from applicants and record these as contacts. These processes should be reviewed.

**Key recommendations relating to Information and activity:**

|      |   |
|------|---|
| KR53 | NHS Berkshire should scrutinise performance on the national benchmarking measures and to share this information with their Board and local authorities. This should include both activity and finance and further understanding of why NHS Berkshire is one of the lowest in the country in terms of numbers of people receiving NHS Continuing Healthcare yet costs are high in comparison to numbers. |
| KR54 | NHS Berkshire should continually assure themselves of the quality of their data relating to NHS Continuing Healthcare performance.  |
| KR55 | NHS Berkshire should undertake comprehensive forecasting taking account of all relevant factors including a provision for retrospective cases and the transition of children into adult services. This will enable realistic budgets to be set for NHS Continuing Healthcare.   |

## Transition

- 4.76 There is a separate Framework which covers the policy context for the assessment of need and provision of care for children and young people. The Framework for Children and Young People relates to Continuing Care rather than NHS Continuing Healthcare and this reflects the different organisational arrangements expected for the care of children and young people. As with adult NHS Continuing Healthcare however, Primary Care Trusts are responsible for leading the continuing care process for children and young people.
- 4.77 The Children and Young People's Framework states that 'all Primary Care Trusts should ensure that they are actively involved in the strategic development and oversight of their local transition planning processes with their partners, and that their representation includes those who understand and can represent adult NHS continuing healthcare. Primary Care Trusts should also ensure that adult NHS continuing healthcare is appropriately represented in all transition planning meetings regarding individual young people wherever the individual's needs suggest that there may be potential eligibility'.
- 4.78 Clear expectations for the NHS are included starting with the identification of children for whom adult NHS Continuing Healthcare may be required at age 14. By the age of 17, an individual's eligibility for adult NHS continuing healthcare should be decided in principle by the relevant PCT in order that, where applicable, effective packages of care can be commissioned in time for the individual reaching adulthood on their 18<sup>th</sup> birthday.
- 4.79 NHS Berkshire has an identified nurse who leads on transition from the adult team. This is good practice.

### Key recommendations relating to Transition:

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|------|--|
| KR56 | A Transitions agreement should be part of or referred to in the overall NHS Continuing Healthcare Operational Policy.  |
| KR57 | NHS Berkshire must ensure the identification of children for whom adult NHS Continuing Healthcare may be required at age 14 and planning organised accordingly. This includes customer centred planning as well as ascertaining resource implications. |

## **Section 5**

### **Summary of Key Findings and Recommendations**

This section sets out the key findings and recommendations

## **5. Summary of key findings and recommendations**

5.1 The review has highlighted areas that will require addressing which have also been explained in section 3 (3.3 to 3.9) of this report.

5.2 From the evidence available it would appear that NHS Berkshire may not be acting within the Directions as laid down by the Secretary of State for Health around the Fast Track Pathway Tool. This means that they could be acting outside of the legal framework for NHS Continuing Healthcare.

5.3 The three major areas that require urgent attention are:

- The Strategic Health Authority requires assurance that the Primary Care Trust is operating with the legal framework and guidance around the Fast Track Pathway Tool;
- The need for an Operational Policy which is clear on all the procedures with regard to implementing the National Framework for Continuing Healthcare. This is key to all areas particularly in ensuring consistency, undertaking training of staff, relationships with the Local Authorities and transparency of process for the public;
- Joint working with the six local authorities. All partners must work together with the patient at the centre and find ways of achieving this at all levels. This should help to eliminate delays, eliminate frustration experienced by both NHS and Local Authority practitioners, stop the need for legal correspondence and for arbitrary practices such as requiring checklists to be completed for all patients and frequent requests for additional information before acceptance of checklists;
- The joint approval of an Operational Policy which makes this clear will smooth the whole process and procedure and allow for better working relationships.
- Checklisting out of hospital.

5.4 Other important areas to address include:

- Timescales for assessment and resolution need to be addressed urgently.
- The dispute resolution process and policy requires revision and agreement.
- Staff training needs addressing at all levels in order to ensure consistency of understanding of and the application of the eligibility criteria and to promote understanding of all processes. Joint training needs to be established on a regular basis.

5.5 A full list of all recommendations is provided at Appendix 4.

## **Section 6**

### **Next Steps and Summary of Actions**

## **6. Next steps and summary of actions**

- 6.1 NHS Berkshire in partnership with the six Local Authorities is now required to produce an action plan setting out how the issues in each organisation will be addressed including appropriate implementation timescales. These should be submitted to NHS South of England by (timescale to be agreed).
- 6.2 The action plans submitted will be monitored by NHS South of England.
- 6.3 It is recommended that NHS Berkshire and the six local authorities regularly review the actions between them and brief their executives/Board as applicable.
- 6.4 Each organisation puts in place a regular review of the benchmarking data and audits and assesses progress accordingly.

## **Appendices**

|                   |  |
|-------------------|--|
| <b>Appendix 1</b> | <b>Terms of Reference</b>  |
| <b>Appendix 2</b> | <b>Key Department of Health policy documents relating to NHS Continuing Healthcare</b> |
| <b>Appendix 3</b> | <b>Issues for Executive Leads / Operational Leads Networks to consider</b>             |
| <b>Appendix 4</b> | <b>Key Recommendations Arising from the Review – to form basis for action plan</b>     |
| <b>Appendix 5</b> | <b>Local Resolution Process</b>  |

## **Appendix 1**

### **Terms of Reference**

## **CONTINUING HEALTHCARE REVIEW**

### **NHS BERKSHIRE /WEST BERKSHIRE COUNCIL (on behalf of all six Local Authorities)**

**FEBRUARY 2012**

#### Terms of Reference

1. To review the application of Continuing Healthcare Policies by NHS Berkshire across the six local authority areas, including any specific NHS Ombudsman guidelines currently used to inform local decision making.
2. To review the way in which the Directions, National Framework and Practice Guidance are being implemented by NHS Berkshire; review current local operational policies and procedures, and to determine the extent to which these are compliant with the national requirements.
3. To review how the application of the test for Primary health Need is being applied, with specific reference to the eligibility criteria for NHS CHC, the use of the Decision Support Tool, and whether the Framework and National Practice Guidance are being interpreted correctly.
4. To review the work of the CHC Panels, specifically in relation to timeliness of decision making and communication of outcomes, and the relationship between MDT recommendations and Panel decisions.

#### Background material

1. Review of existing written procedures in place across Berkshire.
2. Review of the advice and guidance provided to CHC Leads, and to Panel members, by NHS Berkshire.
3. Review of written evidence relating to specific cases where there has been dispute provided by the six Councils.

#### Activities

1. Agree ToR etc with NHS Berkshire, and WBC on behalf of the 6 Councils.
2. Meet with staff from NHS Berkshire.
3. Meet with staff from West Berkshire Council, and representatives of the other 5 Berkshire Councils (this is likely to be one meeting only).
4. Agree timescales for the Review and reporting back arrangements.

5. Agree who receives the report and how it can be shared.
6. Agree how any recommendations are to be implemented, and the timescales for these.
7. Agree how outcomes will be monitored.

## **Appendix 2**

### **Key Department of Health policy documents relating to NHS Continuing Healthcare**

This appendix lists the key policy documents relevant to NHS Continuing Healthcare

## Key Department of Health policy documents relating to NHS Continuing Healthcare

| Document   | Date of publication |
|--|---------------------|
| NHS Continuing Healthcare Frequently Asked Questions   | November 2011       |
| Directions on the National Health Service Acts 1977 and 2006 published in 2009                         | 30 April 2010       |
| NHS continuing healthcare practice guidance  | 1 April 2010        |
| NHS continuing healthcare: refunds guidance  | 30 March 2010       |
| National Framework for Children and Young People's Continuing Care                                     | 25 March 2010       |
| NHS funded-nursing care practice guide (revised) 2009  | 30 September 2009   |
| The NHS Continuing Healthcare (Responsibilities) Directions 2009                                       | 29 September 2009   |
| The national framework for NHS continuing healthcare and NHS-funded nursing care – July 2009 (revised) | 22 July 2009        |
| The Delayed Discharges (Continuing Care) Directions 2007   | 30 August 2007      |
| The National Health Service (Nursing Care in Residential Accommodation) (England) Directions 2007      | 30 August 2007      |
| NHS continuing healthcare: Continuing care redress   | 14 March 2007       |

## **Appendix 3**

### **Issues for Executives Leads / Operational Leads across NHS Berkshire and Berkshire Local Authorities to Consider**

This sets out issues for NHS Berkshire and the six  
Berkshire Local Authorities to consider

## **Issues for NHS Berkshire and the six Local Authorities to consider**

**In addition to the key recommendations this appendix summarises key issues for consideration. Key to success will be how organisations work together in partnership and a workable operational policy.**

### **Assessment and review**

- Skill mixes within assessment teams – including the release of specialist input, for example, MH, LD or other areas, for example, social worker, occupational therapist.
- Interim arrangements to avoid assessing in hospital
- Achieving good multi disciplinary team assessments
- Specialist input into reviews – sharing resources across areas
- Understanding case management requirements to help inform resource requirements for reviews

### **Panels/decisions**

- Audit and/or peer review of eligibility decisions on a regular basis in order to ensure the correct application of the criteria and consistency across the whole area.
- This should include audit of DSTs on a regular basis as well as Panel decisions.
- Clarity of Appeal Panels, who attends and who are the decision makers

### **Training**

- Pooling training resources across the health and social care community to enable relevant, joint training. This should include all six Local Authorities.
- Pooling of training ideas and resources across a wider area e.g. South Central region and/or NHS South
- Learning from national and regional good practice.

### **Patient experience**

- Audit tools to monitor and improve quality of patient experience from referral to outcome.
- Improving the Patient experience.
- Examples of good patient literature.

- Examples of good correspondence.

### **Quality assurance**

- One page KPI sheet / dashboard
- Quality assurance checklist pre-eligibility

### **Information and activity**

- Understand growth areas for future referrals to help in planning both in terms of assessment and review

## **Appendix 4**

### **Key Recommendations arising from the review**

This appendix provides a list of the key recommendations from the review which should be used to form an action plan.

## Key Recommendations arising from the review

|      |   |
|------|---|
| KR1  | Primary Care Trusts and Local Authorities review all possible opportunities to improve activity and outcomes for patients and improve compliance with the National Framework;   |
| KR2  | NHS Berkshire is encouraged to maintain the quality of data returns under the benchmarking project;   |
| KR3  | NHS Berkshire and the six Local Authorities jointly and regularly meet to use the benchmarking data to monitor their performance both regionally and nationally;  |
| KR4  | The NHS Berkshire Board and the Local Authorities review the benchmarking data and consider the factors influencing the local performance on NHS Continuing Healthcare.   |
| KR5  | NHS South Central scrutinises the benchmarking data at a regional level and undertakes further analysis in relation to the issues listed above in support of all its Primary Care Trust areas, and ensures that best practice is shared.  |
|      | <b>Compliance with the National Framework</b>   |
| KR6  | All organisations in Berkshire should ensure they have clear arrangements for the timely review of Fast Track applications. This should ensure that the relevant staff are clear on how to complete the fast track tool in line with the National Framework.  |
| KR7  | NHS Continuing Healthcare funding must be available to patients once a positive Fast Track Tool has been completed. This funding should be available until a person is assessed as no longer eligible.  |
| KR8  | All organisations should consider how to engage clients and their representatives appropriately at all stages in the process including information on how to appeal and to agree a local resolution process which could form part of the operational policy.  |
| KR9  | All organisations should ensure consent for assessment is explicitly obtained at the appropriate stages and is clearly recorded.  |
| KR10 | All organisations need to reach an agreed understanding and appropriate use of the checklist tool when individuals are in hospital. They should pay particular attention to this with particular reference to Section 6 of the Practice Guidance and appropriate arrangements when individuals are in hospital<br>Clarity is also required regarding information required with checklist is required, keeping this as simple as possible. |
| KR11 | The process for completion of the multi-disciplinary assessment and Decision Support Tool must be consistent, transparent and clear. It should include the views of both NHS and local authority organisations and any dissent should be recorded.  |

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| KR12 | When a multi-disciplinary team recommendation is not accepted by the Panel a full rationale and explanation must be given (or the case referred back to the MDT for further work/additional evidence)   |
| KR13 | Decisions regarding a person's eligibility for NHS Continuing Healthcare must be clearly distinct from decisions regarding the approval and funding of care packages and/or Funded Nursing Care.  |
| KR14 | Eligibility decisions should be based on the four key indicators of primary health need which should be supported by the Decision Support Tool. A clear rationale should be given on all the relevant documentation.  |
| KR15 | The right to Appeal and how to do so must be transparent to applicants during each part of the process.   |
| KR16 | It is recommended that Appeals are held as a separate process to regular decision making Panels   |
| KR17 | The Primary Care Trust should set up a resolution process prior to an applicant progressing to Independent Review.  |
|      | <b>Timescales</b>   |
| KR18 | The Primary Care Trust must ensure that there are arrangements in place for achieving timely eligibility decisions alongside the six local authorities. This includes ensuring that fast track referrals are dealt with in a timely way.  |
| KR19 | New regulations must be communicated to the public and to staff in a systematic and timely way. The Primary Care Trust must ensure that there is a process in place to achieve this, and that capacity of teams to meet this need is addressed. Numbers of retrospective cases received will be collected in the national benchmarking figures                    |
|      | <b>Retrospective Cases</b>  |
| KR20 | The backlog of retrospective cases needs to be given clear priority and resources allocated appropriately.  |
| KR21 | It is recommended that the Primary Care Trust assesses the potential for both activity and finance in this area and plans accordingly over the next twelve months.  |
| KR22 | The recent announcement with regard to retrospective cases needs to be communicated effectively to both the public and to staff in all agencies. A national communication toolkit was made available to all Primary Care Trusts together with a comprehensive nationally agreed retrospective review policy for Primary Care Trusts to follow or adapt locally.   |
|      | <b>Capacity</b>   |
| KR23 | NHS Continuing Healthcare is a significant risk area for NHS Berkshire. Senior managers need to be assured of the processes and procedures within their organisation. This includes assessing that sufficient capacity at the right level is available to undertake the work required as well as maximising and sharing resources across East and West Berkshire. |

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| KR24 | Any new structure in relation to NHS Continuing Healthcare should be based on needs not on the present numbers and grades of staff available. The structure must be fit for the future with particular reference to Clinical Commissioning Groups/Commissioning Support Services.   |
| KR25 | Evidence suggests that resources in Berkshire are low for both NHC Continuing Healthcare work and Funded Nursing Care. It is suggested that further benchmarking takes place to ensure that assessment teams are adequately resourced to achieve the necessary assessment and review requirements.  |
| KR26 | Local Authorities must ensure that they have sufficient staff to be part of multi disciplinary teams and be available to attend members of Primary Care Trust Panels/joint decision making processes and Appeal Panels. This should be within a co-ordinated approach across all of the Local Authorities.  |
|      | <b>Operational Policy</b>   |
| KR27 | A clear concise operational policy, taking account of the NSH Continuing Healthcare (Responsibilities) Directions 2009 and the principles laid out in the NHS Continuing Healthcare framework, which is drafted in consultation with relevant partner agencies, and in particular the local authorities is required as a matter of URGENCY. This must be completed within four weeks of the publication of this report for ratification by the Primary Care Trust Board.<br>This must include terms of reference for relevant Panels. |
| KR28 | A local dispute resolution policy must be agreed with the six local authorities urgently i.e. within two months of this report.   |
| KR29 | The Primary Care Trust must make the operational policy available on their website.   |
|      | <b>Patient Centred</b>  |
| KR30 | Local and regularly updated information should be available on the website and also in paper format if required.  |
| KR31 | Applicants should systematically be involved in all assessments including Decision Support Tools, and should be invited to Appeal Panels as applicable.   |
| KR32 | Opportunity for local resolution meetings should be offered to patients and families as a way of explaining the processes and reasons for the decisions made.   |
| KR33 | All letters should be revised to ensure that they convey appropriate information, are user friendly in plain English and include the reasons for decisions made as well as identifying the next steps for appeal or complaint. It is suggested that NHS Berkshire contacts one or two other areas for examples of letters used.   |
|      | <b>Management of appeals, complaints and disputes</b>   |
| KR34 | NHS Berkshire should ensure all those with the potential to request a review of the decision of eligibility for NHS Continuing Healthcare are made aware of how this can happen and the related timescale.  |

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|       | That all applicants must know about their right to appeal.   |
| KR35  | Local Appeal/Review Panel membership should be different to the original decision makers wherever practicable.   |
| KR36  | All decision makers on panels should contribute fully to the decision making processes at Panels with any differences in opinion noted.  |
| KR37  | Letters following the Appeal Panel should be clear and give good explanations for decision made. They should also be clear about the next steps in line with the local resolution process and right to request an independent review of the decision once all local resolution processes have been exhausted.            |
| KR38  | All organisations should ensure they agree and have in place an up to date local dispute policy agreed between NHS Berkshire and the six local authorities.  |
| KR39  | Information should be clear regarding what can be appealed and what should be dealt with through local complaint processes.  |
|       | <b>Training</b>  |
| KR40  | NHS Berkshire and the six local authorities should invest in a suitable training strategy/programme which covers the training needs of each level of staff i.e. whether they complete the checklist, undertake fast track assessments, represent the local authority or are a continuing healthcare assessor or manager. |
| KR41  | Training should be joint and meet the needs of both the NHS and the six local authorities. Urgent training is required at all levels, and should follow shortly after the agreement of the operational policy. It is suggested that external facilitation and training is procured in the first instance.                |
| KR42  | The training strategy and policy should be explicit within the operational policy or at least referred to within that document.  |
|       | <b>Quality assurance/standards</b>   |
| KR43  | Executive Directors should be appropriately briefed and engaged across the field of NHS Continuing Healthcare and should provide strategic direction where required.   |
| KR 44 | Appropriate Directors within the local authorities should also be properly briefed regarding NHS Continuing Healthcare and its associated risks.   |
| KR 45 | NHS Continuing Healthcare performance should be presented as a separate item at Board meetings at least annually and also to the local health scrutiny committees. Ideally this should be the same joint report across the area.   |
|       | <b>Joint working</b>   |
| KR46  | All organisations should be mindful of their responsibilities in relation to NHS Continuing Healthcare as set out in the introduction to this document – 1.6, 1.7 and 1.8.   |
| KR47  | All organisations should prioritise the building and maintenance of constructive strategic and operational working relationships across Berkshire, particularly between the NHS and the six local authorities. This should be led by appropriate senior individuals. Regular joint                                       |

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|      | meetings should take place on at least a monthly basis in the first instance at both strategic and operational levels.   |
| KR48 | Assessment and review is the joint responsibility of health and social care and organisations should work collaboratively to ensure this is achieved.  |
| KR49 | Brokerage and/or advocacy services should be considered, and where possible currently available services used to support patients in their NHS Continuing Healthcare applications.   |
| KR50 | NHS Berkshire should ensure that partner organisations and in particular the mental health trust recognise the importance of NHS Continuing Healthcare assessments and make staff available as required by the National Framework.   |
|      | <b>Networking/Best Practice</b>  |
| KR51 | NHS Berkshire should look outwardly as well as locally to glean ideas and develop practice.  |
| KR52 | NHS Berkshire and the six local authorities should consider setting up a local operational group that meets regularly to discuss issues relating to NHS Continuing Healthcare processes and procedures.  |
|      | <b>Information and activity</b>  |
| KR53 | NHS Berkshire should scrutinise performance on the national benchmarking measures and to share this information with their Board and local authorities. This should include both activity and finance and further understanding of why NHS Berkshire is the lowest in the country in terms of numbers of people receiving NHS Continuing Healthcare yet costs are high in comparison to numbers. |
| KR54 | NHS Berkshire should continually assure themselves of the quality of their data relating to NHS Continuing Healthcare performance.   |
| KR55 | NHS Berkshire should undertake comprehensive forecasting taking account of all relevant factors including a provision for retrospective cases and the transition of children into adult services. This will enable realistic budgets to be set for NHS Continuing Healthcare.  |
|      | <b>Transition</b>  |
| KR56 | A Transitions agreement should be part of or referred to in the overall NHS Continuing Healthcare Operational Policy.  |
| KR57 | NHS Berkshire must ensure the identification of children for whom adult NHS Continuing Healthcare may be required at age 14 and planning organised accordingly. This includes customer centred planning as well as ascertaining resource implications.   |

## **Appendix 5**

### **Outline Local Resolution Process for Appeals from Individuals Regarding Eligibility for Continuing Healthcare**

## **SOUTH WEST STRATEGIC HEALTH AUTHORITY**

### **Outline Local Resolution Process for Appeals from Individuals Regarding Eligibility for Continuing Healthcare**

**Updated May 2012 to reflect the new timescales introduced by the Department of Health applicable from 1 April 2012**

#### **1.0 Background**

1.1 NHS Continuing Healthcare is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing healthcare needs that satisfy the criteria for the funding. You can receive Continuing Healthcare in any setting, including your own home or a care home. NHS Continuing Healthcare is free, unlike help from Social Services, for which a financial charge may be made depending on your income and savings.

1.2 When it is identified that an individual may have ongoing healthcare needs, he or she should be assessed by appropriate professionals to consider eligibility for Continuing Healthcare using the tools provided within the National Framework for Continuing Healthcare and NHS Funded Nursing Care issued by the Department of Health.

1.3 The National Framework sets out in detail the process for considering a person for Continuing Healthcare funding, including the principles and legal framework about eligibility.

1.4 In summary, to qualify for Continuing Healthcare an individual must have a Primary Health Need. Professionals will use the available evidence and assessment material to look at the totality of the individual's needs to agree whether or not the individual has a primary health need. There are three different tools available within the National Framework to aid decision making.

- I. The Fast Track Pathway Tool - is used to gain immediate access to NHS Continuing Healthcare funding where an individual needs an urgent package of care.
- II. The Checklist tool – is a screening tool used to help practitioners identify individuals who may need a referral for a full consideration of eligibility for NHS Continuing Healthcare funding.
- III. The Decision Support Tool (DST) – is used when the checklist indicates that the person may be eligible for Continuing Healthcare, or if the professionals decide this without using the Checklist. A multi-disciplinary assessment should be used by the multi-disciplinary team (MDT) to complete a DST. The multi-disciplinary team should use the DST to decide whether or not to recommend the person has a primary health need and is therefore entitled to full NHS Continuing Healthcare funding.

The recommendation is then passed to the Primary Care Trust (PCT) for approval.

1.5 When an individual or (if appropriate) their representative does not agree with the decision about eligibility for Continuing Healthcare funding, the PCT should try to resolve the matter. This document sets out below the process to be followed if this happens. The timescales set out in this document are a guide of what to expect (but there may be exceptions depending on the circumstances of each case).

1.6 The process will not be the same when an individual or their representative asks for a retrospective review.

## **2.0 What happens if a person does not agree with the outcome of the Checklist?**

2.1 When a Checklist is completed, a copy of it should be given to the individual or (where appropriate) their representative in a timely manner. The Checklist should include enough information to understand how the decision was made. If the Checklist indicates that a full consideration for Continuing Healthcare is not required, then the individual does have the right to request a review of the decision if they disagree with it. Details of who to contact at the PCT should be included with the Checklist.

2.2 The PCT should give such requests due consideration, taking account of all the information available, including additional information from the individual or his or her carer or representative. The PCT may decide to arrange for a full multi-disciplinary assessment and DST to be completed if there is evidence to suggest it should. If not, then a clear and written response should be given to the individual or their representative, as soon as possible (*within 28 days*). The response should also give details of the individual's rights under the NHS complaints procedure. There is no right to request an independent review of a negative checklist decision by a Primary Care Trust.

## **3.0 Local Review Process – what happens when an individual or their representative does not agree with the decision on the DST?**

3.1 All individuals who have been considered for Continuing Healthcare using the DST should be sent a decision letter by the PCT explaining the decision. The letter should be sent *within 28 days of the decision being reached* and should include the contact details of the named officer at the PCT to call if they disagree with the decision or would like more information. **The individual has a time limit of no later than six months from the date that the notification of the eligibility decision is given to request a review of that decision (i.e. to appeal to the PCT).**

3.2 If the individual (or representative) contacts the PCT about the decision, and the matter cannot be resolved during the phone call, then the PCT should provide details of the named coordinator who will be the point of contact for the duration of the local review process.

3.3 Some individuals may need support to understand or challenge a decision made about their continuing healthcare needs. The PCT should ensure that they are made aware of local advocacy and other services that may be able to offer advice and support. Individuals should also be advised of local Independent Complaints Advocacy Service (ICAS) arrangements.

3.4 From this point forward in this document 'the individual or (if appropriate) their representative' will be referred to as 'the applicant'.

3.5 The named coordinator at the PCT should offer to meet with the applicant or arrange a telephone call, whichever the applicant prefers. The date and time of the meeting or booked call should be confirmed in writing with a copy of the PCT's published Local Resolution Process. *The meeting or booked call should take place within 28 days of receiving the call.*

3.6 If the applicant is not satisfied by the end of the discussion in the meeting or by the end of the booked call, the PCT will need to gather and scrutinise additional evidence appropriate to the case to take account of any specific concerns raised by the applicant. The new evidence and DST should be considered by a PCT Panel. In this document, we will refer to this Panel as a Local Review Panel (LRP). The Local Review Panel membership should be different to the original decision makers where practicable, however it is accepted this is not always possible. The applicant should always be invited to attend the Local Review Panel.

3.7 PCTs may wish to appoint an Independent Chair to the LRP, although this is not a requirement or - to add an additional level of independence - may ask another South West PCT to look at the decision. This should not be allowed to cause undue delay. If the PCT does choose to send the case to another PCT for an independent decision, the originating PCT must be prepared to accept the decision made by the independent PCT. The applicant should be invited to attend the Panel whatever approach is taken, with adequate notice being given to the applicant and enough time allocated at the LRP for the applicant's full involvement with the discussion.

3.8 The decision of the Local Review Panel should be given to the applicant without delay. Applicants will usually be asked to leave prior to the Panel's deliberations and therefore would not find out the decision of the Panel on the same day. However the PCT should notify the applicant of the decision in writing, which includes a detailed rationale for how the decision was made. *The letter should be sent within 28 days of the date of the Panel.* The letter from the PCT should give details of how to request a review by NHS South West's Independent Review Panel if they remain dissatisfied.

3.9 **Unless there are exceptional circumstances the PCT should complete the review/appeal process within three months of the receipt of the request.**

PCTs are asked to be mindful of Annex A. This sets out the essential parts of the process to complete at a local level before a case is referred to NHS South West.

## 4.0 Independent Review Panel

4.1 NHS South West is the Strategic Health Authority for the South West and is responsible for appointing Independent Chairs and Panel members to consider requests by individuals for an Independent Review.

4.2 Applicants should contact NHS South West to request the Independent Review *within **six months of the date of the PCT's decision letter*** unless there are exceptional circumstances. NHS South West should acknowledge this request *within one week of receipt of the letter*.

4.4 Included with the acknowledgment letter from NHS South West will be a Public Information Leaflet <sup>1</sup> explaining the role of the Panel and how the process works and a questionnaire (unless one has already been completed) which asks for some additional information about why the applicant is requesting an independent review of the Primary Care Trust decision.

4.5 If the applicant's request for a review is appropriate and accepted by NHS South West, papers will be requested from the PCT, with a view to the Review Meeting taking place *within **three months of the date of receipt of the request for the independent review***. In order to achieve the three month deadline, it is important that PCTs have already gathered and scrutinised all appropriate additional evidence at their local review panel.

4.6 If, for whatever reason, it proves impossible to arrange the Review Meeting within three months of the PCT's Local Review Panel, NHS South West may need to ask the PCT to refresh the assessment of the individual, and re-visit the decision about eligibility for Continuing Healthcare funding.

4.7 The Independent Chair allocated by NHS South West for the Review Meeting will "preview" the file, to ensure that the case is ready for the Review Meeting. In the event of there being flaws in the local process which would or could affect the fair and comprehensive consideration of the individual's needs, the case may be sent back to the PCT or questions may be put to the PCT.

4.8 It should be noted that the Independent Review Panel has a limited remit and is not able to consider any legal challenges to either the eligibility criteria or the responsibilities of the NHS. There is no role for legal professionals at the independent review panel and therefore any costs incurred by individuals will not be reimbursed by the NHS. Legal professionals can attend Panels in an advocacy role.

4.9 The remit of the Independent Review Panel is to:-

- Consider the process followed by the PCT in coming to a decision about eligibility for NHS Continuing Healthcare and to:
- Look at whether the PCT properly applied the eligibility criteria for NHS Continuing Healthcare.

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<sup>1</sup> NHS Strategic Health Authorities Independent Review Panels – Public Information

## **Tasks to be completed by the PCT prior to referring a case to NHS South West for Independent Review**

All reasonable attempts should be made to resolve a dispute at local level by the PCT. PCTs in the South West are asked to observe the process above and whilst it is accepted that each PCT may have a slightly different method of local resolution, the basic principles within the National Framework must be included.

In order not to waste time, or misdirect individuals, PCTs should check the list of tasks below. If any of the tasks have not been completed then the PCT should do more to strengthen the local process before they advise the applicant to request an Independent Review.

1. Has there been a comprehensive multi-disciplinary assessment of the individual's health and social care needs?
2. Was the DST completed by an appropriately constituted MDT and does it include a proper recommendation?
3. Was the recommendation of the MDT accepted by the PCT?
4. Was the individual or their representative given the opportunity to be involved at all stages of the process
5. Has adequate local resolution taken place which includes:
  - a. Offer of a face to face meeting with the individual or their representative (the applicant) or telephone call if preferred
  - b. Consideration of the concerns raised by the applicant
  - c. Gathering and scrutiny of any additional evidence relevant to the case
  - d. Referral to a Local Review Panel at which the applicant should be invited to attend
  - e. A comprehensive letter sent to the applicant which explained in detail the reasons for the Local Review Panel's decision

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22 May 2012