NHS Continuing Healthcare and Joint Packages of Health and Social Care Services Commissioning Policy

Version History:

Version	Date	Author	Reason for change
0.1	3.4.17	Rosa Waddingham based on West Suffolk policy	As agreed at CHC TAG
0.2	25.4.17	Debbie Draper	Comments on drafts and incorporation of IPC PHB principles
0.3	9.5.17	Rosa Waddingham	Incorporating comments from CHC TAG members

Review and Approval:

Reviewed/Approved	Date
Nottingham North and East CCG Governing Body	
Nottingham West CCG Governing Body	
Newark and Sherwood CCG Governing Body	
Mansfield and Ashfield CCG Governing Body	
Rushcliffe CCG Governing Body	

Next review date: June 2018

Contents:

Mission Statement

When commissioning services for people, we will place greater emphasis on the achievement of outcomes and value for money over the level of choice available.

We will always aim to maximise people's independence and take their preferences into account, but the funding made available to support an individual will be determined by the most cost effective care package, based on the local care market, the availability of local care providers and the cost of community based and residential or nursing care.

1. Purpose

This document sets out Newark and Sherwood Clinical Commissioning Group, Mansfield and Ashfield Clinical Commissioning Group, Nottingham North and East Clinical Commissioning Group, Rushcliffe Clinical Commissioning Group and Nottingham West Clinical Commissioning Group (the CCGs) principles and framework for Continuing Healthcare and joint funded packages of health and social care. It defines the way in which resources will be agreed and commissioned. This policy aims to ensure the best use of NHS resources and provide a level of service that is sustainable and equitable (fair) to the health and wellbeing of the people of Nottinghamshire.

2. Legal Context

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 sets out the principles and processes of CCGs to adopt. It concentrates mainly on the process for establishing eligibility for NHS Continuing healthcare and the principles of care planning.

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

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

In all cases the CCGs will follow safeguarding policy and the Mental Capacity Act (2005) to ensure the best interests of the individual are maintained. All staff are responsible for adhering to staff guidance and are expected to understand the legal framework that governs health care.

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

3. Background and Context

3.1 What is NHS Continuing Healthcare?

'NHS continuing healthcare' means a package of on-going care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in 'The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care'. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery.

3.2 What are Joint Packages of Health and Social Care Services?

If a person is not eligible for NHS continuing healthcare, they may receive a package of health and social care (rather than be fully funded by the NHS).
There will be some individuals who, although they are not entitled to NHS continuing healthcare (because 'taken as a whole' their needs are not beyond the powers of a local authority to meet), but nonetheless have some specific needs identified through the Decision Support Tool that are not of a nature that a Local Authority (LA) can solely meet or are beyond the powers of a LA to solely meet. CCGs should work in partnership with their LA colleagues to agree their respective responsibilities in a joint package of care, including which party will take the lead commissioning role.

3.3 What is Fast Track

Fast track is a route into CHC for rapidly deteriorating patients, who may be entering a terminal phase and require an urgent package of care. A review of care provision should be undertaken to ensure that appropriate care is being provided. Fast Track referrals should confirm that all core commissioned and commissioned specialist services are being fully utilised before additional services are commissioned and the principles outlined here support this. Annex A outlines the current process for managing fast track referrals.

3.4 What is Integrated Personal Commissioning?

Integrated Personal Commissioning (IPC) is a partnership programme between NHS England and the Local Government Association. It is a pillar of the NHS Five Year Forward View, and supports the improvement, integration and personalisation of services, building on learning from personal budgets in social care and progress with personal health budgets.

Through IPC, individuals, their carers and families can take an active role in their health and wellbeing, with greater choice and control over the care they need through personalised support planning and personal budgets.

Alongside this, IPC also supports people to develop their knowledge, skills and confidence to self-manage their care, through stronger partnerships with the voluntary and community sector (VCSE), community capacity building and peer support.

As early adopters of IPC, the CCGs and the Nottinghamshire County Council are committed to developing IPC for all people who are eligible for CHC, including fast track and joint funded packages.

3.5 What is a Personal Health and Integrated Budget?

Personal health budgets are an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team.

Any adult eligible for NHS Continuing Healthcare whether receiving a package of care at home or in a care home will have a Personal Health Budget (PHB.) The funds made available via the PHB are for use to meet the individual's agreed health and well-being outcomes as identified in their support plan. PHBs are also available to people in receipt of fast track and jointly funded packages.

As an early adopter and supporter of personalisation the CCGs will support individuals to develop a personalised support plan and then commission care to meet the agreed outcomes. However this approach also needs to balance value for money and PHBs must be affordable within the CCG's overall budgetary allocation for NHS Continuing Healthcare.

The principles of this policy apply to the provision of Personal Health Budgets, and are embedded further in the Support Plan Approval guidance (Annex B).

Health care professionals will continue to focus on securing the best health outcomes for people. Personal health budgets will provide alternative ways of achieving these, with patients able to explore a wider range of options in their support plan.

4. CHC Commissioning Principles

Principles Charter

The CCGs are committed to working in partnership with Nottinghamshire County Council, and have adopted the approach and principles outlined in their Adult Social Care Charter in our commissioning of Continuing Healthcare to reflect our joint approach to personalized commissioning.

We will promote individual health, well-being and independence
We will share responsibility for maintaining the health and well-being of people in our communities with family, carers, friends and other organisations
We will achieve better outcomes by promoting independence and building on the strengths of individuals
We will promote choice and control so people can receive support in ways that are meaningful to them, but will balance this against the effective and efficient use of our resources
We will work to prevent or delay the development of needs for health and social care by providing good quality advice, information and support based on recovery and recuperation
We will support people to live at home or in the community through aligning and developing our community resources
We will work to ensure people are protected from significant harm whilst allowing people to take risks
We will always seek the most cost effective way to provide support, in order to ensure we can continue to meet the needs of all people eligible for health and social care support

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

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

4.3 The CCGs are obliged to meet the health and care needs of individuals who are eligible for NHS Continuing Healthcare. However, guidance does not prescribe the type of healthcare required to meet the need. CCGs have discretion as to the manner of provision of NHS Continuing Healthcare services and must exercise reasonable judgment to provide the most appropriate care within the resources available, taking into account overall expenditure.

4.4 Support will be organised that reflects the choice and preferences of individuals, balanced with the need for the CCGs to strategically commission and manage the demand for healthcare for all people in a safe and effective manner. At all times the CCGs will ensure the best use of NHS resources both locally and nationally commissioned, and a level of service which maximizes individual health and wellbeing, and is fair to the people of Nottinghamshire.

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

4.6 Where there is evidence that a person's outcomes can be met in a more cost effective way, this must be the level of resource that is offered. This may mean that for some individuals, where complex community based support exceeds the cost of a residential or nursing placement with no measurable improved outcomes over time, the residential or nursing options open to that person should be considered.

4.7 The CCGs will not normally fund a package of care that is more than 25% (subject to on- going review) above the most cost effective care package identified by the CCGs. The CCGs will only fund packages above this level in exceptional circumstances, taking into account the following considerations:

- The individual's wishes
- Likely impact on the individual of any potential move, including psychological and emotional impact
- Suitability and/or availability of alternative arrangements
- Risks involved to the individual and others
- The individual's rights and those of his or her family and other carers
- Whether there are any creative alternatives available to enable the best use of resources available and to enable the individual's choice to be realized.
- The CCGs obligation in relation to equality and the Public Sector Equality Duty

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

4.8 To promote consistency of decision making and transparency in how the CCGs comply with their obligations as commissioners of NHS funded services, all decisions will made in line with the Support plan approval guidance (link). This sets out the process of approving support plans for individuals which ensures they are lawful; effective; affordable and appropriate.

4.9 The CCGs will not fund through CHC private provision of therapies which are already provided by the CCGs as part of their mainstream contracts e.g. physiotherapy/OT where the needs can or are being met by core NHS services.

4.10 Provision of any additional services unrelated to an individual's health and care needs should be arranged and contracted separately from any NHS arrangement or contract. It is a private arrangement between the family/patient and those providing the care, for which the NHS is not liable. The CCGs can accept no liability for any failure by individuals to pay for the additional services provided.

4.11 The CCGs have a duty to provide care to an individual with healthcare needs in order to meet assessed needs. An individual cannot make a financial contribution to the cost of the provision NHS healthcare.

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

5. Approving Support Plans

Any adult eligible for NHS Continuing Healthcare whether receiving a package of care at home or in a care home will have a Personal Health Budget (PHB.) The funds made available via the PHB are for use to meet the individual's agreed health and well-being outcomes as identified in their support plan. The support plan is the tool by which the health outcome of the individual are identified and options for meeting these identified.

5.1 Approving a support plan to live at home

As part of the approval process the CCGs will consider the appropriateness of a home based package of care, taking into account the range of factors and principles within this policy. If it is discounted, the reasons for decision should be clearly documented and communicated to the individual.

The CCGs will only consider commissioning packages of care at home providing care can be delivered safely without undue risk to the individual, the staff or other members of the household (including children), and the level of risk that is acceptable to the individual.

The CCGs consider that, in some circumstances, an individual's needs are most appropriately met within a residential setting, most specifically where there is a need for the presence of a Registered Nurse over a 24 hour continuous period. In these circumstances, the CCG would commission a placement within a care home with nursing environment.

This may also be appropriate when a delay in commissioning a home care package delays discharge from hospital or leaves a person without care at home. In these situations rapid and possibly temporary admission to a care home may be required to ensure care and safety is maintained.

However the CCG will work with individuals to ensure that the support plan and care provision is managed on an individual basis and responsive to changing needs and circumstances

5.2 Agreeing a support plan in a residential setting

It is important that the assessment gives a clear picture of the complexity of an individual's needs and provides evidence that the person's needs are at a level that warrants a care home placement, rather than living at home. In this situation the CCG would expect one or more of the following:

- A very high level of complex and fluctuating needs that result in an indicative budget at least the same level as a care home placement
- No carers, family or friends, who are able to support the person or, support previously provided by carers cannot be replaced with alternative services
- A risk assessment identifies risks that cannot be managed in the community and can only be managed with 24 hour care.
- The person requires 24 hour oversight by a registered nurse or registered Mental Health Nurse due to their health needs (nursing home placement only)
- A safeguarding assessment and plan identifies risk factors that can only be managed with 24 hour care
- The person has night time needs which cannot be managed by support in the community
- Repeated admissions into hospital as a result of the person's risks and that they are unable to manage at home.

The evidence provided to support this should demonstrate the six guiding principles (Annex C).

When it is agreed in the support plan to meet individuals assessed needs in a care home, the individual can choose a care home that accepts the CCGs agreed tariffs. The CCGs understand that the location of a care home is an important factor in decision making for many individuals. Where possible, the CCGs will endeavor to provide a choice of care home within a reasonable distance of the individuals preferred location.

The CCGs prefer when possible to use a residential setting which has a formal contract with the CCG in place. As well as agreeing tariffs, these contracts support the delivery of high quality residential care as there are agreed processes, quality monitoring and support mechanisms.

In some circumstances, an individual may wish to live in a care home that has not been identified by the CCGs. In these circumstances, as long as the: fee for care is comparable with the fee agreed by the CCGs (which is published annually in conjunction with the local authority); the care home is able to meet the individual's needs and; the care home satisfies appropriate criteria set by the Care Quality Commission, local authority social services department and CCGs, then the CCGs will consider this option.

Where a care home has had its registration or right to accept admissions suspended or cancelled by the Care Quality Commission, or if the local authority social services or CCGs have embargoed the CCGs will be unable to consider commissioning any new placements within the care home until any suspensions, cancellations and embargoes have been lifted.

If the individual wishes to augment any NHS Continuing Healthcare funded care package to meet their personal preferences, they are at liberty to do so, for example; a bigger room, hairdressing or alternative therapies, provided it does not constitute a subsidy to the core package of care identified by the CCGs. These additional arrangements must be organised and settled outside of the NHS funding agreement, by the individual. If at any point these

additional arrangements are stopped, or the individual can no longer afford to pay for them it will not be the responsibility of the CCGs to provide on-going funding for these arrangements.

5.3 Additional One to One Care in a care home

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

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

- The maximum rate paid for 1:1 care is £12 (as at 1.4.17); however this rate should reflect actual costs paid and will be reviewed annually.
- 1:1 care should be reviewed regularly and only agreed short term
- A small amount of 1:1 care is expected to be included in the package within higher level care home tariffs; it is assumed that the first 2 hours of 1:1 is included in the base fee for all Band C placements.
- Opportunities to investigate more efficient routes to provide the care needed – such as cohort nursing – should be considered where possible.
- Rota's and evidence of care provision relating to 1:1 are required for invoices for 1:1 to be paid. 1:1 care should be invoiced or itemised separately from core care packages to ensure these costs are clearer.

6. Jointly funded packages

In some cases where a person does not demonstrate a primary health need, the CCG may still commission a package with the local authority in which the CCG accepts responsibility for meeting the identified health needs/outcomes in that package. In those cases the general principles outlined in this policy continue to apply to the health element of that funding.

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

A jointly funded package will be agreed based on the care input commissioned and the CCGs will fund the tasks/interventions which are beyond the powers of the local authority to provide. As previously noted, the CCGs will not fund therapies available in a care home e.g. physiotherapy/OT at additional charges that would otherwise be accessed core NHS services.

7. Refusal of NHS Continuing Healthcare Funding

The CCGs will consider that it is a refusal of NHS services where the CCGs have offered the individual what they consider to be an appropriate care package to meet the individual's assessed needs and this is not accepted by the individual, subject to the appeal process outlined This includes situations in which the individual has requested a particular package of care and the CCGs have taken a decision that the package will not be commissioned, but

offered an alternative package of care.

Where there appears to be a refusal, the CCGs will write to the individual with a final offer setting out the care packages that the CCGs are willing to consider, and the consequences of declining a package of care or placement. In this letter the CCGs will provide a period of no less than 14 days for confirmation of acceptance of a package.

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

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

8. Self-Funders who become eligible for NHS Continuing Healthcare

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

If the individual is deemed to lack capacity to make a decision about provision of care, the principles of the Mental Capacity Act (2005) will be applied with regard to a best interest decision. If an individual is found eligible for NHS Continuing Healthcare and there is no evidence of exceptional clinical need the CCGs will:

- Renegotiate fees with the current provider, however, if this is unsuccessful;
- Consider an alternative placement which can meet the individual's assessed needs.

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

9. Funding arrangement for individuals receiving services outside the CCG area.

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

10. Changes in circumstance.

In the event that a review of an individual establishes that their condition has improved or stabilised to such an extent that they no longer meet the eligibility criteria for NHS Continuing Healthcare, the CCGs will no longer be required to fund their care.

The CCGs will provide 28 days written notice of cessation of funding to the individual and the local authority. Any on-going package of care that is needed may qualify for funding by social services, subject to assessment, or the cost of any package of care may need to be met by the

individual themselves. The transition of commissioning responsibility should be seamless, and the individual will be notified of any proposed changes to funding involved when appropriate.

Where an individual who is currently receiving a personal health budget to be supported at home and their assessed needs change, they will have a review of the support plan. The review of the support plan will determine what is working and not working and the appropriate level of support to meet the individual's needs will be offered, in line with the support plan approval guidance: lawful, effective, affordable and appropriate.

If the support plan cannot be approved, it will be returned to the individual and the support planner with an explanation of why it cannot be approved. Where the CCGs and the individual are unable to agree a Support plan that is appropriate, then the approval and escalation process outlined in Section 9 of the support plan approval guidance must be followed.

If the outcome of this process is that the support plan is not is not approved, the individual will be offered support that is approved by the CCGs. Where the individual does not agree to the alternative support offered, and then this would be deemed as a refusal of funding.

In the event that an individual becomes eligible for NHS Continuing Healthcare, who was previously funded by social services, the CCGs will apply the same principles as for other individuals. Namely, that the CCGs have a duty to consider the best use of resources for their population, whilst meeting the healthcare needs of an individual. The CCGs will seek to provide this care with the least disruption to the individual.

Equally, where a provider of care significantly increases their pricing and an alternative provider can deliver the same level of care for better value, the CCGs will consider a change in provider. During this process, the CCGs will ensure the individual is fully informed and case management is provided throughout this process.

11. Mental Capacity

If an individual does not have the mental capacity to make a decision about the location of their commissioned care package and/or suitable placement, the CCGs will comply with the requirements of the Mental Capacity Act, 2005. The CCGs will commission the most cost effective and safe care available based on an assessment of the individual's needs in conjunction with the best interest representation.

All decisions will be evidenced and carried out in consultation with any appointed advocate, Attorney under an Enduring Power of Attorney, Lasting Power of Attorney or a Court Appointed Deputy or the Court of Protection directly and family members will be consulted under the terms of the Mental Capacity Act 2005. Where an individual does not have family or friends to represent them, an Independent Mental Capacity Advocate may be consulted in line with the Mental Capacity Act, 2005.

12. Review

All individuals in receipt of NHS funding will be reviewed to ensure that, the care plan continues to meet the individuals need, the package of care that they are receiving remains appropriate, the PHB is being managed appropriately and wwhether or not the individual still has continuing healthcare needs.

For continuing healthcare for adults, this review is carried out in line with the continuing healthcare national service framework. (more details about the PHB reviews are included in Annex D)

Reviews may need to take place sooner or more frequently if the CCG become aware that the health needs of the individual have changed significantly or if it becomes apparent that the care plan is not being followed or expected health outcomes are not being met.

The individual and care providers should update the CCGs if care needs reduce or increase so further assessment can be made to ensure the individual continues to receive the most clinically effective services and to ensure effective use of NHS resources.

13. Appeal

Where an individual is not satisfied with the choices offered to them, or believes that because of exceptional circumstances the principles in this policy are not applicable in their case they may lodge an appeal by writing to the responsible CCG. The CCGs are only required to provide services that meet reasonable requirements. Exceptionality is determined on a case by case basis and will require a clear clinical rationale and agreement by a CCG Panel with executive decision making ability. The detail of this special/high cost case review panel is included at Annex E.

If the care package offer proposed by the NHS Continuing Healthcare Team is upheld, the individual will be advised of their right to complain through the CCGs complaints process in line with local and national policy, or if the complaint cannot be resolved locally, the individual can be referred to the Parliamentary and Health Service Ombudsman.

Interim arrangements

Where the CCGs, having applied the criteria set out in this policy, decide to place an individual in a care home as opposed to providing a home care package and the individual makes an appeal against this decision, the CCGs will offer an appropriate interim placement taking account of the individual's safety as the over-riding factor. For these purposes, 'interim' refers to the time between the appeal being lodged and then considered by the CCGs. Depending on the outcome of the appeal, such 'interim' placements may become permanent.

The CCGs' decision will be effective until the outcome of the appeal. If the appeal is successful arrangements will then be made to revise the care package provided in consultation with the individual.

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

14. Application of the policy

This revised policy will apply from 1st April 2017 for all individuals deemed eligible from this date.

For people in receipt of existing NHS Continuing Healthcare packages of care, providing the risks to the individual and their carers, including NHS staff, of continuing to provide the existing package are manageable (where applicable) and the package of care does not need to be changed, the CCGs will continue to commission the existing care package until such

time as:

- In the case of a home care package, the risks cease to be manageable.
- A review or re-assessment of needs is undertaken.
- An increase in the level of healthcare is required to meet an individuals need.
- An individual requests their care is provided through a PHB.

15. Policy Monitoring and Review

This policy will be audited as to effectiveness of ensuring choice and equity in the delivery of NHS Continuing Healthcare to individuals across the CCGs.

This policy will be reviewed every two years, or if there are changes in national guidance on individual choice or NHS Continuing Healthcare.

16. List of Annexes

Annex A - Fast Track guidance and forms
Annex B - Support Plan Approval Guidance
Annex C - Six Guiding Principles
Annex D - Audit and Review of Personal Health Budgets – In development
Annex E - Special/High Cost Case Panel Process – In development

17. Associated Documentation & References

National Framework for NHS Continuing Healthcare (2012)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

NHS Continuing Healthcare Responsibilities Directions (2013)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211258/Signed_copy_of_NHS_CHC_Responsibilities_Directions_2013.pdf

Delayed Discharges Directions

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254680/Delayed_discharges_directions.pdf

Mental Capacity Act (2005)

http://www.legislation.gov.uk/ukpga/2005/9/contents

NHS Choice Framework (2014)

https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs

NHS Constitution (2013)

https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

CCGs Safeguarding Policy.

http://psfagreeniis01/nhssintranet/LinkClick.aspx?fileticket=VHlluqjHn-8%3d&tabid=2382&mid=4874

Local Offer for Personal Health Budgets

http://www.ipswichandeastsuffolkccg.nhs.uk/Portals/1/Content/Local%20services/Continuing%20Healthcare/Personal%20Health%20Budget/Suffolk%20Local%20Offer%20FINAL.pdf

Annex A Fast Track Referral Process Guidance

One Page Guide to Continuing Healthcare Fast Track Referrals

Fast Track Continuing Healthcare (CHC) referrals are the means by which care packages or placements can be organised and funded promptly to support people who are nearing the end of their life to die in their preferred place. Clinicians should make a referral if they can demonstrate that the person meets the following criteria:

⇒ The person has a rapidly deteriorating condition AND

⇒ Their condition may be entering a terminal phase AND

⇒ They have health care needs as a result which constitute a ***primary health need***

A Primary Health Need arises where the nursing or other health services required are:

(a) where the person is, or is to be, accommodated in a care home, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for the person's means, under a duty to provide OR

(b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide.

ALL of the above criteria must be met for the person to be eligible for fast track.

Before making a referral consideration should be given to whether or not the person's needs can be met by core health services (e.g. community/ palliative care services)

In order to ensure that referrals are processed quickly clinicians should ensure that the following information is included on the referral form:

⇒ Diagnosis/ Prognosis (include stage on End of Life Pathway)
⇒ Evidence that the person is deteriorating rapidly
⇒ Evidence that the condition may be entering a terminal phase
⇒ The care needs required by the person and in particular those that are over and above needs that could reasonably be met by social services

Completed Fast Track referral forms should be sent to the CityCare CHC Team at:
ncp.fasttrackreferralsnotts@nhs.net (county) / ncp.fasttrackreferrals@nhs.net (city)

If the person does not meet the criteria above but does still have health care needs they may still be eligible for CHC but not Fast Track. In this case a CHC checklist should be completed and sent to
ncp.continuingcarenotts@nhs.uk (county) / ncp.ccteam@nhs.uk (city)

In the event of any queries please contact the CityCare CHC Team on
01623 785410 (option 2) (county) / 0115 883 4740 (city)

Annex B – Support plan approval guidance

NHS Continuing Healthcare and Joint Packages of Health and Social Care Services: Use of Personal Health Budgets

Created – August 2016

The NHS in this guidance applies to:

NHS Nottingham North East Clinical Commissioning Group
NHS Nottingham West Clinical Commissioning group
NHS Rushcliffe Clinical Commissioning Group
NHS Mansfield and Ashfield Clinical Commissioning Group
NHS Newark and Sherwood Clinical Commissioning Group

Version No	Author	Date	Comments	Approved by
V 0.1	Debbie Draper	27.7.16	Draft for discussion	
V 0.2	Debbie Draper	16.9.16	Draft for discussion	
V 0.3	Debbie Draper	17.11.16	**For approval by PCOG**	Recommendation for approval at Governing Body
V 1	Debbie Draper	26.1.17	**For sign off by 5 CCG Governing Body**	Signed off by all 5 CCGs Governing Bodies

Reader information	
Reference	
Department	
Document purpose	• To ensure that staff adhere to agreed standardised procedure across the CCGs, Nottinghamshire County Council (NCC) and Nottingham City Care CIC. • To ensure that all information governance requirements are met
Version	V1.0
Title	Support plan approval guidance
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Approval Date	17/11/16
Approving Committee	Personalisation Commissioning Oversight Group
Review Date	October 2017
Target audience	All Members of the CCG, Members of its Governing Body, Members of its Committees (including sub-committees and joint committees), members of its advisory groups and panels and all employees and individuals working on behalf of the CCG.
Circulation list	All Staff responsible for signing off support plans

	Nottingham Citycare CIC Personalisation Commissioning Oversight Group
Associated documents	
Superseded documents	
Sponsoring Director	Chief Officer

1. **Purpose**

1.1. This document sets out the recommended framework for the process of approving support plans for patients opting to receive their eligible continuing healthcare support or health care needs via a personal health budget. The aim is to ensure that a consistent and transparent approach is applied to the approval of all support plans.

2. **What we will do**

2.1. The Clinical Commissioning Groups (Mansfield & Ashfield, Newark and Sherwood, Nottingham North & East, Nottingham West and Rushcliffe) will provisionally agree an indicative budget that represents a realistic reflection of the patients assessed care needs.

2.2. Before any funding is released, the Clinical Commissioning Groups (CCGs) will check and approve the support plan ensuring that it meets all the assessed, eligible needs of the patient.

2.3. The CCGs will not agree a support plan if there are serious concerns that it will not meet a patient's needs or that it may expose anyone to unacceptable risk.

2.4. The CCGs will ensure that public funds are used equitably in accordance with the purposes for which they are provided and in a way that secures best value.

2.5. Once the support plan is approved, the CCGs, will confirm the final amount of the personal health budget required to implement the plan and release the funding to the patient via the patient's preferred method of delivery.

3. **Context**

3.1. What is NHS Continuing Healthcare?

'NHS continuing healthcare' means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in 'The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care'. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery.[1]

3.2. What are Joint Packages of Health and Social Care Services?

If a person is not eligible for NHS continuing healthcare, they may receive a package of health and social care (rather than be fully funded by the NHS).There will be some

[1] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (Revised) p10

individuals who, although they are not entitled to NHS continuing healthcare (because 'taken as a whole' their needs are not beyond the powers of a local authority to meet), but nonetheless have some specific needs identified through the Decision Support Tool that are not of a nature that an Local Authority (LA) can solely meet or are beyond the powers of an LA to solely meet. CCGs should work in partnership with their LA colleagues to agree their respective responsibilities in a joint package of care, including which party will take the lead commissioning role[2].

3.3. What is Continuing Care for children and Young People?

Some children and young people (up to their 18th birthday), may have very complex health needs. These may be the result of congenital conditions, long-term or life-limiting or life-threatening conditions, disability, or the after-effects of serious illness or injury (Annex A provides more information on these types of need). These needs may be so complex, that they cannot be met by the services which are routinely available from GP practices, hospitals or in the community commissioned by clinical commissioning groups (CCGs) or NHS England. A package of additional health support may be needed. This additional package of care has come to be known as continuing care. After their 18th birthday they transition onto NHS Continuing Healthcare through the adult pathway.

There are significant differences between children and young people's continuing care and NHS Continuing Healthcare for adults. Although a child or young person may be in receipt of a package of continuing care, they may not be eligible for NHS Continuing Healthcare once they turn 18[3].

3.4. The Local Offer

Locally the CCGs are committed to increasing the proportion of people eligible for NHS continuing health care who hold personal health budgets, as well as the number of children and young people eligible for an education, health and care plan benefiting from an integrated care budget offering flexibility and choice and incorporating funding for health care from the NHS.

The CCGs are working closely with Nottinghamshire County Council to improve and expand access to personal health budgets for other groups of individuals with suitable high level needs but who are not eligible for NHS continuing care.

It is important to understand that developing personal health budgets is not about finding new money for additional services but about spending some of the money currently being spent on existing services in a different way. This approach represents a major shift in the way the NHS works and will require comprehensive engagement, careful planning and testing, so as not to compromise the financial sustainability of the NHS or destabilise existing services for other people.

3.5. What are Personal Health Budgets?

Personal health budgets are an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. A personal health budget is not new money, but rather enables people to use funding in different ways, ways that work for them. The NHS vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

[2] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (Revised) p 35

[3] National Framework for Children and young People's Continuing Care Jan 2016

Health care professionals will continue to be focused on securing the best health outcomes for people. Personal health budgets will provide alternative ways of achieving these, with patients able to explore a wider range of options in their support plan.

3.6. The key principles of personal health budgets are:

The person with the personal health budget (or their representative) will:

a. be able to choose the health outcomes they want to achieve, in agreement with a healthcare professional.
b. know how much money they have for their health care and support
c. be enabled to create their own care plan, with support if they want it
d. be able to choose how their budget is held and managed, including the right to ask for a direct payment
e. be able to meet their assessed, eligible needs in ways and at times that make sense to them

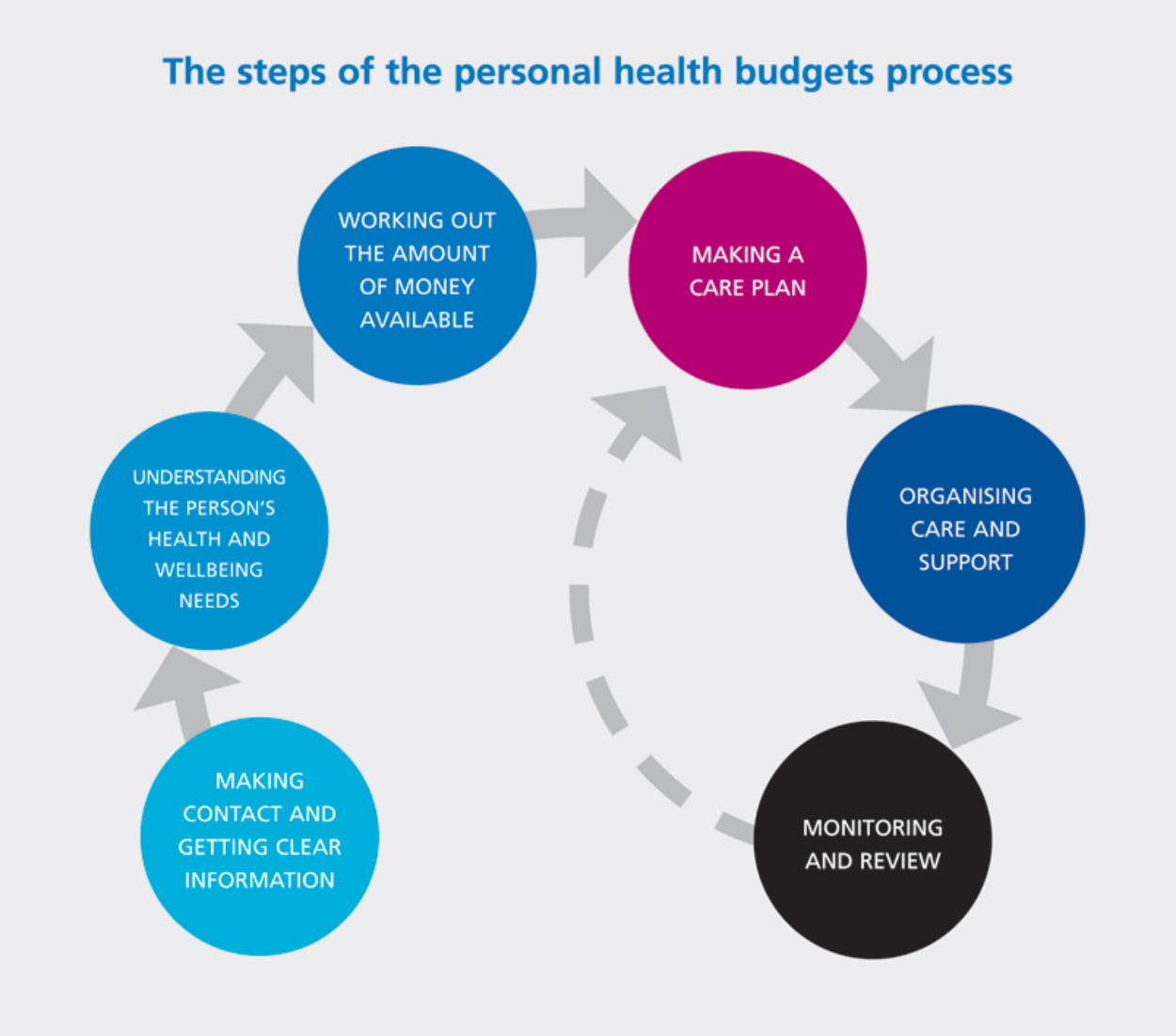
3.7. Personal health budgets can be delivered in three ways, or a combination of them:

a. Notional budget: the money is held by the NHS. No money changes hands. The person is informed how much money is available and is invited to talk to their local NHS team about the different ways to spend that money on meeting their individual support needs. The local NHS team will then arrange the agreed support.

b. Third party budget: the money is paid to an organisation that holds the money on the person's behalf. A different organisation or trust holds the money for the person and helps them to decide what they need. After the person has agreed this with their local NHS team, the organisation then buys the care and support the person has chosen.

c. Direct payment: the money is paid to the person or their representative. The person gets the cash to buy the care and support they and their local NHS team agree is needed. The person has to show how the money has been spent. The person, or their representative, buy and manage services themselves.

The main stages of the personal health budgets process are:



4. Eligible needs

4.1. Which patient needs can be met by a personal health budget?
A personal health budget can be used to meet any health and social care need that has been identified in the patient's assessment (DST or Review).

4.2. What are healthcare and social care needs?
The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care provides the following guidance:

Healthcare - Whilst there is not a legal definition of a healthcare need (in the context of NHS continuing healthcare), in general terms it can be said that such a need is one related to the treatment, control or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).[4]

Social care - In general terms (not a legal definition) it can be said that a social care need is one that is focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society,

[4] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (Revised) p50

protecting them in vulnerable situations, helping them to manage complex relationships and (in some circumstances) accessing a care home or other supported accommodation.[5]

4.3. When support planning, the health and wellbeing outcomes identified in the support plan must relate to the assessed eligible needs as identified in the Decision Support Tool. The plan should ensure that priority be given to health outcomes where priority, severe or high needs have been identified in the DST.

4.4. Patients may also seek to achieve a mixture of outcomes which relate to both health and social care needs, with needs being considered in their entirety, not focussing on one or two health needs, at the expense of others.

4.5. For NHS Continuing Healthcare cases, the CCG's will give consideration to support plans which seek to achieve social care outcomes providing the patient's critical health needs are prioritised and any risks are mitigated.

5. Support planning

5.1. A support plan brings together aspirations, goals and outcomes for a patient and outlines how an indicative budget might be used to meet them. It is a responsive process, showing how a patient and their carer(s) would like their assessed, eligible needs to be met. In general the patient will complete the Support Plan, but if this is not possible it will be completed with the assistance of family, other interested parties, carers, advocates or NHS staff. The key characteristic of the support plan is that the patient has ownership of the plan and it should be agreed by them, wherever possible.

5.2. A straightforward explanation of an outcome is that it is an 'end result' or 'end effect' (concrete or abstract). At an individual level, a good outcome means the benefit or positive difference (end result/end effect) that support can bring to the quality of someone's life, as defined by the individual. For example, as a result of a carer providing a person with support they are able to wash. The **outcome** is that the person can have a wash.

5.3. While patients will be responsible for developing their own support plan, the CCGs retain their statutory duty to ensure that people's assessed eligible needs are met. To discharge this responsibility, the CCGs will make sure that the indicative personal health budget offered to the patient is a reasonable amount within which the person can plan their support. The CCGs will ensure that any risks have been properly identified and addressed. These include risks to the patient or anyone else but also risks to the service or to the CCGs. Finally, the CCGs will check and agree the patient's support plan – the approval process.

5.4. The CCGs have a statutory duty to ensure funding is used effectively and in accordance with the principle of best value. The CCGs will therefore make sure that the patient's needs and desired support outcomes are taken into account and that the measures proposed in the support plan represent an effective use of the personal health budget.

5.5. The CCGs recognise that some measures involving a significant short term cost can eventually contribute to increased independence and thereby reduce support needs or avoid further costs in the long term. In these circumstances the CCGs will expect support planners to justify how short term measures will yield longer term benefits.

[5] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (Revised) p50

5.6. The CCGs recognise that prioritising prevention and early intervention promotes greater wellbeing and independence and can reduce the need for on-going support.

5.7. The CCGs will work to build on the capacity of patients to plan and manage their own support needs while providing them with easy access to information, advice and professional assistance when required.

5.8. During support planning, the patient will also be supported to undertake a risk assessment to identify how any risks arising from their needs or proposed support will be addressed. Provided the risks are clearly identified and addressed in the support plan, the plan will be considered. If, following the support planning process any risks remain unresolved, attempts should be made to resolve these as part of the approval process.

5.9. A patient who has the mental capacity to make a decision, and chooses voluntarily to live with a level of risk, is entitled to do so.

5.10. However, the CCGs remain accountable for the proper use of public funds and whilst the patient is entitled to accept a degree of risk, the NHS is not obliged to fund it. In contentious cases, the process of approving support plans will need to address and resolve conflict about the treatment of risk.

5.11. As a commissioner of services, the CCGs could be liable if it places people in a position in which they are exposed to risk. There is an important distinction between enabling people to choose to take a reasonable risk and putting people at risk. In such cases, the approval process will provide the means to consider the issue and find the correct balance.

5.12. Clinical governance should support flexibility and innovation where possible, so people can try alternative approaches to achieving their health goals providing all risks are identified and managed.

6. Confirmation of the indicative personal health budget

6.1. The patient's eligible needs will be assessed by means of the Decision Support Tool (DST). The domain levels specified in the DST will be entered into a budget setting tool – the Manchester tool. The budget setting tool will assign a recommended number of 'traditional' support hours based on the domain levels in the DST. Local benchmark support rates are applied to the recommended support hours to provide the indicative personal health budget. This provides the person with a guide as to how much money they may have to fund their support plan.

6.2. If the value of the Indicative budget exceeds the value of commissioned services, the Indicative budget offered will be the within the commissioned costs. A personal health budget can be used instead of commissioned services (either partially or totally) but cannot be in addition to the total current service offer. In this case, the cost of the commissioned offer must be based on the current level of the patient's eligible needs as determined by means of the Decision Support Tool (DST).

6.3. Where necessary, the CCGs will authorise a temporary support package to meet the assessed eligible needs while support planning proceeds. This will ensure that the patient's needs are met in line with the CCGs statutory duties but that they retain the freedom to plan their own support on a longer time scale.

6.4. The budget setting tool cannot be relied upon to calculate an accurate indicative budget for very complex cases involving exceptionally high levels of clinical need. In these cases it will calculate an indicative personal health budget up to an agreed maximum threshold. For cases that meet the threshold an exception will be applied and budget holders will

use local knowledge and experience to set a realistic indicative budget.

6.5. In other cases, where the indicative budget generated by the budget setting tool is felt to be inappropriate but the DST domain levels have been correctly completed, support planning should proceed. The indicative budget will always be a guide amount and the patient/support planner should consider creative ways of meeting eligible need, applying best value principles and the use of universal services and assistive technology.

6.6. It is important to note that the use of a maximum threshold and the setting of a guide amount does not mean that the CCGs will not fund support above this figure. The CCGs have a statutory duty to meet a patient's assessed eligible needs. However it is expected that these cases are likely to involve a greater degree of complexity and will require more careful consideration to ensure that the patient's needs are met appropriately. Where the eligible needs cannot be met within the indicative budget, priority will be given to identifying the most cost effective and available options to do this over personal preferences for any particular type of support. The CCGs will not agree to a personal budget that is higher than the cost of a traditionally commissioned package, unless there are particular evidenced reasons as to why the indicative budget is higher.

7. Approval of the support plan and the personal health budget

7.1. Once a patient knows their indicative budget they will be supported to develop a personal support plan that identifies:

a. Who they are
b. What they would like to achieve
c. What things they would like to change or keep the same
d. Their support needs and priorities
e. How they intend to meet their assessed needs and support goals using their personal health budget
f. What support they need to keep healthy and safe
g. How they will spend the budget

7.2. Each support plan will have the following essential features:

a. Is proportionate to the level of need of the patient.
b. Outlines the assessed needs, goals and priorities of the patient.
c. The plan is well balanced with the highest needs receiving priority.
d. Details the combination of formal and informal support that will meet the assessed needs of the patient and help achieve their outcomes.
e. Shows that universal services, assistive technology and 'free' community resources have been utilised where appropriate.
f. Where applicable other relevant public funding sources including Local authority provision have been accessed in conjunction with the personal health budget.
g. Takes account of the views and needs of carers.
h. Is adaptable and flexible, so patients can revise their plans as they learn what works best for them or as their circumstances change.

7.3. The CCGs will give full consideration to the different kinds of health care and support patients will request. Some patients will want to keep their existing support, but have it tailored better to their needs. Others will choose to spend their budget differently, on everyday and community-based support not currently available from the NHS.

7.4. The CCGs will not exclude unusual requests without examining the proposal on a case-by- case basis as these may have significant benefits for people's health and wellbeing.

7.5. The value of a personal health budget should not exceed the value of commissioned services i.e. a personal health budget can be used instead of commissioned services (either partially or totally) but not in addition to the total current service offer.

7.6. Where there is evidence that a person's outcomes can be met in the most cost effective way, this must be the level of resource that is offered. This may mean that for some people, where complex community based support exceeds the cost of a residential or nursing placement with no measurable improved outcomes over time, the residential options open to that person should be considered.

7.7. Once the patient has drawn up their support plan it will be submitted to the CCGs for approval at a panel meeting, to ensure consistency and quality of decision making. The panel is comprised of agreed administratively and professionally qualified staff from Nottinghamshire County Council, the CCGs and from Nottingham CityCare Partnership, the local social enterprise commissioned by the CCGs to undertake healthcare assessments on their behalf. The panel meets every week. The CCGs will review the support plan against the criteria set out in Section 8. If the CCG are satisfied that the support plan meets the criteria, they will agree the support plan and confirm the final amount of the personal health budget. No money will be released to the person until an approved support plan is in place.

7.8. Where the support plan cannot be approved against any one of the criteria, the plan should be returned to the patient or their support planner with details of what further development is needed before the support plan can be re-submitted for approval.

7.9. If the issue cannot be resolved the support plan should be considered by a commissioner / budget holder, who has not been involved in the planning and approval process up to that point. If the support plan cannot be resolved through this process, it will be escalated to the Personalisation Commissioning Oversight Group – See Section 9 for details.

7.10. If the issue is not likely to be resolved quickly, the approver should consider whether the support plan can be partially approved to avoid any delay in meeting the patient's needs. If this is not possible, a managed service should be put in place to ensure that the patient's needs are met while their support plan is under discussion. Where necessary the CCGs will authorise a temporary support package to meet the assessed eligible needs while support planning proceeds. This will ensure that the patient's needs are met in line with the CCGs' statutory duties but that they retain the freedom to plan their own support on a longer time scale.

8. Criteria for approval of support plans

8.1. The proposals for meeting the patient's assessed eligible needs, as set out in the support plan, must be:

a. Lawful
b. Effective
c. Affordable
d. Appropriate

8.2. **Lawful** – the proposals should be legitimately within the scope of the funds and resources that will be used. The proposals must be lawful and regulatory requirements relating to specific measures proposed must be addressed.

In deciding whether the support plan meets with legal requirements it must show that:

a. The support plan will fulfil the CCG's statutory duty to meet the patients assessed, eligible needs.
b. The measures proposed in the support plan must in all cases be lawful.
c. In line with the Mental Capacity Act 2005, if the person appears to lack capacity, the support plan must make clear how their wishes have been ascertained and incorporated into the support plan.
d. The patient must be made aware of any legal responsibilities they will incur as a result of measures proposed in the support plan (e.g. employment law, health and safety)
e. Any service providers identified in the plan must meet applicable regulatory requirements.
f. The patient and carers must receive guidance on any health and safety issues or regulatory requirements in relation to any equipment to be used or any adaptations to their home.

8.3. **Effective** – The proposals must meet the patient's assessed eligible needs and support the patient's independence, health and wellbeing. A risk assessment must be carried out and any risks identified that might jeopardise the effectiveness of the plan or threaten the safety or wellbeing of the patient or others must be addressed. The proposals must make effective use of the funds and resources available in accordance with the principle of best value.

In deciding whether the support plan is effective it must show that:

a. The support plan meets all the assessed eligible needs
b. The proposed measures will be effective in supporting the patient's independence, health and wellbeing
c. Where there is a carer, the carer's needs have been assessed and the proposals take account of their needs too.
d. The proposals represent the most effective use of the resources and funds available
e. A risk assessment has been carried out and any risks identified in the plan have been addressed.
f. The support plan includes measures to address outcomes that will help the patient develop their independence or independent living skills and will enhance their health and wellbeing.
g. The support plan demonstrates due regard to the need to safeguard the patient and their carers.

8.4. **Affordable** – All costs have been identified and can realistically be met within the budget.

In deciding whether the support plan is affordable it must show that:

a. The support plan is within the indicative budget or, if the indicative budget is exceeded, a clear and reasoned explanation is provided to justify the additional spend.
b. In the case of support plans that exceed the indicative budget, the plan is thoroughly checked by commissioners before being sourced to ensure best value.
c. The use of universal services, community resources, informal support and assistive technology has been explored.
d. All relevant sources of funding have been identified and utilised.
e. All costs have been identified and fall within the indicative budget allocated.
f. A suitable contingency amount is included within the support plan.
g. The proposals represent the most effective use of the resources and funds available.
h. The support plan meets the assessed, eligible needs in the most cost effective way possible.
i. Where the support plan requires a budget that is lower than the indicative budget, the lower budget will be approved.

j. The value of the personal health budget does not exceed the value of commissioned services.
k. The support plans cost is not substantially disproportionate to the potential benefit.

"Where NICE has concluded that a treatment is not cost effective, CCGs should apply their existing exceptions process before agreeing to such a service. However, when NICE has not ruled on the cost effectiveness or otherwise of a specific treatment, CCGs should not use this as a barrier to people purchasing the service, if it could meet the individual's health and wellbeing needs. People need the right information and support to enable them to make an informed decision about how to use their direct payments. Where relevant, individuals should be given the opportunity to review the underpinning evidence and the conclusions drawn up by NICE. NICE provide a lay version of their guidance that can help people make decisions about this type of healthcare." [6]

8.5. **Appropriate** – the support plan should not detail the purchase of items or services that are inappropriate for the state to fund or that would bring the NHS into disrepute. The support plan must have clear and strong links to a health or social care outcome. The following items are deemed as inappropriate spend.

a. Alcohol
b. Tobacco
c. Gambling
d. Debt repayment

Self- employed personal assistants

Someone's employment status is not a matter of choice and depends on the relationship and tasks being carried out. In order to safeguard patients from potential unforeseen tax liabilities, it is the CCG's view that self- employed personal assistants should not be used, as they would rarely be deemed to be self- employed when the tasks are measured against Her Majesty's Revenue and Customs (HMRC) status indicator tool

The CCG's will not make direct payments available in cases where the prospective recipient proposes to employ an individual who claims to be self-employed without evidence being supplied to demonstrate that the self-employed status is authentic in relation to the specific job role in question.

In order to demonstrate the employment status of the proposed working relationship, the individual must complete the HMRC Employment Status Indicator (ESI) Tool with the Personal health budget co-ordinator, nurse assessor or social care worker. The answers given must accurately reflect the job description and the terms and conditions under which it is proposed the services are to be provided at the relevant time of the contract, therefore these must be provided to the worker at the time of completing the ESI tool. HMRC will be bound by the ESI outcome where the employer or their authorised representative provides copies of the printer-friendly version of the ESI Result screen, bearing the 14 digit ESI reference number, and the Enquiry Details screen.

If the Personal health budget co-ordinator, nurse assessor or social care worker is confident that the tasks are such that the personal assistant would be considered self-employed after checking the HMRC status indicator tool as above. This will be recorded in System 1 and communicated to the patient in a letter.

The CCG will only agree to self-employed personal assistants in exceptional circumstances, for example, where a patient had been fast tracked for an urgent package of Continuing NHS healthcare.

[6] Para 101: Guidance on direct payments for Healthcare: Understanding the regulations

Working out employment status for an employee

This is defined on the Gov.uk website https://www.gov.uk/employment-status/employee

Someone who works for a business is probably an employee if most of the following are true:

- they're required to work regularly unless they're on leave, for example holiday, sick leave or maternity leave
- they're required to do a minimum number of hours and expect to be paid for time worked
- a manager or supervisor is responsible for their workload, saying when a piece of work should be finished and how it should be done
- they can't send someone else to do their work
- the business deducts tax and National Insurance contributions from their wages
- they get paid holiday
- they're entitled to contractual or Statutory Sick Pay, and maternity or paternity pay
- they can join the business's pension scheme
- the business's disciplinary and grievance procedures apply to them
- they work at the business's premises or at an address specified by the business
- their contract sets out redundancy procedures
- the business provides the materials, tools and equipment for their work
- they only work for the business or if they do have another job, it's completely different from their work for the business
- their contract, statement of terms and conditions or offer letter (which can be described as an 'employment contract') uses terms like 'employer' and 'employee'

This list is not exhaustive and approvers should apply a common sense approach when determining whether an item of spend or service can be deemed appropriate.

8.6. National guidance also includes the following excluded spend:

a. The purchase of primary medical services provided by GPs, such as diagnostic tests, basic medical treatment or vaccinations
b. Urgent or emergency treatment services, such as unplanned in-person admissions to hospital.
c. To pay a close family carer living in the same household except in circumstances when 'it is necessary to meet satisfactorily the person's need for that service; or to promote the welfare of a person who is a child'.
d. The employment of people in ways which breach national employment regulation.

9. Approval and escalation of decisions and of issues involving risk

9.1. Where support plans meet all the criteria outlined in Section 8, the decision to approve the support plan and personal health budget will be taken by the relevant commissioner / budget holder at the weekly panel meeting (as stated in Section 7.6).

9.2. If the plan cannot be agreed, it should be returned to the patient or their support planner with details of what further development is needed before the support plan can be re-submitted for approval.

9.3. If the issue cannot be resolved at the weekly panel, the support plan should be considered by a commissioner / budget holder, who has not been involved in the planning and approval up to that point (as stated in Section 7.7).

9.4. Where any one of the criteria outlined in Section 8 is not met and the issue is not, or cannot be, resolved by referring the support plan back to the patient concerned, or by being considered by a commissioner / budget holder who has not been involved up to that point: the support plan will be escalated to the Personalisation Oversight Commissioning Group (PCOG – see appendix 3 for membership).

9.5. The PCOG, in consultation with relevant health professionals will be expected to take responsibility for decisions where:

a. The support plan is likely to be ineffective
b. There are unmet assessed eligible needs
c. There are unmet carer's needs
d. The proposals do not represent best value
e. The support plan exceeds the indicative personal health budget by 10%, which is above the level that the commissioning team have authority to agree.
f. The person may lack capacity and there is cause to doubt that this has been properly addressed in the support plan and/or concern that the patient does not have the capacity to consent to decisions regarding the potential risk
g. The support plan or the risk assessment identifies a risk to the CCG's
h. The risks to the patient are such that they cannot be resolved through support planning or safeguarding processes
i. The plan has risks that could endanger third parties
j. There is a risk of political or reputational damage to Nottinghamshire CCG's
k. There is reason to suspect actual or potential fraud
l. There are risks relating to the availability or suitability of services or facilities
m. There are risks relating to wider organisational issues (i.e. not specific to the patient or their support plan), including potential service failure, financial or budgetary risks that cannot be resolved through the normal approval process.

9.6. If the support plan exceeds the indicative personal health budget but it is evident that this is due to additional needs that have been identified during support planning, then this should be reviewed with the patient, clinician and the support planner to ensure that all eligible needs have been identified and the indicative personal health budget re-calculated if necessary.

9.7. PCOG will identify any gaps in services revealed through the support planning and approval process and refer these to the commissioning team for future market development.

9.8. The CCGs will ensure that a quality monitoring process is introduced, involving sampling of cases, to confirm the quality and consistency of decision-making and ensure that the right criteria are being used effectively.

10. Outcomes of Approval

10.1. When the support plan is approved, the final amount of the personal health budget will be set. The person and their support planner will be notified and the commissioner will authorise the release of the money according to the delivery method selected.

10.2. If the support plan cannot be approved, it will be returned to the patient concerned and their support planner with an explanation of why it cannot be approved. Wherever possible the person or their support planner will also be offered guidance or support on alternative means of meeting the assessed eligible need.

10.3. **Partial Approval:** If only one element of a support plan cannot be approved, the CCGs will approve the support plan with that specific exception, which will then be explored separately with the person and their support planner. In the interim, the personal health budget will be set at a level to meet the approved part of the plan.

10.4. **Variations to the support plan or personal health budget**: The CCGs may agree to vary the support plan or the personal health budget if there is a change in circumstances. In the case of significant changes, this will take place following a review of the patient's needs. In the case of minor changes, the CCGs may agree to a variation without a review being required. The CCGs may also agree to add to or amend a support plan and / or personal health budget that have previously been partially approved, once agreement has been reached on any outstanding elements. A variation may also be made following the outcome of an appeal. Irrespective of whether the change involved is major or minor, the support plan must be looked at as a whole in order to assess the full effect of the change and identify any changes in need.

11. Support plan review

11.1. The support plan will be reviewed at three months and then at least annually. The patient must agree to the review and understand that part of that process may include a reassessment of their needs.

12. Complaints

12.1. Where a patient is unhappy with the CCG's final decision on approval of their support plan or personal health budget, they will have the right to make representations through the complaints procedure.

Appendix 1

Checklist to approving a support plan

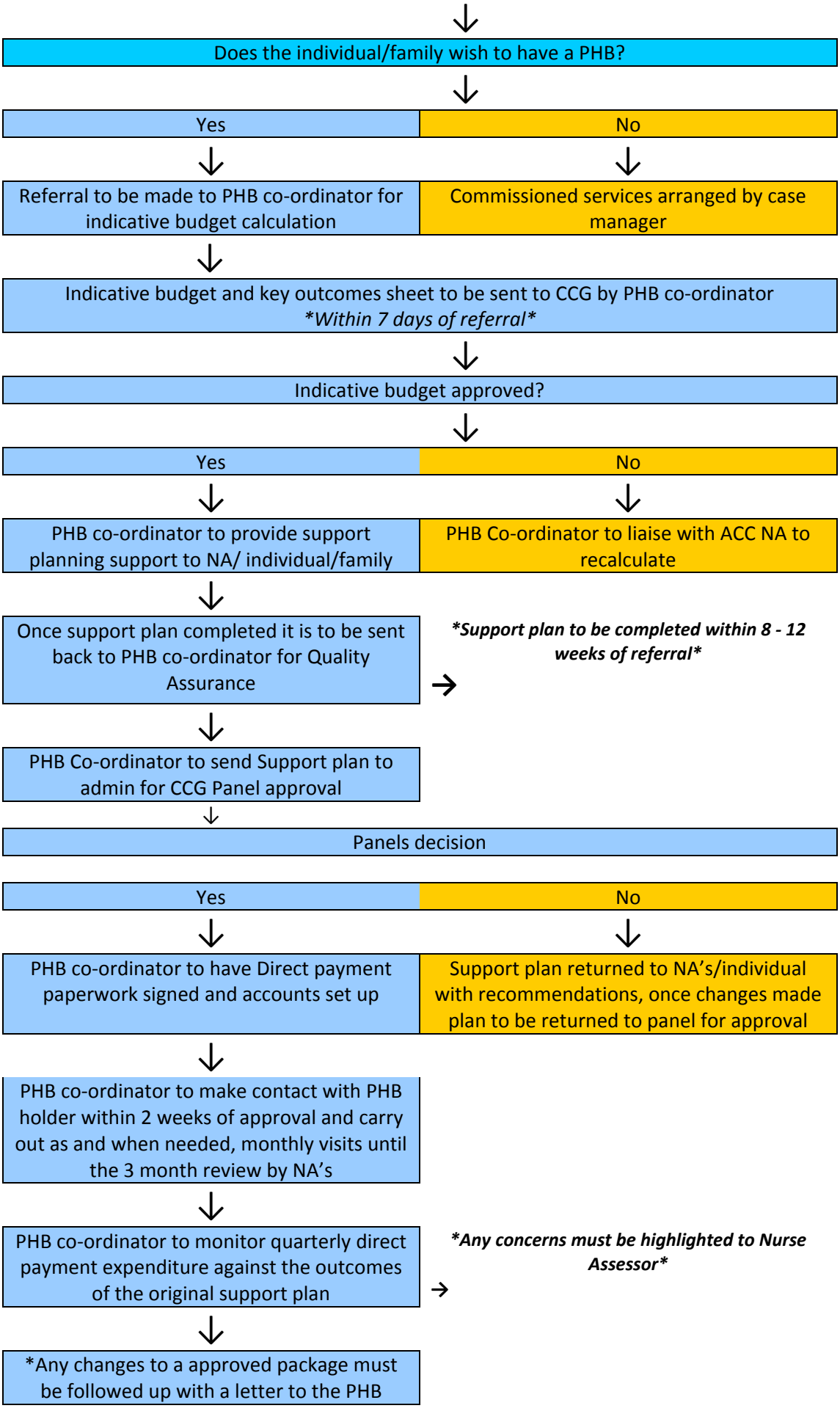
Theme	Question
1. Lawful	• Does the support plan fulfil Nottinghamshire CCG's statutory duty to meet the patients assessed, eligible needs? • Are the measures proposed in the support plan are lawful? • In line with the Mental Capacity Act 2005, if the person appears to lack capacity, does the support plan make clear how their wishes have been ascertained and are they incorporated into the support plan? • Has the patient been made aware of any legal responsibilities they will incur as a result of measures proposed in the support plan (e.g. employment law, health and safety)? • Do any service providers identified in the plan meet applicable regulatory requirements? • Has the patient and carers received guidance on any health and safety issues or regulatory requirements in relation to any equipment to be used or any adaptations to their home?
2. Effective	• Does the support plan meets all the assessed eligible needs? • Are the proposed measures an effective way to support the patient's independence, health and wellbeing? • Where there is a carer, have the carer's needs been assessed and do the proposals take account of their needs? • Do the proposals represent the most effective use of the resources and funds available? • Has a risk assessment been carried out and any risks identified in the plan have been addressed? • Does the support plan include measures to address outcomes that will help the patient develop their independence or independent living skills and enhance their health and wellbeing? • Does the support plan demonstrate due regard to the need to safeguard the patient and their carers?
3. Affordable	• Is the support plan within the indicative budget? • If the indicative budget is exceeded, is a clear and reasoned explanation provided to justify the additional spending? • If the support plan exceeds the indicative budget, has the plan been thoroughly checked by commissioners before being sourced to ensure best value? • Has the use of universal services, community resources, informal support and assistive technology been fully explored? • Have all relevant sources of funding have been identified and utilised? • Do all the costs identified fall within the indicative budget allocated? • Is a suitable contingency amount included within the support plan? • Do the proposals represent the most effective use of the resources and funds available? • Does the support plan meet the assessed, eligible needs in

	the most cost effective way possible? • Does the support plan require a budget that is lower than the indicative budget; the lower budget will be approved? • Are the support plans costs substantially disproportionate to the potential benefit?
4. Appropriate	• Does the support plan detail the purchase of items or services that are inappropriate for the state to fund or that would bring the NHS into disrepute? • Does the support plan have clear and strong links to a health or social care outcome? • Does the support plan include items that are deemed as inappropriate spend? • Does the support plan breach national employment regulations? • Does the support plan pay a close family carer living in the same household? • If so, 'it is necessary to meet satisfactorily the person's need for that service; or to promote the welfare of a person who is a child' and is this evidenced? • Does the support plan purchase primary medical services that must be provided by GPs, such as diagnostic tests, basic medical treatment or vaccinations?

Appendix 2

Adults Continuing Care Personal Health budget Process

ACC Nurse assessors (NA) carry out DST assessment and discuss PHB with individual/family


Does the individual/family wish to have a PHB?
Yes
No
Referral to be made to PHB co-ordinator for indicative budget calculation
Commissioned services arranged by case manager
Indicative budget and key outcomes sheet to be sent to CCG by PHB co-ordinator *Within 7 days of referral*
Indicative budget approved?
Yes
No
PHB co-ordinator to provide support planning support to NA/ individual/family
PHB Co-ordinator to liaise with ACC NA to recalculate
Once support plan completed it is to be sent back to PHB co-ordinator for Quality Assurance
Support plan to be completed within 8 - 12 weeks of referral
PHB Co-ordinator to send Support plan to admin for CCG Panel approval
Panels decision
Yes
No
PHB co-ordinator to have Direct payment paperwork signed and accounts set up
Support plan returned to NA's/individual with recommendations, once changes made plan to be returned to panel for approval
PHB co-ordinator to make contact with PHB holder within 2 weeks of approval and carry out as and when needed, monthly visits until the 3 month review by NA's
PHB co-ordinator to monitor quarterly direct payment expenditure against the outcomes of the original support plan
Any concerns must be highlighted to Nurse Assessor
*Any changes to a approved package must be followed up with a letter to the PHB

holder*

Appendix 3

Membership of the Personalisation Oversight Commissioning Group

Constituent Members

Chair: NHS Rushcliffe CCG, Chief Officer and Lead Commissioner
NHS Nottingham North and East CCG, Director of Nursing and Quality on behalf of South Notts County CCGs
NHS Mansfield and Ashfield/Newark and Sherwood CCGs, Director of Procurement and Market Management
NHS Mansfield and Ashfield/Newark and Sherwood CCGs, Chief Nurse, Director of Quality and Governance
NHS Mansfield and Ashfield/Newark and Sherwood CCGs, Deputy Chief Finance Officer
NHS Nottingham West, Contract and Performance Lead on behalf of South Notts County CCGs
NHS Rushcliffe CCG, Finance Lead on behalf of South Notts County CCGs
NHS Rushcliffe CCG, CHC Relationship Manager and Workstream Lead on behalf of South Notts County CCGs
Nottinghamshire County Council, Senior Public Health Manager, Children's Integrated Commissioning Hub
Nottinghamshire County Council, Adult Social Care, Health and Public Protection
NHS Nottingham City CCG Workstream Lead for Personal Health Budgets

Annex C - Six Guiding Principles

These principles apply to people with capacity, as well as best interest considerations where a person cannot choose and consent. IPC begins with the assumption that the individual is best placed to judge their own wellbeing. This assumption can of course be overridden if there are good reasons to do so. For example, there may be safeguarding concerns or resource considerations which lead to the CCGs concluding that an alternative decision or action is necessary to secure or promote the person's wellbeing.

In summary, this means we have to consider:

- Choice and control
- Suitability of living accommodation
- Contribution to society
- The person's views, wishes and feelings
- The outcomes the person wishes to achieve.

Whilst cost and resources to the CCGS should be taken into account, where there are a number of options available to meet outcomes, the decision must promote the person's wellbeing and independence.

There is no order of importance in the principles, and the weight afforded to each will differ according to the circumstances of the individual case.

This means there is not a hierarchy of principles and they do not all have to be in place. Rather, they must all be considered to assist in making a balanced and defensible decision when working with people, on the most appropriate way to meet their needs and achieve their outcomes.

The six guiding principles

1. Will admission to a care home promote living independently and wellbeing compared to other options that have been considered?

2. Is admission to a care home an appropriate and effective way to meet the person's needs and outcomes?

3. Is admission to a care home the informed choice of the person and takes account of reasonable preferences?

4. Is admission to a care home the only available and viable option?

5. Is a care home placement an efficient use of public resources?

6. Is a care home placement affordable for the lifetime of the person?

Annex D - Audit and Review of Personal Health Budgets – In development

Currently in development- will be added once finalised.

Annex E - Special/High Cost Case Panel Process – In development

Currently in development- will be added once finalised.