NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Nottingham City Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

Continuing Healthcare Children and Young People's Continuing Care and Joint Packages of Health and Social Care Services Commissioning Policy

2019-2022

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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. Introduction

1.1. This policy defines the way in which Nottingham and Nottinghamshire Clinical Commissioning Groups (CCGs), (which consist of NHS Nottingham City CCG, NHS Nottingham West CCG, NHS Nottingham North and East CCG, NHS Rushcliffe CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG) will commission packages of care for those individuals for whom the CCGs are the responsible commissioners.

1.2. It relates to people who have been assessed as eligible for fully-funded NHS Continuing Healthcare or Children and Young Person's Continuing Care; and joint funded packages of health and social care in accordance with the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (2018) and the Children and Young Person's Continuing Care National Framework (2016).

1.3. This Policy will define the way in which resources will be agreed and commissioned aiming to ensure the best use of NHS resources, providing a level of service that is sustainable and equitable (fair) to the health and well-being of the people of Nottingham and Nottinghamshire.

1.4. This policy supports the CCGs' strategic objectives in relation to:

- Delivering financial balance;
- Supporting the urgent care system;
- Establishing new commissioning and contracting currencies that support behaviour change;
- Establish ongoing underpinning and effective cultural and organisational development.

1.5. For the purpose of this policy the CCGs operating in Nottingham and Nottinghamshire will be collectively be known as the CCGs.

2. Purpose

2.1. The purpose of this policy is to ensure the quality of care delivered within the limitations of the CCGs' available financial resources, and to support consistency and equity of access to services for individuals assessed as eligible for NHS Continuing Healthcare, a health contribution to a joint package of health and social care and Children and Young People's Continuing Care.

2.2. The CCGs have a duty to operate within its financial framework which must be considered in addition to the Human Rights Act. The CCGs also have an obligation of equality under the Public Sector Equality Duty.

2.3. The policy should be read in conjunction with the National Framework for Continuing Healthcare and NHS Funded Nursing Care (2018) and the Children and Young Person's Continuing Care National Framework (2016).

2.4. The principles of this policy apply to the provision of Personal Health Budgets (PHB) and the Guidance for Use of PHB can be viewed by following the link - https://gnccpintranet.notts-his.nhs.uk/media/3051/personal-health-budget-guidance-july2019-final-for-sign-off.pdf

3. Scope

3.1. This policy applies to all the CCGs' staff, NHS Continuing Healthcare delivery team staff and individuals in receipt of NHS funding plus their representatives.

4. Definitions

4.1 A full list of definitions can be found at Appendix I.

5. Roles and Responsibilities

Roles	Responsibilities
Directors	Directors have overall accountability for all aspects of an individual's safety within the CCGs and to ensure appropriate care is delivered. The CCGs' Directors are responsible for the implementation of all relevant policies and arrangements within their areas of control and to lead their managers and staff in proactive and effective risk management.
Chief Nurse	The Chief Nurse leads the Continuing Healthcare Team and has a consultative and advisory role in clinical and operational aspects within the team. The Chief Nurse ensures that the CCGs have met their responsibilities as set out in the National

Roles	Responsibilities
	Health Service (Commissioning Board and Clinical Commissioning Groups Standing Rules) Regulations 2012.
Heads of CHC and Case Managers	Responsible for ensuring that the CHC team work to the National Framework and the CCGs' policies related to CHC and for ensuring the delivery of best possible health and well-being outcomes, as well as working to promote equality, and achieving this with the best use of available resources.
CHC Delivery Unit staff	All members of CHC staff have a responsibility to familiarise themselves with the contents of the Policy.

6. Commissioning

6.1. The CCGs are committed to working in partnership with Nottinghamshire County Council and Nottingham City Council, and have adopted the approach and principles outlined in Nottinghamshire County Council's Adult Social Care Charter, in the commissioning of Continuing Healthcare and Continuing Care, to reflect our joint approach to personalised 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, wherever possible, 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.

7. Principles

7.1. Where an individual is eligible for NHS Continuing Healthcare or Continuing Care (Children and Young Persons), the CCGs are responsible for care planning, commissioning services, and for case management. Individuals will be in receipt of a package of care delivered either in a specialist environment (e.g. Care Home with Nursing) or as a domiciliary care package.

7.2. It is the CCGs' responsibility to determine what type of package will be suitable and appropriate in meeting the individual's needs whilst at the same time having due regard to personal wishes and preferences.

7.3. The CCGs have obligations of equality under the Public Sector Equality Duty and a duty to operate within its financial framework which must be considered in addition the Human Rights Act.

7.4. The CCGs also have a responsibility to promote a comprehensive health service on behalf of the Secretary of State and to offer individual choice but within the constraints of the resources available to it.

7.5. The balance between cost and individual choice should be applied consistently and equitably across all individuals eligible for Continuing Healthcare and Continuing Care thus this policy sets out the principles which will be applied to all decisions.

7.6. It is the responsibility of the NHS to make reasonable offers of services to individuals eligible for Continuing Healthcare to meet their assessed needs. If offers of reasonable services are made to individuals to meet their assessed needs and refused, the CCGs have discharged their legal duty to those individuals.

8. Safer Patients, Safer Cultures and Safer Systems

8.1. Whilst safety is not an absolute concept and evolves with the changing demands of needs and system priorities, the CCGs are continuously working to improve patient safety. Patient safety will always remain paramount in planning a care package and will not be compromised.

8.2. The CCGs will only commission packages of care provided that the care can be delivered safely without undue risk to the individual, the staff or other members of the household (if a domiciliary package) and the level of risk is acceptable to the individual with capacity. If the individual lacks capacity to make a decision regarding risk, the CCGs' policy on decision-making under the Mental Capacity Act 2005 must be followed.

8.3. It is vital that the person centred support plan and any undertaken assessments, capture the complexity of the individual's needs, providing the necessary evidence

that the needs are of such a level which warrants the requested care package. This will enable the CCGs to better understand, better commission and to effectively manage the needs of individuals within the population they serve.

8.4. For assessed needs to be approved by the CCGs, they must be identified and detailed in the person centred care and support plan and must be:

- **Lawful**: The proposed package of care should be legitimately within the scope of the funds and resources that will be used. The package of care must be lawful and regulatory requirements relating to specific measures proposed must be addressed.

- **Effective**: The proposals must meet the person's assessed eligible needs and support the person's independence, health and well-being. A risk assessment must be carried out and any risks identified that might jeopardise the effectiveness of the plan or threaten the safety or well-being of the person 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.

- **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 it is within the indicative budget or, if the indicative budget is exceeded, a clear and reasoned explanation is provided to justify the additional spend.

- **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.

8.5. There may be circumstances where concerns are raised about the quality of care from a provider. The CCGs will work with individuals and their families to commission an alternative package of care whilst quality concerns are investigated.

8.6. In all cases, the CCGs will work with individuals to ensure that the person-centred support plan and care provision is managed on an individual basis and responsive to their changing needs and circumstances.

8.7. The CCGs are committed to ensuring that a high quality, person-centred approach is at the heart of everything we do, whilst remaining focused on safe and effective care.

9. Assessment and Decision-Making

9.1. The process of assessment and decision making should be person-centred. This means placing the individual, their perception of their support needs, and their

preferred models of support at the heart of the assessment and care planning process.

9.2. When deciding on how their needs are met, the individual's wishes and expectations of how and where the care is delivered should be documented and taken into account, along with the risks of different types of provision and access to resources (National Framework 2018).

9.3. The need to balance individual choice alongside safety and value for money means the CCGs have to ensure consistent decision-making providing transparency so that decisions are:

- Person-centred;
- Robust, fair, consistent and transparent;
- Based on objective assessment of the individual's clinical need, safety and best interests;
- Have regard for the safety and appropriateness of care to the individual and those involved in care delivery;
- Involve the individual and their appointed representative wherever this is possible and appropriate;
- Take into account the need for the CCGs to allocate resources in the most cost effective way;
- Support choice to the greatest extent possible in the light of the above factors.

9.4. The PHB Guidance details the particulars and specifics of individualised personalised care supported by an individual's support plan.

10. Commissioning Care Placements (Residential or Home Care)

10.1. The package of care to be provided will be assessed by the CCGs to meet all of the individual's assessed health needs and associated care and support needs. It is the CCGs responsibility to determine what this appropriate package should be involving the wishes of the individual and their family in every step where possible.

10.2. The CCGs have a legal duty to commission services for assessed needs as determined in the care plans and CHC/CC assessment tool. The CHC assessment and the Decision Support Tool (DST) are enhanced by the Person Centred Care and Support Plan.

10.3. 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. The CCGs have discretion as to the manner of provision of NHS Continuing Healthcare and Continuing Care services and must exercise reasonable judgment to provide the most appropriate care within the resources available taking into account overall expenditure.

10.4. The CCGs will therefore always consider value for money when commissioning packages of care for individuals.

10.5. Where there is evidence that a person's outcomes can be met in a more cost effective way, this will be the level of resource that is offered.

10.6. The CCGs do not routinely fund:

- Care at home when a risk assessment identifies risks that cannot be managed in the community and can only be managed with 24 hour care which is not provided in a domiciliary setting.
- Care at home when the person requires 24 hour oversight by a registered nurse or registered Mental Health Nurse due to their health needs (nursing home placement only).
- Care at home when a safeguarding assessment and plan identifies risk factors that can only be managed with 24 hour care.
- Care at home when a person has night time needs which cannot be managed by support in the community.
- Care at home when there are repeated admissions into hospital as a result of the person's risks and that they are unable to manage at home.
- Ongoing payment for care packages (at home or in the community) where the person is in hospital for longer than six weeks.
- 24 hour one-to-one care in a nursing home setting.
- Cases where the provision of care at home is significantly more expensive than the cost for care in a residential setting.

10.7. The CCGs will only fund packages detailed above in exceptional circumstances, taking into account the following considerations:

- 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 their 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 realised.
- 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. This excludes single periods of cost increase to cover an acute episode and end of life care where the individual is in the terminal stage and hospital admission can be prevented.

10.8. The CCGs will require additional assurance, for example High Cost packages where the cost of care exceeds £3,000 per week, and contentious cases irrespective of cost. High cost packages will be managed in accordance with the Special/High Cost Funding Policy at **Appendix A**.

10.9. Any authorisation will be made in reference to the legal duties of the CCGs and its financial obligations as stated above.

11. One-to-One Observations (1:1)

11.1. This a guide to all care homes and NHS continuing healthcare staff when requesting One to One observations within the adult NHS Continuing Healthcare Services in the CCGs (see **Appendix D**). The purpose is to:

- Implement the 1:1 pathway across all care homes commissioned to provide services for CHC eligible residents.
- Implement standardised forms to use when requesting 1:1.
- Ensure that providers have accessed NHS universal services prior to requesting 1:1.

  Ensure all requests for 1:1 by care homes adhere to the NHS Continuing Healthcare (2018) Framework which stipulates the elements of a good multidisciplinary assessment of needs (paragraph 21).

12. Respite

12.1. Respite is an interim short term arrangement for carers which provides relief from their caring duties.

12.2. The CCGs will commission a maximum of 42 nights for respite in any continuous 12 month period.

12.3. Requests for respite which surpasses the allocated 42 nights per annum will not be classified as respite and trigger a package review to determine the appropriateness in meeting clinically assessed needs.

13. Night Sitting Service (Waking Nights)

13.1. Night sits provide individuals with the care and support needed at home overnight and who may be at risk of hospital admission.

13.2. The CCGs will commission a maximum of three waking night sits per week as detailed in the person-centred support health plan.

14. Transport

14.1. The CCGs will only pay for the individual's assessed needs or services as outlined and agreed in their person-centred care and support plan.

14.2. Funding will not be authorised for those individuals with a Motability Scheme or on a Higher Mobility Allowance as running costs for these vehicles will be met[1] by the Motability Scheme, Department of Work and Pensions and other government funding.

14.3. In all cases receipts most be produced at all time as part of the CCGs quality and auditing process ensuring accountability and responsible spending of tax payer funded care.

15. Day Care Centres

15.1. It is expected that care home weekly fees will cover resident entertainment and activities provided within the home setting as part of their contractual obligations and duty of care to residents. The CCGs will not commission extracurricular activities for care home residents to attend day centres.

16. Jointly Funded Packages

16.1. In some cases where a person does not demonstrate a primary health need, the CCGs may still commission a package with the local authority in which the CCGs accept 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.

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

16.3. 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. The CCGs will not fund therapies available in a care home (e.g. physiotherapy/ occupational therapies at additional charges) that would otherwise be accessed via core NHS services.

[1] (https://www.motability.co.uk/about/how-the-scheme-works/how-your-vehicle-can-be-used/)

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

17.1. If an individual who is currently self-funding a home care package or care home placement becomes eligible for NHS Continuing Healthcare and the current charge 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.

17.2. In all cases, the principles around what care is commissioned will be in line with the principles detailed in Section 7 of this policy.

18. Funding Arrangements for Individuals receiving Services outside the CCG area

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

19. Private Funding of Care

19.1. The decision to purchase private care services should always be a voluntary one and not imposed upon individuals. The CCGs do not permit individuals or their representatives to 'top-up' the cost of placements, accommodation and packages of care. This is in line with the NHS Constitution which affirms that individuals should never be charged for their NHS care, or be allowed to pay towards an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.

19.2. Individuals cannot pay for top-up for higher cost services and/or accommodation if it is considered part of their assessed needs and package of care. The only alternative would be for the individual to fund the entirety of their own package.

19.3. Where top-up funding is to meet an individual's preference not an assessed need, there should be a clear separation between NHS and private care.

19.4. A 'separation' is described as usually requiring the privately-funded care to take place in a different location and at a different time to the NHS-funded care (Guidance on NHS Individuals Who Wish to Pay for Additional Private Care, 2009). Private services which can be purchased separately include hairdressing, aromatherapy, beauty treatments and entertainment services.

20. Changes in Circumstance

20.1. 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 or Continuing Care, the CCGs will no longer be required to fund their care.

20.2. The CCGs will provide 28 days' written notice of cessation of funding to the individual and the local authority from the date of the CCGs' decision. 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.

20.3. 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 care with the least disruption to the individual.

21. Mental Capacity

21.1. 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.

21.2. 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.

22. Review

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

22.2. For continuing healthcare for adults, this review is carried out in line with the continuing healthcare national service framework. For children this will be in line with the Children and Young Person's Continuing Care Framework.

22.3. 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.

22.4. 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.

23. Appeals

23.1. Where an individual is not satisfied with the choices offered to them, or believes that because of exceptional circumstances the principles in this policy are not applicable in their case, they may lodge an appeal by writing to the responsible CCG. The CCGs are only required to provide services that meet the assessed needs of the individual. 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 authority.

23.2. 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.

23.3. 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.

23.4. 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, the CCGs 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.

23.5. 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.

24. Article 8 of the Human Rights Act

24.1. The CCGs have obligations of equality under the Public Sector Equality Duty and a duty to operate within its financial framework which must be considered in addition the Human Rights Act.

24.2. The CCGs also have a responsibility to promote a comprehensive health service on behalf of the Secretary of State and to offer individual choice, but within the constraints of the resources available to it.

24.3. The Human Rights Act means an individual can take action in the UK courts if their human rights have been breached.

24.4. However Article 8 of the Human Rights Act is limited; this means rights can be restricted in specific situations set out in the Act. Interference is therefore permissible but must be justified with a legitimate aim making Article 8 a qualified right.

24.5. To prove objective justification, the aim must be a real objective consideration and not in itself discriminatory. For example, ensuring the health and safety of others would be a legitimate aim. Other examples of legitimate aim include the protection of other people's rights, the health, safety and welfare of individuals, running an efficient service, etc.

25. Equality and Diversity Statement

25.1 The Nottingham and Nottinghamshire CCGs pay due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, both as commissioners and as employers.

25.2 As a commissioning organisation, we are committed to ensuring our activities do not unlawfully discriminate on the grounds of any of the protected characteristics defined by the Equality Act, which are age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

25.3 We are committed to ensuring that our commissioning activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, roma and travellers.

25.4 As employers, we are committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

25.5 To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed for, and is attached to, this policy.

26. Communication, Monitoring and Review

26.1. The CCGs will establish effective arrangements for communicating the requirements of this policy and will provide guidance and support to line management in relation to their responsibilities.

26.2. This policy will be audited as to effectiveness of ensuring choice and equity in the delivery of NHS Continuing Healthcare or Children and Young Person's Continuing Care to individuals across the CCGs.

26.3. This policy will be reviewed every three years, or if there are changes in national guidance on individual choice or NHS Continuing Healthcare or Children and Young Person's Continuing Care.

26.4. Any individual who has queries regarding the content of the Policy, or has difficulty understanding how this relates to their role, should contact the CCGs' Continuing Healthcare Team via email: NCCCG.CHCTeam@nhs.net

27. Staff Training

27.1 Awareness of this policy will be proactively undertaken across the CCGs and ongoing support will be provided to individuals to enable them to discharge their responsibilities.

28. Interaction with other Policies

28.1. The policy should be read in conjunction with the National Framework for Continuing Healthcare and NHS Funded Nursing Care (2018) and the Children and Young Person's Continuing Care National Framework (2016).

29. References

1. CCG Commissioning Strategy: https://gnccpintranet.notts-his.nhs.uk/media/2954/nn-commissioning-strategy-2020-22.pdf

2. CCG Financial Strategy: https://gnccpintranet.notts-his.nhs.uk/media/2956/nn-financial-strategy-2019-20-to-2023-24.pdf

3. CCGs Safeguarding Policy: https://gnccpintranet.notts-his.nhs.uk/media/2931/nn-qual-001-safeguarding-policy-inc-prevent-and-safeguarding-training-strategy.pdf

4. Delayed Discharges Directions: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784710/Delayed_Discharges__Continuing_Care__Directions_2013.pdf and https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784711/Delayed_Discharges__Continuing_Care___Amendment__Directions_2018.pdf

5. Direct Payment: https://www.england.nhs.uk/wp-content/uploads/2017/06/guid-dirct-paymnt.pdf

6. Carers' Breaks and Respite Care: https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carer-breaks-and-respite-care/

7. Human Rights Act 1998, Citizens Advice Bureau & Equality and Human Rights Commission: https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty

8. Mental Capacity Act 2005: www.legislation.gov.uk/ukpga/2005/9/contents

9. Motability Scheme: https://www.motability.co.uk/about/how-the-scheme-works/how-your-vehicle-can-be-used/

10. National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care: https://www.events.england.nhs.uk/upload/entity/30215/national-framework-for-chc-and-fnc-october-2018-revised.pdf

11. NHS Choices Framework (2019): https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs

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

13. Patient Safety Strategy: https://improvement.nhs.uk/resources/patient-safety-strategy/

30. Equality Impact Assessment

Date of assessment:	**November 2019**			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Age[2]	Yes, there is a potential adverse impact on people of all ages but in particular the elderly as the CCGs may not fund a home care package due to risk and cost when significantly above a care home that can meet the assessed needs.	A personalised approach is offered through individual choice and control within the CCGs' available resources. The CCGs will ensure the balance between cost and individual choice is applied consistently and equitably across all individuals who are eligible for NHS funded care.	It may not always be possible to fund a home care package to the extent that a person/family desires. The CCGs will always work with patients and families to find the most appropriate way to meet identified needs. The CCGs will be responsive to changing needs and circumstances.	A person-centred approach will achieve better outcomes by promoting health, well-being and independence through choice and control.

[2] A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).

Date of assessment:	**November 2019**			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Disability[3]	Yes, there is a potential impact on people who do not have capacity to make decisions and choices about their care. The policy may impact on people with physical or learning disabilities when the person's preference is for a package of care at home which is high cost due to complexity and intensity of needs. There is a potential impact on people who have communication difficulties due to a sensory impairment.	CHC assessors are fully trained in use of the Mental Capacity Act and will work with fellow professionals and families to make best interest decisions where required. The CCGs will always give careful consideration to funding large complex homecare packages and take into full account where there is a lack of suitable care homes in the area.	No	N/A
Gender reassignment[4]	No, the CCGs' approach is to provide person-centred care to meet assessed needs which are taken into account as part of the care and support planning	N/A	N/A	N/A

[3] A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

[4] The process of transitioning from one gender to another.

Date of assessment:	**November 2019**			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
	along with the exceptional circumstances set out in section 10.7 of the policy.			
Marriage and civil partnership[5]	No, the CCGs' approach is to provide person-centred care to meet assessed needs which are taken into account as part of the care and support planning along with the exceptional circumstances set out in section 10.7 of the policy.	N/A	N/A	N/A
Pregnancy and maternity[6]	No, as the CCGs' approach is to provide person-centred care to meet assessed needs which are taken into account as part of the care and support planning.	N/A	N/A	N/A

[5] Marriage is a union between a man and a woman or between a same-sex couple.

Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.

[6] Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Date of assessment:	**November 2019**			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Race[7]	No, as the CCGs' approach is to provide person-centred care to meet assessed needs. Therefore any cultural needs are taken into account as part of the care and support planning along with the exceptional circumstances set out in section 10.7 of the policy. There is a potential impact on people who do not have English as a first language.	Mechanisms are in place via the Communications and Engagement Team to receive information in a range of languages.	N/A	N/A
Religion or belief[8]	No, as the CCGs' approach is to provide person-centred care to meet assessed needs which are taken into account as part of the care and support	N/A	N/A	N/A

[7] Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

[8] Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Date of assessment:	November 2019			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
	planning along with the exceptional circumstances set out in section 10.7 of the policy.			
Sex[9]	No, as the CCGs' approach is to provide person-centred care to meet assessed needs which are taken into account as part of the care and support planning.	N/A	N/A	N/A
Sexual orientation[10]	No, as the CCGs' approach is to provide person-centred care to meet assessed needs. Therefore all assessed needs are taken into account as part of the care and support planning along with the exceptional circumstances set out in section 10.7 of the policy.	N/A	N/A	N/A
Carers[11]	Yes, where a home care package	The CCG will endeavour to	No	N/A

[9] A man or a woman.

[10] Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

Date of assessment:	**November 2019**			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
	cannot be provided then attention should be paid to the location of the care setting to minimise the impact on family/carers for travel/ visiting etc. Where a homecare package is provided which relies on continued carer input then it is important to ensure there is some respite built into the package to give the carer a break.	place individuals in a care setting of their choice that can both meet assessed needs and is within the CCGs' contract with that care provider. Respite is always considered as part of a homecare package where informal/family carers are delivering some of the care.		

[11] Individuals within the CCGs which may have carer responsibilities.

Appendix A:

Continuing Healthcare (CHC) and Children and Young People's Continuing Care (CYPCC) Special/High Cost Funding Policy

CHC and CYPCC 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.

INTRODUCTION

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). Clinical Commissioning Groups (CCGs) have a responsibility to provide health benefits for the whole of their population, whilst commissioning appropriate care to meet the clinical needs of individual patients.

The CCGs have established the CHC and CYPCC commissioning policy to make best use of the resources available to them to provide care through the CHC and CYPCC process. As part of this policy there are a number of areas where additional approval may be required;

1. High cost packages where the cost of care exceeds £3,000.00 per week.
2. Contentious cases irrespective of cost.
3. Cases where the provision of a Personal Health Budget (PHB) to support care at home is significantly more than a PHB for care in a residential setting.

Additionally, the process set out in this document will be used to consider all funding requests for CHC and CYPCC which fall outside the agreed policies or where there is there is significant concern or complexity around the funding requested.

This process will ensure that these requests are considered in a fair and transparent way, with decisions based on the best available evidence and in accordance with the CCGs' commissioning principles.

PROCESS

This process will apply to any patient for whom the CCGs are the responsible commissioner.

The CHC or CYPCC process should be followed as usual, as soon as it becomes clear that a case may fall into one of the categories identified above additional approval should be sought. This can happen at any stage in the process but should be as soon as all relevant needs, health outcomes, care options and costs have been established so that the appropriate decisions are shared with the patients and local authority in a timely manner.

All requests for consideration under this policy should be discussed with the Head of Quality and

Personalised Care who will work with the Head of CHC to undertake a quality review and identify a course of action, or potential options in line with the CHC and CYPCC Commissioning Policy, previous cases and/or legal or professional advice

Requests will be emailed to the Deputy Chief Nurse for consideration who, will, form a virtual Panel including senior finance and contracting managers.

If the Head of CHC determines that a case is clinically urgent at any point in the process the decision will be expedited as soon as reasonably possible.

The Head of CHC will maintain a record of referrals and responses in order to inform consistent decision-making and future reviews of the CHC and CYPCC Commissioning Policy.

COMMISSIONING PRINCIPLES THAT UNDERPIN DECISION MAKING

When considering a request, in addition to the principles and process outlined in the CHC and CYPCC Commissioning policy the Panel will also ensure that decisions:

- Comply with relevant national policies or local policies and priorities that have been adopted by the CCGs concerning specific conditions or treatments.

- Are based on the available evidence concerning the clinical and cost effectiveness of the proposed care package or placement.

- Address any contractual, CQC or safeguarding issues.

- Are taken without undue delay; a pragmatic approach may need to be taken when dealing with urgent requests i.e. where a delay in reaching a decision to fund adversely affects the clinical outcome.

- The CCGs consider all lives of all patients to be of equal value and in making decisions about funding treatments will seek not to discriminate on the grounds of age, sex, sexuality, race, religion, lifestyle, occupation, family and caring responsibilities, social position, financial status, family status (including responsibility for dependents), intellectual/cognitive functioning or physical functioning save where a difference in the treatment options made available to patients is directly related to the patients clinical condition or is related to the anticipated clinical benefits for this individual to be derived from a proposed form of treatment.

Last Reviewed: **September 2019**

Next Review: **April 2020**

Appendix B: High Cost Cases Template

Sign off for High Cost Cases
(packages of £3k plus per week and contentious cases)

Patient's Name:	
Patient's Date of Birth:	
Patient's QA Number:	
Proposed cost of Package:	Weekly:
	Annually:
Proposed start date:	
Details of Package *[Include details of existing package, any alternatives explored, confirmation of any negotiation with Providers etc.]*	
Rationale as to why this Package is the best option *[In terms of value for money and quality]* Or: **Reason for referral to the Special/ High Cost Virtual Panel** *[In terms of contentious nature of significant cost]*	
Signed:	Printed Name: Title: Date:
Signed:	Printed Name: Title: Date:

Appendix C:

Decision Framework Document for Continuing Care High Cost/ Contentious Packages Panel

STRICTLY PRIVATE AND CONFIDENTIAL

All attendees should be aware of the Clinical Commissioning Groups' participation in the Freedom of Information Act. The minutes and papers from this meeting could be published on the Publication Scheme and be made available to the referring clinician and patient.

Notes of Guidance:

1. A copy of this form is to be provided to each panel member for each person in respect of whom an application is being considered.

2. The copies will, at the end of the meeting, be collected and retained by the CHC administrator.

3. The Framework will be used to inform the letter to be written by the Chair of the Panel.

Case to be considered	
Patient's QA number:	
Patient's Date of Birth	
Current cost of Package:	Weekly:
	Annually:
Proposed cost of Package:	Weekly:
	Annually:
Proposed start date:	
Details of Package *[Include details of any existing package, any alternatives explored, confirmation of any negotiation with Providers etc.]*	
Rationale as to why this Package is the best option *[In terms of value for money and quality]* Or: **Reason for referral to the Special / High Cost Panel** *[In terms of its contentious nature and or significant cost]*	
Referrer: Signed:	Signature: Title: Date:
Decision: Signed:	Signature: Title: Date:

No	Points for consideration	Discussion notes	Decision
	Individual Need for Care		**Yes/No**
1.	Is this request for a new package of care or to update an existing package?	New/Existing	
2.	Is the request person-centred?		
3.	Has the least restrictive offer been considered?		
4.	Is this request for 24 hour nursing care at home?		
5.	Is this request for 24 hour trained carers support?		

No	Affordability	Discussion notes	Decision
6.	Is the cost more than 50% of the existing care package?		
7.	Is the cost more than 25% of a care home placement that would be able to meet the assessed needs?		
8.	Children and SEN only - Should/could education be contributing to this package?		
	Other factors		
9.	Are there any other factors which were considered relevant by the Panel?		

	SUMMARY		
	Funding Approved:	**Any conditions / review mechanisms required.** **Outcome measures to be monitored and date of review.**	
	Funding Denied	**Reasons**	

RETURN THIS FORM TO THE PANEL ADMINISTRATOR AFTER THE MEETING

Appendix D:

One-to-One Observations Guide for Fully Funded NHS Continuing Healthcare Residents in Care Homes

Introduction

This is a guide to all care homes and NHS Continuing healthcare staff when requesting One to One observations within the adult NHS Continuing Healthcare services in Nottingham and Nottinghamshire Clinical Commissioning Groups which are NHS Nottingham City CCG, NHS Nottingham West CCG, NHS Nottingham North and East CCG, NHS Rushcliffe CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG).

In addition to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care *October 2018 (Revised),* this policy will serve as a framework to support the decision making process as to whether additional levels of One to One observations should be commissioned by Nottingham and Nottinghamshire Clinical Commissioning Groups as part of a resident's care package within a care home.

The primary aim of One to One observations is to ensure the resident's safety following an appropriate clinical and risk assessment. This type of observation is highly restrictive and should not be regarded as part of a routine practice - rather, it must be based on the resident's current assessed clinical needs. Care homes are encouraged to employ the least intrusive method of observations where possible.

For the purpose of this policy, One to One observations shall mean:

> "*One designated healthcare staff member who is knowledgeable and trained about the resident's care plans and risk assessments, assigned to one resident for attentive continuous observations during a set period of time each day. The healthcare member of staff must have immediate access to the resident at all times and ensure the resident is always kept within arms' length and eyesight."*

The assigned resident becomes the member of staff's sole responsibility for the duration of the prescribed One to One observational hours therefore no other resident shall be assigned to that member of staff during that period. Care homes should make arrangements for interim cover when the member of staff providing One to One observations has a break, etc.

The Department of Health advocates a culture whereby care providers should use restrictive interventions such as One to One only as a *last* resort and for the shortest possible time *(Positive and Proactive Care: reducing the need for restrictive interventions, 2014).*

Purpose

The purpose of this guide is to:

- Implement the 1:1pathway (**Appendix E**) across all care homes commissioned to look after CHC eligible residents

- Implement standardised forms to use when requesting 1:1 (**Appendixes F, G and H**)

- Clarify the request and approval process of 1:1

- Ensure that providers have accessed NHS universal services (Community Mental Health, Falls clinic, etc.) prior to requesting 1:1

- Ensure all requests for 1:1 by care homes adhere to the NHS Continuing Healthcare (2018) framework which stipulates "*the need for a clear clinical rational and evidence to support any subjective judgement in relation to resident needs to enable the commissioning of an appropriate care package."*(PG 21.2)

Definitions

One to One observations (1:1)	Attentive continuous observations during a set period of time each day. For the purpose of this guide, One to One observations shall hitherto be referred to as 1:1.
Observation Levels: NICE Guidelines 10 (2015) describes four levels of observation:	**Low level intermittent observation (Level 1):** This is the minimum level of observation for all residents in resident areas. Staff should know the location of all residents in their area, but residents need not be kept in sight. Residents subject to general observations will normally have been assessed as being a low-risk to themselves or others. Their location and safety will be checked at a minimum of hourly intervals.
	High level intermittent observation (Level 2): Usually used if a resident is at risk of becoming violent or aggressive but does not represent an immediate risk. The frequency of observation is once every 15–30 minutes. This means that the resident's location and safety must be visibly checked at specified intervals and recorded in the Care Plan.
	Continuous observation (Level 3): Usually used when a resident presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated 1:1 healthcare staff, with immediate access to other members of staff if needed.
	Multi-professional continuous observation (Level 4): Usually used when a resident is at the highest risk of harming themselves or others and needs to be kept within eyesight of two or three staff members and at arm's-length of at least one staff member.

The Nottingham and Nottinghamshire Clinical Commissioning Groups (CCG)	Responsible for commissioning health services for the population of Nottingham and Nottinghamshire.
NHS Continuing Healthcare (CHC)	CHC applies to care provided to persons aged 18 or over to meet the physical or mental health needs which have arisen as a result of disability, accident or illness. It may require provision by the NHS of health services and social care services and can be provided in a range of settings. CHC is not awarded indefinitely, but is subject to regular eligibility reviews.
NICE Guidelines (NG)	National Institute for Health and Clinical Excellence Guidelines- provides national guidance and advice to improve health and social care.
Mental Capacity Act (MCA)	An act designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.
Deprivation of Liberty (DOLS)	This applies when the person is under continuous supervision control and is not free to leave lacking capacity to consent to these arrangements.

Roles and Responsibilities

Directors	Directors have overall accountability for all aspects of resident safety within the CCG and to ensure appropriate care is delivered. CCG Directors are responsible for the implementation of all relevant policies and arrangements within their areas of control and to lead their managers and staff in proactive and effective risk management.
Deputy Chief Nurse (DCN)	The DCN is responsible for ensuring there are appropriate systems and processes in place for the safe observation and supervision of residents whilst improving their care & wellbeing, as far as reasonably practicable.
Heads of CHC (Delivery Units) and Case Managers	Have responsibility for supporting CHC staff to identify residents who may need additional observations. They should support staff to review submitted clinical documents to inform appropriate decision making around those people who may require additional care and supervision and signpost for additional support e.g. Dementia Outreach, Falls Clinic, etc. They also have a duty to ensure all staff and providers are aware of and comply with this policy.
CCG CHC Delivery	All CHC staff have a responsibility to familiarise themselves

Unit staff	with the contents of this policy ensuring that all requests receive from providers for 1:1 have adhered strictly to the guidelines. Clinical staff should make sure that there is no mismatch with evidence submitted and the request.

Process

The 1:1 pathway (**Appendix E**) ***must*** be followed by all care homes requesting level 3 or level 4 1:1 support for residents. The CCGs will authorise 1:1 ***only*** where there is *a* ***clear documented clinical rationale which is evidenced and supported by appropriate risk assessments.***

All 1:1 requests ***must be emailed*** to the resident's CHC Case Manager and be accompanied by the *Request Log (L1), 24hr Record Log (L2) and Daily Care Log (L3)* {see **Appendixes F, G and H**}; with the relevant resident care plans, risk assessments and records, etc. which clinically evidences the need for level 3 or level 4 1:1.

The CCGs acknowledge that some care homes will already have care records which replicate forms L1, L2 & L3. In this instance, the care home records which mirror the precise content of forms L1, L2 & L3 will be accepted eliminating duplication of records.

In line with the Caldicott Principles, care homes should ensure that Resident Identifiable Data should not be used and that likelihood of identifiability is minimal. Therefore all 1:1 requests and supporting documents emailed to the CCG should not contain residents' names but rather their QA number and date of birth. All CHC fully funded residents in care homes have a QA number.

The Request Log (L1) must state the hours of the 1:1 request and intended length (see **Appendix F**). Care homes should also state what clinical or therapeutic interventions have been undertaken prior to requesting 1:1

Residents with a falls history or assessed as high risk of falls will not typically be approved for 1:1 funding by the CCG as care homes are expected to utilise assistive technology , multifactorial assessments and interventions to abate any associated falls risk. This is in line with NICE Clinical Guidelines 2013 [CG161 2013].

Upon receipt of the documentation outlined in 6.2 above the CHC Case Manager can authorise 1:1 for a maximum of two weeks and advice the CCG within 24 hours so this can be recorded on the database for invoice purposes. It should be noted that not all 1:1 request will automatically be authorised for two weeks. The needs of residents at the time of request will be assessed and a shorter period of less than two weeks may be authorised as appropriate.

1:1s must be reviewed and documented three times daily (AM, PM, EVE and when needs change) by the care home. The Daily Care Log (L3) must be sent to the CHC Case Manager when seeking a further extension beyond an initial 1:1 approved date.

In the first instance the CCG will only approve additional funding for level 3 or level 4 1:1 for a maximum of two weeks only. Any requests for 1:1 exceeding two weeks will trigger a CHC review to enable the CHC Case Manager to assess the appropriateness of the care package in meeting the resident's clinical needs. This review may be conducted face to face or by telephone but in either case will require forms L1, L2 and L3 to be updated by the care home in advance.

Care Homes must ensure that healthcare staff who provide1:1 support are rostered in as ***additional*** support specifically for the provision of 1:1. Therefore they do not count as part of the core healthcare staff on floor duty for looked after residents. In the event of the home using external healthcare agencies to provide1:1 support, these agencies must be Care Quality Commission (CQC) registered and compliant. It is expected that if any registered nurses are used by care homes, that they are registered with the Nursing and Midwifery Council (NMC) and have a valid pin.

The hourly rate for level 3 or 4 1:1 will be set by the CCGs on an annual basis; care homes must always obtain approval in email or writing from the CHC Case Manager before implementing level 3 or level 4 1:1. The CCG will not fund care for which there is no agreed, evidenced clinical rational and where the 1:1 pathway has not been followed.

To facilitate payment, copies of 1:1charts, care plans and any other additional validation information must be provided upon request including staff timesheets and daily staff rotas.

Requests from family members/representatives to initiate or continue 1:1where there is no clinical rationale will not be authorised and invoices will not be paid. Families, however, are at liberty to make private contractual arrangement with the care home for interventions and care outside of the assessed clinical need as indicated within the residents care plan. It must not, however, include any core services/costs funded under contract by the CCG.

1:1 observations should only be in place as an interim measure for the least amount of time clinically, after all steps and interventions taken to reduce the risk of harm to the resident and others has failed.

Out of Hours 1:1 Request
All requests made for 1:1 outside of the CCGs' operational hours (Monday to Friday, 9:00 – 17:00) ***must*** follow the 1:1 pathway (**Appendix E**).

Care homes have a statutory duty to ensure residents' safety balanced by appropriate staffing levels. It is expected that if after following the 1:1 pathway clinical assessments evidence the need for level 3 or level 4 1:1 observations, outside of the CCGs' working hours, a care home is to implement 1:1 as an interim measure for the wellbeing of its residents.

The onus is on care homes to provide CCGs with the ***clinical rationale*** and ***clinical evidence*** which supports the need for 1:1so the CCGs are able to retrospectively approve the 1:1 request on the following working day facilitating payment.

However the CCGs will ***not*** approve a 1:1 for which there is no ***evidenced*** clinical rational and where the 1:1 pathway has not been followed.

Mental Capacity Act and Deprivation of Liberty Considerations
The Mental Capacity Act places responsibility on organisations to protect an individual's right to liberty and to undertake certain procedures where they are, or need to deprive an individual of their liberty. These procedures are known as Deprivation of Liberty Safeguards (DOLS).

If an individual is assessed as lacking mental capacity to make decisions in relation to their care and support needs, any act undertaken for, or any decision made on behalf of that person, must be made in their best interest. The Mental Capacity Act sets out a checklist of factors to be considered when undertaking best interest decisions. The two stage capacity assessment (as outlined in the MCA 2005 Code of Practice) must be completed in relation to the specific decision in order for you to be able to evidence that the individual lacks the capacity to make that decision.

You must then go on to make the decisions in their best interest and following the guidance in the MCA Code of Practice Chapter 5 (2005).

1:1 must be set at the least restrictive level for the least amount of time within the least restrictive environment. General observations will be the presumed level of 1:1required. Justification through assessment will be required to move up (or down) the levels in response to the resident's condition. It is essential that any change in requirement is communicated effectively and the situation managed sensitively and effectively.

If an organisation, through assessment, deems it necessary to place one or a number of restrictions on an individual for their own safety or the safety of others, or the required level of 1:1requires restrictions to the individual's liberty, then Deprivation of Liberty Safeguards (DOLS) will need to be considered.

The MCA applies to people aged 16years and over and who are assessed to lack capacity to make decisions commonly (but not exclusively) around residency and their care and support needs.

A Deprivation of Liberty Standard Authorisation will apply to those aged 18 years and over and are deprived of their liberty in a managing authority such as a care home or hospital.

The local authority is responsible for authorising that deprivation. Where the deprivation of liberty occurs in a person's own home or supported living and they are aged 18 years and over then an application must be made to the Court of Protection to authorise the deprivation.

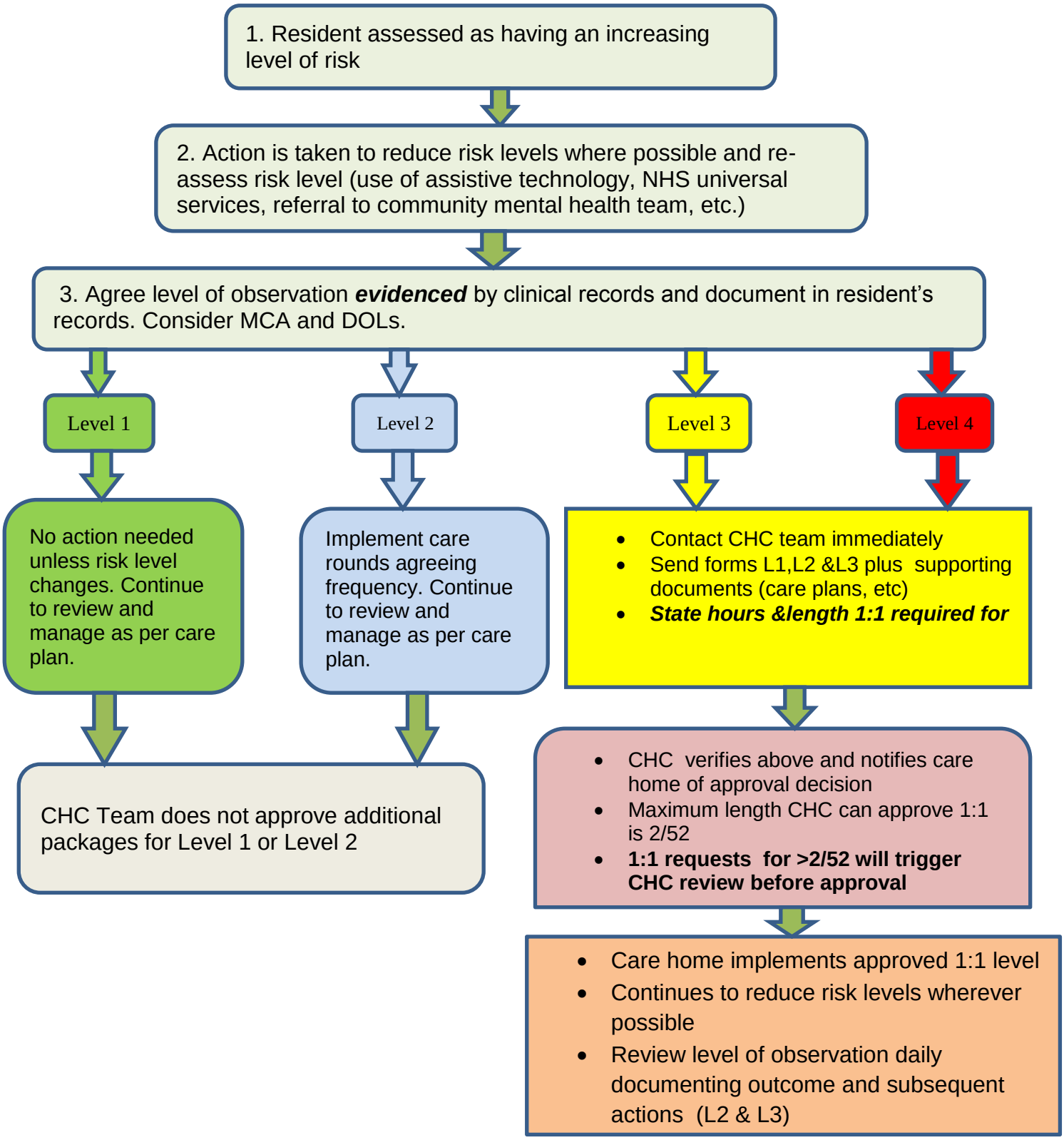
In situations where residents without capacity are supervised as part of their 1:1 observations in the confinement of a room or separated from all other people other than members of staff, it may be interpreted as seclusion. A clear rationale for seclusion must be identified and documented in the resident's notes. If a DoLS standard authorisation is in place, then consideration must be made to contacting the best interest assessor if and when restrictions and restraints are required so the authorisation can be amended.

Mental Health Act Considerations

In residents believed to be at risk to themselves or others as a result of a mental health diagnosis and any associated symptoms, it may be necessary to enforce treatment and admission to hospital. This must be done in accordance with the Mental Health Act 1983.

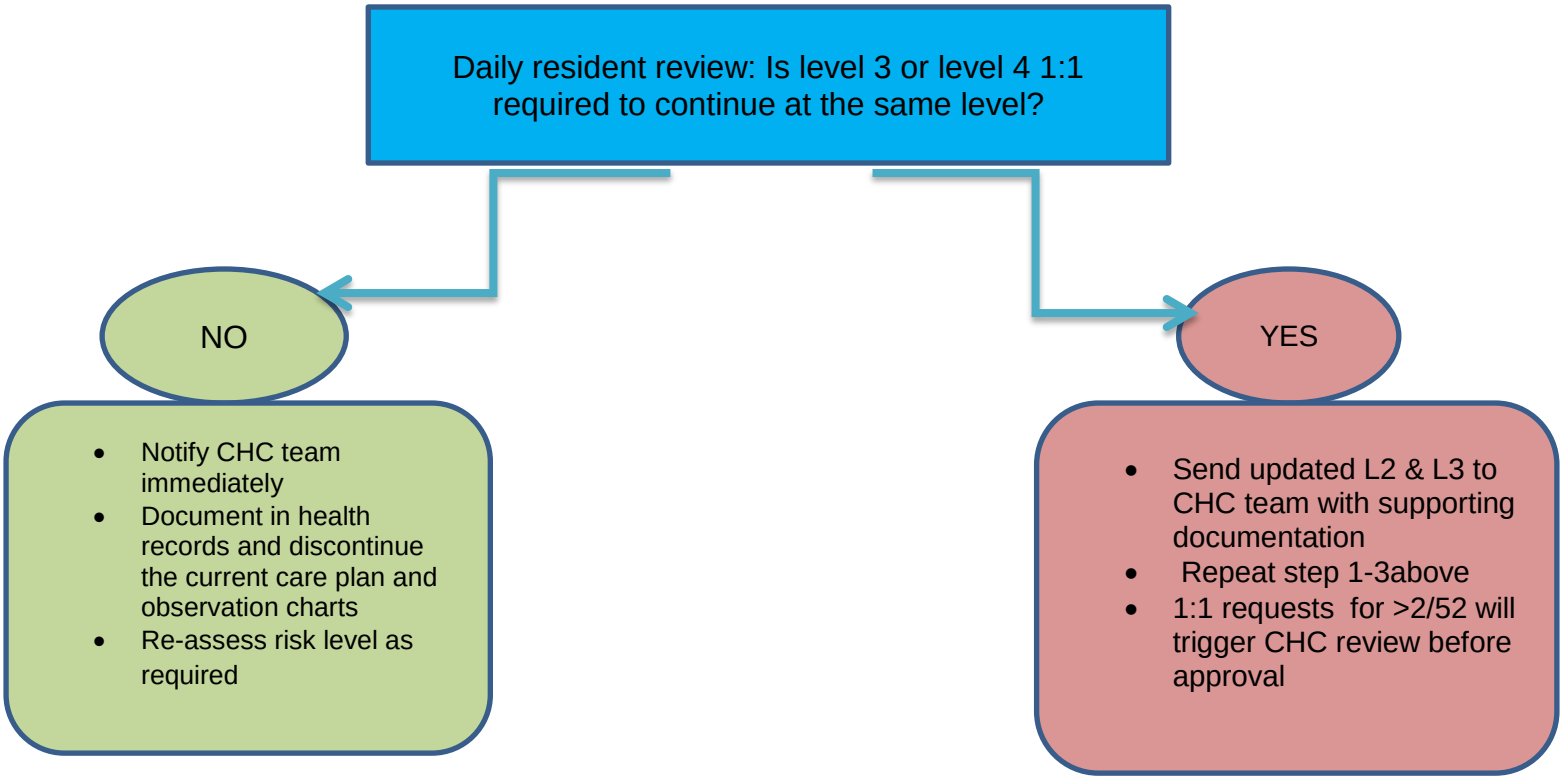
Appendix E

1:1 Pathway for fully funded NHS Continuing Healthcare residents in Care Homes



Appendix E (cont.)

1:1 Pathway for fully funded NHS Continuing Healthcare residents in care homes



All 1:1 requests and accompanying documents must be emailed to:
NCCCG.CHCTeam@nhs.net

Appendix F

Request Log (L1)

Date: **QA Number:** **DOB:** **Nursing Home:**

Resident Condition & Diagnosis	***Clinical*** **Rationale for Requesting 1:1** ***(please also submit clinical current evidence which supports this request)***	**Specific Requirement**
Example: Recently Diagnosed with Alzheimer's on 24/08/19	*Example: Daily episodes of distress expressed by violence and restlessness between 17:00-20:00 towards staff and residents. Lashing out unprovoked hitting and punching other residents. Behaviour consistent with symptoms of sun downing. Recent evidence of 1:1 records, behaviour charts, incident forms, behaviour care plans and risks assessments attached. GP aware & Community Mental Health Team (CMHT) reviewing on 1/10/19.* **Clinical & Therapeutic Interventions Undertaken Prior To Requesting 1:1*****(please state what clinical measures are in place as per care plan to manage above and if this has been followed):*** *As per the care plan, staff have sought to engage positively with XXX speaking calmly and reassuringly. Responds positively well to alone time in quiet room with a member of staff providing 1:1. Staff engage with XXX during this period playing games and listening to music. Therefore 1:1 required during this period only until reviewed by CMHT on 1/10/19.*	*Example: Three hours of 1:1 care requested between 17:00 – 20:00 until 1/10/19.*

Name, job title & signature:

Appendix G

24hr Record Log Form (L2)

Date: **QA Number:** **DOB:** **Nursing Home:**

Time	Describe Mental State/behaviour/interaction with staff and residents	State Care Intervention Given	Any other comments	Name, job tittle & signature
Example 17:00	*Restless and agitated. Attempted to hit another resident during supper*	*Reassured xxx speaking calmly – taken to the quiet room to finish his meal*	*Remained with xxx in the quiet room until he finished his supper and took his medications. Played games after meals and listened to music. No further incidents*	
0800				
0900				
1000				
1100				
1200				
1300				
1400				
1500				
1600				
1700				
1800				
1900				
2000				
2100				
2200				
2300				

A detailed One to One record log completed within a 24 hour period over must accompany all requests for One to One

Appendix G (cont.)

24hr Record Log Form (L2)

Date: **QA Number:** **DOB:** **Nursing Home:**

0000				
0100				
0200				
0300				
0400				
0500				
0600				
0700				

A detailed One to One record log completed within a 24 hour period over *must* accompany all requests for 1:1

Appendix H

Daily Care Logs (L3)

QA Number: **DOB:** **Nursing Home:**

Date & Time	Current Level of 1:1 (3 or 4)	Describe the resident's condition during 1:1	Level of 1:1 still required	What is the ***clinical rationale*** for this level of 1:1 post review (if applicable)	Next Review Date & Time	Name, job tittle & signature
Example 24.9.19 20:00	*Level 3*	*Consistently distressed expressed by aggressive and violent behaviours towards staff and residents during periods of 17:00-20:00*	*3*	*Remains aggressive during hours of 17:00 -20:00. Responds positively to 1:1 during this time.*	*25.9.19 08:00*	

***1:1s *must* be reviewed & documented three times daily (am, pm, eve & when needs change).**
This form must be sent to the CHC team when seeking a further extension beyond the initial 1:1 approval date*
All requests for 1:1 lasting over a two week period will have a CHC review to determine the accurate change in residents' clinical needs

Appendix I:

Definitions

What is NHS Continuing Healthcare?
A package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a primary health need. Such care is provided to an individual aged 18 or over to meet health and associated social care needs that have risen as a result of disability, accident or illness.

CHC therefore describes a package of on-going care arranged and funded solely by the NHS. This includes all assessed health and associated social care needs including accommodation if that is part of the overall need.

The CCGs will commission CHC packages for individuals registered with a General Practitioner whose practice is a member of the CCG, and for individuals without GP registration who are usually resident in the areas of the CCGs.

The CCGs will only commission a package of CHC for individuals where a Decision Support Tool (DST) or Fast Track Tool (FTT) has been completed and it has been agreed that the individual has primary health need and therefore eligible for NHS Continuing Healthcare. This is supported by the National Framework, 2018, (pg. 19 – 68).

The assessment will be completed in accordance with the National Framework by a multi-disciplinary team of professionals trained in the assessment of Continuing Healthcare.

What is Children and Young People's Continuing Care?
A Children and Young Person's Continuing Care (CYPCC) package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

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 CCGs or NHS England. A package of additional health support may be needed which is known as continuing care.

Continuing care is not needed by children or young people whose needs can be met appropriately through existing universal or specialist services through a case management approach.

What are Joint Packages of Health and Social Care Services?
If a person is not eligible for NHS Continuing Healthcare, they may potentially receive a joint package of health and social care. This is where an individual's care or support package is funded by both the NHS and the local authority. This may apply where specific needs have been identified through the DST that are beyond the powers of the local authority to meet on its own.

This could be because the specific needs are not of a nature that a local authority could be expected to meet, or because they are not incidental or ancillary to something which the Local Authority would be doing to meet needs under sections 18-20 of the Care Act 2014. It should be noted that joint packages can be provided in any setting.

What is Fast Track?
Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require 'fast tracking' for immediate provision of NHS Continuing Healthcare. The intention of Fast Track is that it should identify individuals who need to access NHS Continuing Healthcare quickly, with minimum delay, and with no requirement to complete a DST. However not everyone at the end of their life will be eligible for, or require, NHS Continuing Healthcare as there are a number of end-of-life pathways which may be appropriate within local health and care systems.

What is a Personal Health Budget?
Personal health budgets are an amount of money to support a person's identified health and well-being needs, planned and agreed between the person or their representative 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 has the right to have a Personal Health Budget (PHB) but if they are offered one and they refuse one they are entitled to do so and care will need to be directly commissioned in those circumstances. 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 CCGs' overall budgetary allocation for NHS Continuing Healthcare.