NHS
North Cumbria
Clinical Commissioning Group

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Continuing Healthcare Equity & Choice Policy

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1. Preface

This policy describes the way in which the North of England Commissioning Support Unit's (NECSU) Continuing Healthcare Service (CHC), acting on behalf of North Cumbria Clinical Commissioning Group ('The CCG'), will make provision for the care of people who have been assessed as eligible for NHS Continuing Healthcare.

The purpose of this policy is to balance patient preference with safety, value for money and to provide transparency for those wishing to scrutinise the application of the CCG's Policy for NHS Continuing Healthcare and NHS-funded Nursing Care (see below)

Link: https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/nhs-continuing-healthcare/

All managers and staff (at all levels) are responsible for ensuring that they are viewing and working to the current version of this policy. If this document is printed in hard copy or saved to another location, it must be checked that the version number in use matches with that of the live policy on the CCG intranet.

All staff are responsible for implementing policies as part of their normal responsibilities, and are responsible for ensuring they maintain an up to date awareness of policies.

2. Introduction

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

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.

NHS Funded Nursing Care (FNC) is funding provided by the NHS to nursing care homes to support the need of nursing care by a registered nurse. In all cases the individual should be considered for NHS Continuing Healthcare before a decision is reached about the need for FNC.

In the delivery of CHC, North Cumbia Clinical Commissioning Group (The CCG) is obliged to ensure consistency in the application of the national framework, whilst implementing and maintaining good practice and ensuring that quality & safety standards are met and sustained.

3. Purpose and Scope

This policy should be used to inform practice and decision making where an individual wishes to exercise choice in relation to where and/or how their care is arranged and delivered.

The policy describes the ways in which the CCG will procure and provide care in a timely manner, that reflects the choices and preferences of individuals whilst balancing the need for commissioners to procure care that is, a) safe, b) effective in meeting identified need, and c) demonstrates good value for money by making the best possible use of available resources across the health and care system.

This policy ensures that individuals who are in receipt of NHS Continuing Healthcare in North Cumbria will receive care in line with the following principles:

- The CCG will ensure that decisions about care provision will be robust, fair, consistent and transparent;
- Ensure that care provision is based on an objective assessment of an individual's clinical needs, safety and best interests
- Ensure that every effort is made to involve the person and their family/representatives, whilst taking into account the need for the CCG to allocate its financial resources in the most cost effective and equitable way possible
- Ensure that the equality of individuals will be upheld and any agreements will not be discriminatory in favor of any one individual or situation
- Ensure that services it procures and provides are clinically appropriate and meet agreed quality standards. The safety, welfare and potential risks to the individual are taken into account in care purchased.
- To support choice to the greatest extent possible in view of the above factors.

The CCG has developed this policy in light of the need to balance personal choice alongside safety and effective use of finite resources. It is also necessary to have a policy which supports consistent and equitable decisions about the provision of care regardless of the person's age, condition or disability. These decisions need to provide transparency and fairness in the allocation of resources.

This policy does not include children and young people who are eligible for continuing care.

4. The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care, October 2018 (Revised)

The National Framework states that:

''Where an individual is eligible for NHS Continuing Healthcare, the CCG is responsible for care planning, commissioning services, and for case management. It is the responsibility of the CCG to plan strategically, specify outcomes and procure services, to manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare. The services commissioned must include ongoing case management for all those eligible for NHS Continuing Healthcare, including review and/or reassessment of the individual's needs'' (Paragraph 165).

''Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health and associated care and support needs. The CCG has responsibility for ensuring this is the case, and determining what the appropriate package should be. In doing so, the CCG should have due regard to the individual's wishes and preferred outcomes. Although the CCG is not bound by the views of the local authority on what services the individual requires, any local authority assessment under the Care Act 2014 will be important in identifying the individual's needs and in some cases the options for meeting them. Whichever mechanism is used for meeting an individual's assessed needs, the approach taken should be in line with the principles of personalisation (refer to paragraphs 296-300). (Paragraph 172).

5. Roles and Responsibilities

The CCG

- The CCG has an obligation to meet the assessed care needs of Eligible Individuals in a way that is considered to be reasonable and affordable whilst also in accordance with the CCG's relevant legal obligations.

- The CCG will maintain transparent and robust processes to ensure that the assessment of an Eligible Individual's care needs complies with the National Framework.

- When considering how and what care services can be commissioned, the CCG has a responsibility towards taxpayers to comply with its own Standing Financial Instructions to ensure that decisions take full account of the most cost effective options available, whilst also ensuring the assessed care needs of Eligible Individuals are met.

- The CCG will consider the appropriateness of funding care services for a variety of care settings which may include an individual's own home or residential setting. In the case of a residential setting, such as for example a Care Home, the CCG will also fund reasonable accommodation (board and lodging) costs.

- The CCG will make a reasonable offer of care to Eligible Individuals, which is able to meet care needs assessed under the National Framework, complies with its own Standing Financial Instructions and takes account of the rights and preferences of the individual.

- The CCG is not responsible for any alterations required to a property to enable a home care package to be provided. For the avoidance of doubt, where an individual or their representatives has made alterations to the home but the CCG has declined to fund the package, the CCG will not provide any compensation for those alterations.

- The CCG will undertake audits of this Guidance to determine the extent to which it is delivering choice, equity and value for money in the delivery of NHS Continuing Healthcare to Eligible Individuals.

Delegated Responsibility – The Continuing Healthcare Team (CHC)

The CCG delegates responsibility to the Continuing Healthcare Team with regard to the delivery of the of CHC Process:

- The CHC Team on behalf of CCG has an on-going responsibility for the delivery of the continuing healthcare process/to manage all individuals outside of the hospital setting, whose primary need is for healthcare.

- In North Cumbria, The CHC clinical team forms part of the multi-disciplinary team (MDT), and are responsible for facilitating the assessment process within Nursing Care Homes. The CHC team may also co-ordinate community assessment processes in co-working with the community teams and the Local Authority using the Decision Support Tool (DST). The CHC Team will become responsible for the on-going case management and review of eligible clients, where assessments have been completed by the core team. This responsibility will be retained by community nursing teams where they have been the lead heath professional for the eligible client.

- All cases are ratified on behalf of The CCG by the CHC Team, who will ratify the MDT recommendations of eligibility as recorded on the Decision Support Tool (DST) recommendation. CCGs retain overall responsibility for decision making regarding NHS Continuing Healthcare, as per the process set out in the National Framework. Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed (The CCGs scheme of delegation, which is part of its constitution - published on its website - also details authorities to both named panels and individuals in respect of financial limits to agree/approve individual patient agreements following assessment against national criteria).

- The CHC Team will procure all contracts for care provision in care homes, or individuals' own homes. They will also ensure that service specifications are developed and reflect the NHS Continuing Healthcare Framework and the CCGs contracting policies. The CHC Team will ensure the delivery of the agreed health and wellbeing outcomes of those eligible for CHC, with the best use of available resources. Contracts with providers of CHC funded services will be monitored on a regular basis by the CCGs

Contracts Manager.

- All NHS continuing healthcare members of staff in the CCG are responsible for compliance with The National Framework with regards to standards, decision making and actions.

6. The Provision of Services for People who are eligible for NHS Continuing Healthcare – Applying the Equity and Choice Policy and Procedure

Anyone can qualify for NHS Continuing Healthcare as long as their assessed needs meet the eligibility criteria, as set out in the National Framework. This care can be provided in any setting and may include funding for social, personal, nursing, medical care and, if within a care home, reasonable accommodation costs. The CCG will establish the costs for these services with the service provider, in line with the care plan and the CCGs contracted rates.

The Department of Health guidance requires that once eligibility is confirmed for NHS Continuing Healthcare, the CCG should discuss with the individual and/or their representative where care services could best be provided and take their views into account when arranging services.

Individuals found eligible for NHS continuing healthcare (or their representative) will be involved fully in deciding about their care. Their needs will be assessed by appropriate professionals and care packages will be personalised to meet the identified needs.

Access to NHS services is free at the point of delivery and does not depend on an individual's ability to pay for care. The CCG will not charge a fee, or require a co-payment from any NHS patient in relation to meeting assessed health needs. The principle that NHS services remain free at the point of delivery has not changed and remains the statutory position under the NHS Act 2006.

Following eligibility decision, the CHC process is as follows:

1) The CCG will inform the individual and/or representative in writing that they are eligible for continuing healthcare funding (Including the Local Authority, where appropriate).

(If the individual lacks mental capacity under the MCA, the CCG will consult with their representative or instruct/consult an IMCA if the individual has no representatives that are available (or appropriate) for consultation on their behalf).

2) The CCG will scrutinise a breakdown of the care costs in line with the clinical recommendation and established costs of care. Commissioning in co-working with the clinical team will also to identify non care costs as part of this process (i.e. services which are not health or social care related such as hairdressing, meals and snacks for families) and communicate clearly any areas which will not be funded by the NHS.

3) The CCG will consider available, feasible options for reliably and safely meeting the assessed needs of the individual. The CCG, where possible, will endeavor to accommodate the wishes of the individual and their family/carer when arranging the location of care. However, The CCG is only obliged to provide services that meet the reasonable requirements of a care package, and are also obliged to make best use of public funds. In light of this, the CCG may be unable to grant all requests made by the individual, carer and/or family. This decision will always be explained to families.

4) Whilst there is no set upper limit on the cost of care, the expectation is that the most cost-effective option will be commissioned to meet the individual's assessed health needs and circumstances.

5) As of 01 April 2019, all patients who require a package of care which is deemed to be based in the community (i.e. a care package in their own home), who is in receipt of NHS Continuing Healthcare, funding will be offered a Personal Health Budget (see link below for the CCG's policy on PHBs)

Link: http://www.northcumbriaccg.nhs.uk/health-services/continuing-healthcare/PHBdocuments/nhs-north-cumbria-clinical-commissioning-group-phb-operational-policy.pdf

6) Where an individual is receiving support from the Local Authority and/or Community Services (i.e. via a 'Direct Payment') and they become eligible for Continuing Healthcare, the responsibility for the total cost of care passes to the CCG. Wherever appropriate and/or possible a Personal Health Budget (PHB) will be offered to a service user previously in receipt of a direct payment. The CCG has a duty to consider the best use of resources for their population whilst meeting the healthcare needs of an individual. The CCG will seek to provide care with the least disruption to the individual. Where possible the NHS community services will support the care provider to meet the healthcare needs of the individual.

NOTE: Patients requiring placements through the Fast Track pathway will usually be offered choice. However, due to the required speed of the procurement process and considering limited availability of providers this choice may be restricted.

7. Procurement and Placement Options

In instances where more than one suitable care option is available (i.e. a nursing home placement and a domiciliary care package) The CCG will consider the total cost of each package, identifying the overall cost effectiveness in line with the most safe and sustainable option for the provision of care. Wherever possible The CCG will support the individuals preferred place of care, within available budget. When identifying appropriate care provision the CCG will, by exercising clinical judgment, consider what is deemed to be the safest option for the individual, within the resources available. For patients who lack capacity, options will be considered as part of a best interest meeting involving

family members and other significant individuals in the decision.

8. Continuing Healthcare - Funded Packages of Care at Home

Many patients wish to be cared for in their own homes, rather than in residential or nursing care settings - especially people who are in the terminal stages of illness. A person's choice of care setting should be taken into account, but there is no automatic right to a package of care at home. The option of a package of care at home should be considered if requested, and the CCG should give consideration to this request, giving clear reasons for its final decisions.

Patients who are eligible for continuing healthcare funding generally have a complexity, intensity, frequency and/or unpredictability in their care needs which mean it can be less common for care to be safely delivered at home, especially where the care is provided to support the terminal phase of illness. The CCG does not have the resources and/or facilities to provide either a 24-hour registered nursing hospital at home service, or the equivalent of nursing/residential care provision in the home environment.

In such cases, The CCG must consider whether care can be delivered safely, without undue risk to the individual, the staff involved or other members of the household (including children) when arranging a package of care in the home. Safety will be determined by a written assessment of risk undertaken by an appropriately qualified professional. The risk assessment will include the availability of equipment, the appropriateness of the physical environment and the availability of appropriately trained care staff and/or other people to consistently deliver the care at the intensity and frequency required.

The following will be considered before The CCG agrees to commission a package of care at home:

- Care can be delivered safely and without undue risk to the person, the staff or other members of the household (including children).

- Safety will be determined by a written assessment of risk undertaken by an appropriately qualified professional in consultation with the person or their family. The risk assessment will include the availability of equipment, the appropriateness of the physical environment and the availability of appropriately trained care staff and/or other staff to deliver the care at the intensity and frequency required.

- Where equipment and/or assistive technology can be used to support the safe delivery of care, it is expected that this will be accepted and used appropriately.

- The acceptance by the CCG and each person involved in the person's care of any identified risks in providing care, and the person's acceptance of the risks and potential consequences of receiving care at home.

- Where an identified risk to the care providers or the person can be minimised

through actions by the person or their family and carers, those individuals agree to comply and confirmed in writing with the steps required to minimise such identified risk.

- The person's GP agrees to provide primary care medical support (where appropriate).
- The suitability and availability of alternative care options.
- The cost of providing the care at home in the context of cost effectiveness.
- The relative costs of providing the package of choice considered against the relative benefit to the person.
- The psychological, social and physical impact on the person.
- The willingness and ability of family, friends or informal carers to provide elements of care where this is part of the care plan and the agreement of those persons to the care plan.
- The individual's current and likely future needs.

When determining the Service provision for an individual the primary consideration is to ensure the individual's safety and it is essential that all risks are identified and managed. Risk management must be proportionate. Individuals with capacity have the right to manage their own risk and make unwise choices.

The setting in which CHC is provided is ultimately a matter for a decision by the CCG and not the individual or their family. However the CCG will take into account all reasonable requests in accordance with the paragraphs below:

1) A home care package may not be directly comparable to a care home package because of the psychological impact of the place of care. The CCG will take this into account in considering the most appropriate placement for the individual.

2) When a person who is CHC Eligible is discharged into the community the CCG takes on the responsibility for their care provision.

3) Home care packages in excess of eight hours per day would indicate a high level of need which may be more appropriately met within a residential/nursing placement. These cases would be carefully considered and a full risk assessment undertaken.

4) Persons who need waking night care may be more appropriately cared for in a residential/nursing placement. The need for waking night care indicates a high level of supervision day and night.

5) Residential/Nursing placements are deemed more appropriate for persons who have complex and high levels of need. Residential/Nursing placements benefit from direct oversight by registered professionals and the option of 24-hour monitoring of persons.

6) If the clinical need is for registered nurse direct supervision or intervention throughout the 24 hour period, the care would normally be expected to be provided within a nursing home placement.

7) Each assessment will consider the appropriateness of a home based package of care, taking into account the range of factors.

9. Continuing Healthcare Funded Care Home Placements

There will be circumstances whereby an individual's needs are most appropriately met within a care home setting. Placements are generally deemed more appropriate for individuals who have complex and high levels of need. Placements benefit from direct oversight by registered professionals and the option for 24 hour monitoring of individuals. The general assumptions are set out below:

- Where a person has been assessed as needing placement within a nursing care home and the CCG has an accredited provider list for the type of care needs concerned, the expectation is that individuals will have their needs met in this care setting.

- The person may wish to move into a home outside of the preferred provider list, or their family/representative may wish to place the individual in a home outside of the accredited provider list. As long as the fee for the bed is comparable to the fee agreed with the preferred providers, and the provider can meet the patients care needs safely, the CCG team may consider this option. The CCG will make the final decision taking these issues into account, and it will depend on appropriate CQC registration.

- Geographical proximity of identified care homes to family and friends will be given full consideration.

- Should an individual's first choice of placement not be currently available, a provisional placement will be offered. This provisional placement is defined in this context as one that is suitable to meet the individuals assessed needs and can be provided whilst waiting for the individual's first choice.

- All placements offered will meet the Care Quality Commission standards of registration. only single rooms will be commissioned unless there is an identified health need for a shared room and this health need has to be agreed by a clinician

- If the fee is higher than the fee charged by a care home on the preferred provider list, only where the CCG is satisfied that the extra fees are for non-core care costs or

for a higher level of accommodation, and that the provider could offer a service to the Patient at the CHC approved rate, will the CCG agree a placement. The provider will only be able to invoice the CCGs for the core care costs and reasonable accommodation costs and will have to invoice the client separately for the non-core care costs and extra accommodation costs. The invoices will detail what the CCG and client is being charged for.

NOTE: In cases of higher than normal cost the CCG would only continue to fund at the home's rates if there were exceptional clinical reasons why the individual's needs could only be met in that specific placement. Exceptional circumstances would be considered for providing funding above the agreed budget. However, equity of provision cannot be ignored. Exceptionality will be considered on a case-by-case basis by the CCG.

If the weekly cost of the care increases due to an Individual's deteriorating condition and consequent increase in health needs, apart from a single period of up to two weeks to cover either an acute episode, or for end of life care to prevent a hospital admission, the care package will be reviewed and other options (for example a nursing home placement) will be explored following consideration of the issues.

'Top Ups' to meet identified needs are not permitted. If the client wishes to top up any additional cost for their chosen placement, the additional cost must be based on a genuine lifestyle choice (see point)

If the provider refuses to enter into the CCG's contract, the CCG will not be able to purchase the care at this home and the family will be advised that they will need to consider other homes that are on the preferred provider list.

9. **Personal Contributions For Optional Extras**

All NHS continuing healthcare is free at the point of delivery. Where an individual has been assessed as eligible for NHS continuing healthcare there is no provision for "top-up" fees for individual contributions to fund assessed care needs, including costs of accommodation in the care home.

The CCG is not able to allow personal top up payments into the package of healthcare services under CHC, where the additional payment relates to core services assessed as meeting the needs of the individual and covered by the fee negotiated with the service provider (e.g. the care home) as part of the contract.

However, individuals can choose to make arrangements with the care home to pay for services and/or optional extras which are not part of the assessed needs. Optional extras include non-essential services, for example, hairdressing, reflexology, social outings, or a bigger room/nicer view, etc. Any additional services which are unrelated to the person's primary healthcare needs will not be funded by the CCG as these are services over and above those which the service user has been assessed as requiring, and the NHS could not therefore reasonably be expected to fund those elements.

Where service providers offer additional services which are unrelated to health needs (as assessed under NHS CHC assessment), the person may choose to use personal funds to take advantage of these services, where it can be clearly demonstrated that this additional cost relates to a genuine lifestyle choice. This will be considered as a private arrangement between the individual and the provider.

10. The Review Process

All individuals will have their care reviewed at three months and thereafter on an annual basis (or sooner if their care needs indicate that this is necessary).

The review may result in either an increase or a decrease in support offered and will be based on the assessed care need of the individual at that time. The individual's condition may have improved and/or stabilised to such an extent that they no longer meet the criteria for NHS continuing healthcare. Consequently, the individual will have a right to assessment by the Local Authority. Where there are ongoing social care needs, The CCG will ensure an appropriate transfer of care provision to the Local Authority so there is no gap in funding. Where the individual is in receipt of a home care package and the assessment determines that this is no longer appropriate, then an alternative package will be discussed and agreed.

Where eligibility ceases, The CCG will no longer be required to fund the care package. In such cases, the CCG will give 28 days' notice of cessation of funding to the individual and/or their representative (This notice will also be served to the Local Authority, where appropriate). Any on-going package of care that is needed may qualify for funding by the Local Authority, subject to assessment, or the cost of any on-going package of care may need to be met by the individual themselves. The transition of care should be seamless and will be coordinated by the CCG case manager. The individual and/or their representative will be notified of proposed reviews, and involved wherever appropriate.

In the event that the CCG considers that identified health needs cannot be met safely, or if the costs of meeting identified needs are in excess of the notional health budget, then the CCG reserves the right to commission alternative care which meets all reasonable requirements of a care package. As guidance, if the total cost of the care package is more than 10% higher than the notional healthcare budget, then the decision will be referred to The CCG for a decision on the continuation of care, based on any exceptional/mitigating circumstances.

Working with the individual and/or their family or representative, the CCG will identify, wherever possible, alternative placement options which can meet the individual's needs. The CCG will endeavor to offer a suitable choice of placement, depending on the availability of vacancies at the time. The CCG will take into account the individual's or their representative's wishes around geographical location, GP and cultural and spiritual needs (but are not obliged to prioritise these requests).

There may occasionally be circumstances where the individual declines to accept

alternative suitable provision and a suitable package, which may result in the CCG issuing a 'Withdrawal of Care Notice'. The CCG will advise the individual when the funding of care will be withdrawn and a timescale will be given for this. The risks will be explained and documented in the individual's notes. This will also be confirmed in writing to the individual and/or their family or representative.

11. Refusal of NHS Funding

An individual has the right to decline NHS continuing healthcare and make their own private arrangements if they wish to do so.

If the individual/representative refuses alternative placements then the CCG will consider that they have refused NHS funding and are continuing with the private contract with the home. The CCG may also consider a refusal of NHS Services (where the CCG has offered the individual what it considers is an appropriate care package to meet the individual's assessed needs) as not being accepted by the individual or their representative (including where the individual has requested a particular package and the CCG has 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 CCG will write to the individual (and/or representative) with a final offer letter setting out the care packages that the CCG is willing to consider and the consequences of refusing a placement. In this letter the CCG will provide a period of not less than 14 days for confirmation of acceptance or final refusal of a care package.

If the individual does not respond within the stated time period then the CCG will provide a written notice confirming that NHS funding will cease on a specified date which will be no earlier than 28 days from the date of the notice. The CCG will work within the guidance of the National Framework, which states that Neither the NHS nor an LA should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement. It is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding, in order to ensure continuity of care. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. Therefore the CCG would not remove funding before the above actions have been progressed.

NOTE: Self funders who become eligible for CHC. Before a continuing healthcare assessment starts for any individual who is already in a home which does not meet the CCG's contractual requirements, the individual and/or their family or representative will be given a leaflet. This will explain the process to enable them to make an informed decision to proceed with the assessment. This will usually be when a checklist is completed

Where an individual is assessed as eligible for NHS continuing healthcare in a care home they cannot choose to return to Local Authority funded care in a care home, with or without NHS-funded nursing care as to do so would place the Local Authority beyond

its legal powers. As an individual's eligibility for continuing healthcare will be kept under review, an individual may be reassessed and found no longer to be eligible for continuing healthcare and may at this time return to Local Authority provided they meet their criteria for accommodation and/or social care.

12. Consent and Capacity to Make Choices

Non acceptance of available placement choices by competent individuals

Individuals can elect to refuse NHS continuing healthcare. However, any individual making this decision must have the potential risks assessed and the implications fully explained to them. So long as an individual has mental capacity they are entitled to choose to take risks, even if professionals or other parties consider the decision to be unwise. It is important to work with the individual to explain any risks involved and not to make generalized assumptions about these. This decision and its outcome must be documented in the individual's notes.

If the individual or their representative refuses to consider or accept any of the placements offered, the CCG will consider that it has fulfilled its statutory duty to provide NHS continuing healthcare and inform the individual in writing that they will need to make their own arrangements for ongoing care within 28 days. This letter will explain the risks of refusing a placement and the right to challenge that decision. These risks will also be documented on the individual's notes. If the individual is considered vulnerable, the CCG will follow vulnerable adult protocols and make an appropriate referral to the Local Authority.

Patients who lack mental capacity to make decisions about care/placement

If an individual's condition affects their ability to make decisions, a mental capacity assessment will be undertaken, in line with the current guidance in the National Framework for NHS Continuing Healthcare and Funded Nursing Care,
October 2018.

If an individual is assessed as lacking capacity to make decisions and there is an Lasting Power of Attorney (LPA) or Deputyship for health and welfare in place, then they may make decisions on behalf of the individual (In the absence of such an individual, an independent advocate will be offered to support the individual during this process, under the provisions of the Mental Capacity Act 2005).

If the individual does not have the capacity to make an informed choice The CCG will deliver the most cost effective, safe and sustainable care option available based on an assessment of best interests and in conjunction with any advocate, close family member or other person who should be consulted under the terms of the Mental Capacity Act 2005.

The five key principles of the Mental Capacity Act 2005 will be applied by the CCG when working with NHS continuing healthcare funded individuals and their representatives.

These will seek to balance individual preference, safety and value for money when developing a care package or identifying suitable placements:

- every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise;
- an individual must be given all practicable help before anyone treats them as not being able to make their own decisions;
- just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision;
- anything done or any decision made on behalf of an individual who lacks capacity must be done in their best interests;
- anything done for or on behalf of an individual who lacks capacity should be the least restrictive of their basic rights and freedoms.

If an individual lacks the mental capacity to make a decision about their care home placement and their representative refuses to accept any of the placements offered, the CCG will place the individual in a placement in their best interests in accordance with the procedures under the MCA, the Code of Practice to the MCA and the CCG's Policy on MCA. The MCA gives the CCG the authority to make decisions on behalf of incapacitated individuals in their best interests including transferring an individual to a care home placement. Where disputes with the representative arise, it may, in some circumstances be necessary to seek a decision from the Court of Protection.

13. Other Circumstances to be Taken into Consideration

NHS Obligations on Choice

Whilst the CCG's starting point in the decision making process will be individual preference, the CCG does not have an absolute obligation to meet individual choice or preference and is not subject to specific directions on Choice of Accommodation in the same way as the Local Authority.

The CCG will seek to take account of the wishes expressed by persons and their families when making decisions as to the location(s) of care packages and placements to be offered to satisfy the obligations of the CCG to provide continuing healthcare. The CCGs accept that many persons with complex medical conditions wish to remain in their own homes and to continue to live with their families, with a package of support provided to the person in their own homes. Where a person or their family expresses such a desire the CCG will investigate to determine whether it is clinically feasible and cost effective to provide a sustainable package of continuing care for a person in their own home.

Packages of care in a person's own home are bespoke in nature and thus can often be

considerably more expensive for the CCGs than delivery of an equivalent package of services for a person in a care home. Such packages have the benefit of keeping a person in familiar surroundings and / or enabling a family to stay together. However, the CCG needs to act fairly to balance the resources spent on an individual person with those available to fund services to other persons.

The individual or their family/representative may wish to identify another placement which is within the individual's notional budget and the CCG will agree to this placement provided it can safely and sustainably meet the individual's assessed needs within the required quality criteria and the Provider signs up to the CCG's proposed terms and conditions for the placement. The CCG cannot currently make direct payments to individuals who have a traditional commissioned care package and the CCG can only commission care from agencies that are registered with the Care Quality Commission (CQC).

The CCG has resolved that, in an exceptional case and in an attempt to balance these different interests it will be prepared to support a clinically sustainable package of care which keeps a person in their own home provided the anticipated cost to the CCG is ordinarily no more than 10% higher than the anticipated cost of a care package delivered in an alternative appropriate location such as a care home. The CCG will consider the cost comparison on the basis of the genuine costs of alternative models. A comparison with the cost of supporting a person in a care home should be based on actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care cost.

Exceptionality is determined on a case by case basis and would require Director level agreement using the delegated authorisation process for high cost case.

14. Appeal Regarding Care Provision

By reference to the Individuals' personalised care plan an indicative level of funding/care setting can be identified by the CHC team. If this conflicts with the wishes of the Individual or their representative, the CHC team will refer the decision to members of the CCGs senior management in the first instance for consideration. The CCG may need to consider further where the person lacks capacity and there is potential for a DoLS requirement, least restrictive means and potential application to the Court if the personal objects with the potential for a 21a challenge.

If the decision of the CCG is upheld, the Individual or their representative will be advised of this and their right of complaint through the CCG complaints process.

If the complaint cannot be resolved locally the Individual or their representative can be referred directly to the Health Service Ombudsman.

15. Agreement to Fund

The authorisation for the commissioning and funding of packages of care at home/ or in placement lies with the CCG. There is a process for the delegated authorisation of eligibility

and the authorisation of care packages and placements.

In the event that the CCG considers that the safety of any member of its staff or any staff contracted to provide the care is at risk it shall take such action as it considers appropriate. Harassment or bullying, verbal or physical abuse of care workers will not be accepted and the CCG will take any action necessary including immediate withdrawal of services. Where in exceptional circumstances it is necessary to consider the withdrawal of services, the CCG will notify the individual of the risk and urgently consider how else (if at all) services can be offered.