Policy

Continuing Healthcare / Complex Care Commissioning Policy

May 2017

NHS Eastern Cheshire Clinical Commissioning Group
NHS South Cheshire Clinical Commissioning Group
NHS Vale Royal Clinical Commissioning Group
NHS West Cheshire Clinical Commissioning Group
NHS Wirral Clinical Commissioning Group

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1. Introduction

1.1 This policy describes the way the following Clinical Commissioning Groups (CCGs) NHS Wirral CCG, NHS South Cheshire CCG, NHS Vale Royal CCG, NHS Eastern Cheshire CCG and NHS West Cheshire CCG (the Commissioner) will make provision for patients who have been assessed as eligible for an episode of NHS Continuing Healthcare (CHC) funding including Funded Nursing Care (FNC) or a contribution to a Joint package of Care (JPC). The purpose of this policy is to assist the Commissioner to ensure that the reasonable requirements for eligible individuals are met in line with Clinical Commissioning Groups Responsibilities and Standing Rules Regulations 2012.

1.2 This policy applies to newly referred patients and existing patients who are already in receipt of a care package. Once an individual has received a comprehensive, multidisciplinary assessment of their health and social care needs and the outcome shows that they are therefore eligible for an episode of:

- NHS Continuing Healthcare funding
- The NHS element to a Joint Package of Care
- NHS Funded Nursing Care

1.3 The policy details the legal requirements, CCG responsibilities and agreed course of action in commissioning care which meets the individual's assessed needs. It has been developed to assist the Commissioner to meet its responsibilities under:

- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (revised)
- The Care Act 2014
- Mental Capacity Act 2005
- Who Pays? Establishing the Responsible Commissioner (2013)

1.4 This policy has been developed to help provide a common and shared understanding of CCG commitments in relation to individual choice and resource allocation. The benefits of this policy are to:

- Inform robust and consistent commissioning decisions.
- Promote individual choice as far as reasonably possible.
- Ensure the provision of safe, high quality and clinically effective care.
- Ensure that there is consistency in the local area over the services that individuals are offered.
- Ensure the CCG achieves value for money in its purchasing of services for individuals eligible for a package of care.
- Facilitate effective partnership working between health care providers, NHS bodies and the Local Authority in the area.

1.5 Whilst improving quality and consistency of care, this policy is intended to assist the Commissioner to make decisions about clinically appropriate care provision for individuals in a robust way and thus achieving the most efficient use of resources available to the CCG.

1.6 The Continuing Healthcare eligibility process is outlined in the National Framework for NHS continuing healthcare and NHS funded nursing care (2012) and the National Framework for Children and Young People's Continuing Care (January 2016), it is not within the scope of this policy.

2. Principles

2.1 The process will be **person-centred.** Consideration of individuals' and carers' views will be given, particularly when nearing the end of their life; this includes considerations of distance and transport requirements for families and carers.

2.2 The Commissioner will take **choice** into account when arranging a suitable package of care. However there is no legal obligation for the Commissioner to provide a care package greater than the assessed need.

2.3 Where an individual qualifies for an NHS contribution to a package the Commissioner will resource a reasonable and appropriate package based on the needs that have been **formally assessed** by a qualified professional. The Commissioner will secure and fund (in part or fully) a package necessary to meet the assessed health needs.

2.4 The Commissioner will seek to promote the individual's **independence** subject to the factors set out in 2.7. The Commissioner aims to support individuals to take reasonable risks whilst ensuring that care provided is **clinically safe**, including through the use of a personal health budget, where appropriate.

2.5 The Commissioner is committed to using NHS resources **effectively and efficiently** in the most cost effective manner in the provision of care services which are **reasonable and affordable**.

2.6 The Commissioners responsibility to commission, procure or provide a package of care is **not indefinite**, as needs could change. **Regular reviews** are built into the process to ensure that the care provision continues to meet the individual's needs.

2.7 When commissioning services with individuals, the Commissioner will **balance** a range of factors including:

- individual safety;
- individual choice and preference;
- individual's rights to family life;
- value for money;
- the best use of resources for the population.
- ensuring services are of sufficient quality;
- ensuring services are culturally sensitive; and
- ensuring services are personalised to meet individual need.

3. Referral Criteria

3.1. Referrals for assessment by the Cheshire and Wirral Continuing Healthcare / Complex Care Team will be accepted for:

I. Individuals who are the responsibility of the CCG in accordance with Who Pays? Determining Responsibility for Payments to Providers (August 2013).

AND who fit within one of the categories detailed below:

Complex Mental Health

II. Individuals eligible for after care under Section 117 of the Mental Health Act 1983 (MHA). This refers to those individuals for whom it is required that the clinical commissioning group and the local authority, in cooperation with voluntary agencies to,

provide or arrange for the provision of aftercare. This applies to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the MHA who then cease to be detained. This includes patients granted leave of absence under section 17 and patients going on community treatment orders (CTO).

III. Individuals who are detained in an Independent Hospital.

NHS Continuing Healthcare

IV. Individuals aged 18 or over and where a positive NHS Continuing Healthcare checklist has been completed as detailed in National Framework for NHS continuing healthcare and NHS funded nursing care (2012).

Children's Continuing Healthcare

V. Individuals under the age of 18 whose needs cannot be met by existing universal and specialist services alone and where a pre-assessment has taken place which indicates a full assessment is necessary as detailed in National Framework for Children and Young People's Continuing Care (2016).

4. Roles and Responsibilities

4.1. The Commissioner delegates responsibility and authority to the Cheshire and Wirral Continuing Healthcare/ Complex Care Service to ensure that:

- The Commissioner complies with The NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.
- The National Framework for NHS continuing healthcare and NHS funded nursing care 2012.
- Adherence to this Policy and other policies of the Commissioner.
- NHS resources are utilised effectively and efficiently to commission in the most cost effective manner, care services which are reasonable and affordable.
- Where the package of care is defined as "high cost" then the case may be referred to a CCG High Cost Panel to consider the suggested package and the rationale for it exceeding the normal level of expenditure. The membership and terms of reference for any panel will be the responsibility of the individual CCG.

5. Responsibilities of the commissioner

5.1 The Commissioner's duty is to provide a care package to meet the reasonable needs of patients as assessed by the relevant professionals.

5.2 The Commissioner aims to offer individuals a choice of care packages which meet their assessed health needs. Where there is a request for a care package by the eligible individual or their representative which is not usually commissioned the expectation is that the most cost effective package that meets the assessed needs will be commissioned.

5.3 Where a care package requested by an individual is more expensive than the options offered by the Commissioner, then the Commissioner, taking into account the considerations set out in paragraph 2.7, may agree to fund such a package of care in appropriate circumstances. While there is no set upper limit on expenditure, the usual principle is that care provision will not be agreed where costs exceed 10% over the most cost effective package that has been assessed as able to meet an individual's needs. Funding decisions relating to such circumstances will be clearly documented and discussed with the individual or their representative. Where decisions of

this nature are required a Commissioner may consider using a “High Cost Panel” to consider the request in order to ensure equitable and consistent use of resources.

5.4 In exceptional circumstances, the Commissioner may agree to fund care provision where the costs exceed 10% over the most cost effective care package that has been assessed as able to meet an individual’s needs.

The Commissioner will support an individual in making the decision as to where they wish to receive their package of care. However, if concerns remain that an individual does not have the mental capacity to make the decision as to where they live, a mental capacity assessment will be undertaken.

5.5 All individuals will have their care reviewed at 3 months and thereafter on at least an annual basis or sooner if their care needs indicate that this is necessary. Individuals with palliative care needs will have their care reviewed more frequently in response to their medical condition.

5.6 The review may result in either an increase or a decrease in support offered and will be based on the assessed need of the individual at that time.

5.7 The individual’s condition may have improved or stabilized to such an extent that they no longer meet the criteria for the package of care. Consequently, the individual will be referred to the Local Authority who will assess their needs. This may mean that the individual will be charged for aspects of their ongoing care or may need to fully fund their ongoing care. Where possible, transition to Local Authority care will be managed by agreement between the respective authorities within 28 days of the individual being found no longer eligible for the package of care.

5.8 Where an individual is no longer eligible for a package of care the Commissioner will issue a notice withdrawing the care package. The individual is able to appeal this decision through the outlined appeals process.

6. Provision

6.1 Within the law, the Commissioner is the appointed body to determine the appropriate setting in which it is prepared to commission care for individuals, but in so doing will take account of and consider all reasonable requests.

7. Care at Home Packages

7.1 The Commissioner supports the use of ‘care at home’ packages where appropriate and recognises the importance of patient choice. However, there may be situations where the Commissioner cannot provide the individual's choice of having a ‘care at home’ package either because of the cost or risks associated with the package. The Commissioner considers that packages which require a high level of input may be more appropriately and safely met in another care setting.

7.2 The duty to fund services does not extend to funding for the wide variety of different, non-health and non-personal care related services that may be necessary to maintain the patient in their home environment. Should the Commissioner identify that such basic needs are not going to be (or have not been) properly met, the Commissioner may find that a ‘care at home’ package is not or is no longer appropriate. The cost of funding a care at home package of care will not usually be met if it exceeds more than 10% over the cost of providing care within a care home setting. If this occurs the following options arise:

1) Care package in the Care Home setting is accepted.
2) If not accepted, then the individual will be declining the offer of a funding for a care package.

7.3 The Commissioner will take account of the following considerations when considering a request to deliver a complex 'care at home' package:

- Can care be delivered safely to the individual and without undue risk to the individual, the staff or other resident members of the household.
- The acceptance by the individual, the Commissioner and each person involved in the individual's care of any risks relating to the care package.
- The General Practitioner's opinion on the suitability of the package and confirmation that he/she agrees to provide primary medical support.
- It is the individual's preferred choice.
- The suitability, accessibility and availability of alternative arrangements
- The extent of a patient's needs (e.g. frequency of qualified nurse intervention required)
- The cost of providing the package of choice to ensure best value and efficient use of resources.
- The cost (or range of costs) of the care package(s) identified by the Commissioner as suitable to meet the individual's assessed care needs.
- The psychological, social and physical impact on the individual
- The individual's human rights and the rights of their family and/or carers including the right to respect for home and family life.
- The willingness and ability of family members or friends to provide elements of care where this is a necessary/desirable part of the care plan and the agreement of those persons to the care plan.

7.4 At all times, individuals with capacity to make decisions about their residence, care and treatment retain their right to decline any offer made by the Commissioner and to make and fund their own private arrangements. Where individuals lack capacity the Commissioners will make best interest determination following the practice outlined in Section 15 of this policy.

7.5 The Commissioner aims to offer individuals a choice of Care Providers. To ensure consistent high quality care and equity in provision the Commissioner has a list of pre-approved Care Providers, who have demonstrated that they can provide care for individuals who meet eligibility described within this policy. The commissioner will set standards for the quality of care to be delivered; only providers which meet these standards will make the pre-approved Care Provider list. The Commissioner will use all the clinical information from the assessment to match assessed needs to those approved care providers which have the ability to meet those assessed needs, and have capacity to undertake the provision.

7.6 Care Providers have the opportunity to conduct a pre-admission assessment plan detailing how they will meet needs and requirements, and outlining how they will deliver care. The Commissioner will review all the options, and select the care provider which can best meet individual needs, based on quality and value for money. If more than one care provider is identified (maximum of three), then the Commissioner will discuss the options with the individual or their representative.

8. Assessments for Care at Home Package

8.1 The Commissioner will ensure that prior to agreeing to any 'care at home' package an appraisal of the following will be completed:

- Staff risks in relation to the use of equipment within the environment.

- Staff training necessary to use the equipment.
- Staffing contingency in the event of package breakdown.

9. Care Home Placements

9.1 The Commissioner aims to offer individuals a choice of care homes. To ensure consistent high quality care and equity in provision the Commissioner has a list (Care Home List) of pre-approved Care Homes with nursing who have demonstrated that they can provide care for individuals who meet eligibility described within this policy. The commissioner will set standards for the quality of care to be delivered; only providers which meet these standards will make the pre-approved Care Provider list. The Commissioner will use all the clinical information from the assessment to match assessed needs to those approved care providers which have the ability to meet those assessed needs, have availability and are located within a radius that can extend up to 50 miles from the individuals normal place of residence. The Commissioner may choose to set the radius at a lower limit; this will be the responsibility of the individual CCG.

9.2 Care Providers have the opportunity to conduct a pre-admission assessment plan detailing how they will meet needs and requirements, and outlining how they will deliver care. The Commissioner will review all the options, and select the care provider which can best meet individual needs, based on quality and value for money. If more than one care provider is identified (maximum of three), then the Commissioner will discuss the options with the individual or their representative.

9.3 An individual has the right to decline NHS funding and make private arrangements. For the avoidance of doubt, in the event that an individual has been assessed and found to be eligible for NHS Continuing Healthcare they will no longer be able to receive funding from the Local Authority towards their care even if they decline NHS funding.

9.4 Where, immediately prior to being found eligible for NHS Continuing Healthcare, an individual is residing in a care home which is not on the Care Home List and that individual does not wish to move, the Commissioner will undertake a clinical assessment of the individual to consider the clinical or psychological risk of a move to an alternative placement.

9.5 The Commissioner will consider whether it is appropriate to commission a package outside of the Care Home List. The Commissioner will consider:

- the cost of the package
- the individual’s preferences
- the Care Quality Commission's assessed standard
- the appropriateness of the package
- the clinical assessment of the individual's needs and the risk of any change to the individual's health
- the likely length of the proposed package

9.6 In the event that care is commissioned in a home that is not on the Care Home List, the cost of the placement cannot exceed more than an equivalent package of care from a care home on the approved list. It would be expected, that unless there is a clear and identifiable risk to an individual’s health that the individual would move to a care home derived from the approved list. The appropriateness of the placement will be reviewed at all subsequent review points.

9.7 In exceptional circumstances, the Commissioner may agree to fund a care home placement which exceeds the cost of an equivalent package of care from a care home on the approved list.

The Commissioner will not normally fund a placement where the requested care home is not the most suitable place for the provision of care and the care package can only be provided safely or resiliently at the current home with additional staffing at significant extra cost.

9.8 If the individual or their family/representative indicates that they are unwilling to accept any of the placements offered by the CCG then the CCG shall issue a final offer letter setting out the options available. If the CCG does not receive confirmation that the individual has accepted one of the placements within 14 days then the CCG will issue a Notice of Care being declined by a service user confirming that the NHS funding has been turned down and NHS funding will cease from 28 days after the date of the Notice of Care being declined by a service user.

9.9 If during the period of the notice the patient or patient's representative chooses to accept the offered care, this offer will be reinstated. Where the individual or their family/representative choose to turn down NHS Continuing Healthcare funding they will not be able to access local authority funding for the care and will need to make private arrangements.

9.10 If after a notice of care being declined is issued the individual or their representatives want to access NHS services they remain entitled to do so and can re-enter the NHS Continuing Healthcare process.

10. Contracting

10.1 In order to ensure that there is no confusion between the NHS and privately funded services, the Commissioner will enter into a legally binding contract with the selected care provider which details the provision by the care home of a defined level of health and social care to the individual. This will expressly be independent of any arrangement between the care provider and the individual or their representative(s) and will be expressed to continue notwithstanding the termination of any arrangements made between the individual and the care provider. Any payments made by the individual under a contract with the care provider for additional services cannot be made under the Commissioner's contract.

10.2 Should the private arrangement cease, this should not have an adverse impact on the arrangement with the provider to deliver a package of care which is funded through the NHS. This reiterates the importance of separating private and NHS funded care so that it is distinct and entirely separate and not financially and contractually interdependent.

11. Top Up Care

11.1 The CCG is only obliged to provide services that meet the assessed needs and reasonable requirements of an individual. A patient has the right to decline NHS services and make their own private arrangements.

11.2 Where an individual is found eligible for NHS Continuing Healthcare, the CCG must provide any services that it is required to provide, free of charge. In the context of care home placements this will be limited to the cost of providing accommodation, care and support necessary to meet the assessed needs of the patient. For 'care at home' packages this will be the cost of providing the services to meet the assessed needs of the individual. The package of care which the Commissioner has assessed as being reasonably required to meet the individual's needs is known as the core package.

11.3 Where an individual wishes to augment any NHS funded care package to meet their personal preferences they are at liberty to do so. However, this is provided that it does not constitute a

subsidy to the core package of care identified by the Commissioner. Joint funding arrangements are not lawful.

11.4 As a general rule individuals can make a contribution to their care package where the additional services are optional, non-essential services which an individual has chosen (but was not obliged) to include in their care package. Examples include private hairdressers or a personal television. In addition where health services, beyond those assessed as required as part of the care package, are needed by the individual they would be accessed in the same way as do the wider community, for example physiotherapy.

12. Exceptional Circumstances

12.1 The Commissioner recognises that exceptional circumstances may require exceptional consideration but will retain its obligation to make best use of NHS resources to meet the needs of the whole population served. In such circumstances, the Commissioner would be prepared to consider funding provision where the anticipated cost to the Commissioner is higher than 10% over the most cost effective care provision identified but will need to take account of what is fair and reasonable.

12.2 In order to determine whether exceptional circumstances exist for this purpose, a two- stage process will apply:

1. Are the individual's needs significantly different to other individuals with the same or similar conditions?

   and

2. Will the individual benefit significantly more from the additional or alternative services than other individuals with the same or similar conditions would?

12.3 Exceptionality will be determined on a case by case basis and will require agreement by personnel at Director level or as determined by the Commissioner's Standing Rules and Financial Instruction.

13. Change of Circumstance

13.1 The NHS has a responsibility to regularly review the care needs of individuals eligible for NHS funding in order to ensure that the care services being commissioned for them remain appropriate or to consider how those services may need to change. An initial review will take place 3 months after the first assessment. Thereafter case reviews will take place at a minimum on an annual basis unless more frequently indicated by clinical need.

13.2 Reviews will be person-centred, taking place 'at the bedside' with families and carers invited to attend and contribute. If they are unable to attend, every effort will be made to obtain their feedback. The review will harness the views of the individual by utilising a questionnaire based on the 'I' statements as outlined in the Continuing Healthcare Assurance Framework. The outcome of such reviews will be formally communicated to the individual and, where appropriate, their family or carer.

13.3 Eligibility to have care funded by the NHS is not a permanent arrangement and remains subject to regular reviews and confirmation of continuing eligibility. The health and/or health needs of

individuals may improve or stabilise to the extent that they no longer meet the eligibility criteria for NHS Continuing Healthcare and other care packages covered by this policy.

13.4 Where evidence no longer supports an individual's eligibility for NHS Continuing Healthcare or other care packages covered by this policy, the Commissioner will review the case before making a decision and communicating this to the individual and their family or carer.

13.5 Details of individuals no longer eligible for NHS Continuing Healthcare or other packages of care covered by this policy will, with the consent of the individual, be forwarded to Adult Social Services within the Local Authority so that an assessment can be arranged to determine the extent to which the individual may qualify for Local Authority funded care. The Commissioner will liaise effectively and provide 28 days notice to the client, or their representative as well as the Local Authority to ensure that any transition of responsibilities for commissioning care services are coordinated effectively by an appointed Case Manager and that there are no gaps in care provision.

13.6 Individuals no longer eligible for NHS Continuing Healthcare may be eligible for NHS Funded Nursing Care which will be considered by the Commissioner in accordance with The National Framework.

14. Personal Health Budgets

14.1 The Commissioner will ensure that people eligible for NHS Continuing Healthcare or other care packages covered by this policy benefit from the "right to have" a personal health budget.

14.2 The Commissioner will ensure that the guidelines laid out in the agreed Personal Health Budgets Policy (May 2016) are fully utilised.

14.3 The Commissioner will be open and transparent with people about what elements of their care can be included in a personal health budget and how this budget has been calculated. This will be based, in principle, on the amount of money that would have normally been spent on NHS services as part of an individual's package of care. This enables greater choice and flexibility over the services received which is one of the key components of ensuring improved outcomes

14.4 The commissioner will strive to include as much of this budget as possible into a person's personal health budget and where this is not possible work with them, their representatives, family and carers to tailor the support provided for their assessed needs.

14.5 Any agreed budget will be of a sufficient amount to ensure the health and wellbeing outcomes required for an individual can be realistically met. As with any NHS funded package of care, any privately funded arrangements must be distinct from that funded under a personal health budget and any contractual arrangements must be separate.

15. Mental Capacity

15.1 Where there is reason to believe that an individual may lack capacity to make a decision regarding the provision of (or change to) their care or accommodation a mental capacity assessment shall be undertaken. If the assessment confirms that the individual lacks the relevant capacity, best interest decision making shall be undertaken in accordance with the Mental Capacity Act 2005 and the Code of Practice which accompanies it. Any decisions made should also take consider any potential Deprivation of Liberty.

15.2 Any best interest decision made will be in accordance with the best interests process and considerations described in the Mental Capacity Act 2005. In particular, the Commissioner will consider the following as part of the best interests assessment:

- The individual's wishes and feeling (whether expressed verbally, in writing or behaviour);
- The individual's, beliefs and values that would influence him or her if they had capacity;
- The views of anyone named who should be consulted, any deputy or attorney for the person or anyone engaged in caring for or interested in the welfare of the person.

15.3 The Commissioner will appoint an Independent Mental Capacity Advocate to support the individual in decision making, where required, in accordance with the Act.

15.4 In some circumstances the individual may have given another person authority to make a decision on their behalf. Where the Commissioner is made aware of this, and a best interest decision is required in respect of an offer of care, it will ask to see one of the following documents:

- A Lasting Power of Attorney, which has been registered with the Office of the Public Guardian. This can be either a Health and Welfare Lasting Power of Attorney or a Property and Financial Affairs Lasting Power of Attorney;
- An Enduring Power of Attorney (which can only be for property and finances), which has been registered with the Office of the Public Guardian

Alternatively, there may be:-

- An order of the Court of Protection appointing them as Welfare Deputy (this could potentially include being able to decide on the care or accommodation of the individual);
- An order of the Court of Protection appointing them as Financial Deputy.
- An order from the Court of Protection under Mental Capacity Act 2005, in respect of the care or accommodation of the individual.

15.5 Where one of the above documents is provided to the Commissioner, it will consider how best interest decisions should be made appropriately. The Commissioner will take its decision in accordance with the Mental Capacity Act guidance, and will seek specific legal advice where appropriate.

15.6 If there is a dispute about best interests in relation to where an individual should live and receive care, the Commissioner may need to make an application to the Court of Protection and will obtain legal advice where appropriate.

16. Appeal

16.1 In line with its legal obligations, Government guidance and this Policy, the Commissioner will make a reasonable offer of care to individuals deemed eligible for NHS Continuing Healthcare funding.

16.2 In the case of such offer either being considered to be inappropriate, unreasonable and/or unacceptable to the individual, this should be notified to the Commissioner within 3 days outlining the reasons or objections to the offer of care.

16.3 Upon receipt of a request to reconsider its offer of care, the Commissioner will arrange for a timely review to take place within a timescale appropriate to the urgency of the case as ensuring

the individual's safety and welfare is paramount. The review will examine the relevant factors informing the decision.

16.4 Following its review, where the Commissioner determines to uphold the offer of care, this will be confirmed to the individual, advising of the right to make a formal complaint and how such a complaint may be made in accordance with the NHS complaints process.

16.5 Any dispute in care provision should not lead to a delay in discharge from Acute (Hospital care) and while the dispute is resolved the service user will receive their care in an appropriate environment outside of acute hospital.

17. Review

17.1 This policy will be reviewed once every year or sooner where relevant changes occur with regard to the law, national policy or guidance.

18. Definitions

'Continuing Care' - refers to care provided over an extended period of time to a person aged 18 or over, to meet physical and/or mental health needs which have arisen as a result of disability, accident or illness.

'NHS Continuing Healthcare (or "CHC")' - refers to a package of continuing care that is commissioned (arranged and funded) solely by or on behalf of the NHS where an individual has been found to have a 'primary health need.'

'The National Framework' – refers to The National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (published by the Department of Health 2012) which provides the context for the commissioning of NHS Continuing Healthcare, providing clarity and consistency of decision making with regard to eligibility and setting out the systems and processes to be used by the NHS.

'Funded Nursing Care' – is the funded provided by the NHS to homes providing nursing to support the provision of nursing care by registered a nurse. In all cases individuals should be considered for eligibility for NHS continuing healthcare before a decision is reached about the decision for NHS funded nursing care.

'Joint Package of Care' – this refers to the following care packages:

- An individual who is not entitled to NHS continuing healthcare (because 'taken as a whole' their needs are not beyond the powers of a local authority to meet), but nonetheless have some specific needs identified through the decision support tool that are not of a nature that a local authority can solely meet or are beyond the powers of a local authority to solely meet. This will include access to core health services and only where these cannot meet the assessed health needs will these be individually funded by the Commissioner.

- Individuals under Section 117 of the Mental Health Act (1983) (MHA). Clinical Commissioning Groups and Local Authorities have a duty to provide after care services to individuals who have been detained under certain provisions of the Mental Health Act for needs arising from their mental disorder. This will include access to core health services and only where these

cannot meet the assessed health needs will these be individually funded by the Commissioner.

'The Individual' - within this Policy this refers to any individual, service user or client, who has been assessed by the commissioner under The National Framework to be eligible, to have their assessed health and social care needs met and fully funded by the NHS.

'Representative' - includes any friend, unpaid carer or family member who is supporting the individual in the process as well as anyone acting in a more formal capacity (e.g. welfare deputy or power of attorney, or an organisation representing the individual).

19. References

- Department of Health: National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, *November 2012 (revised)*
- NHS England » NHS Continuing Healthcare
- NHS England » 2015/16 NHS standard contract
- Department of Health Policy Paper: Framework agreement between DH and NHS England
- Department of Health Guidance: NHS Continuing Healthcare and NHS Funded Nursing Care: Public Information Leaflet
- Decision Support Tool for NHS Continuing Healthcare, *June 2016 (amended)*
- NHS England: Guide for Health and Social Care practitioners: Ensuring a consistent person-centred assessment
- Department of Health Guidance: Mental Capacity Act Code of Practice
- NHS England » Compassion in Practice, Nursing, Midwifery and Care Staff: Our Vision and Strategy
- GOV.UK: Definition of disability under the Equality Act 2010
- NHS Commissioning Board: Commissioning Policy: Defining the boundaries between NHS and Private Healthcare, April 2013 Reference : NHSCB/CP/12
- Department of Health: Care and Support Statutory Guidance
- Department of Health: Factsheet 8, the law for carers
- NHS Choices: Your guide to care and support; Carers' assessments
- Office of the Public Guardian: Making decisions…about your health, welfare or finances. Who decides when you can't?