Northern, Eastern and Western Devon Clinical Commissioning Group

Previously unassessed periods of care operational policy

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Scrutinised by: (name & title) **Date:**	Head of Quality Assurance NEW Devon CCG Executive Committee September 2017	

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Review date of approved document:	September 2018

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Appendices

Linked strategies, policies and other documents	• National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (revised) • www.england.nhs.uk • Department of Health NHS Choices • Continuing Healthcare Retrospective Review Process July 2012 • NHS Continuing Healthcare - Dealing with requests for assessments of previously unassessed periods of care October 2012 • NHS Continuing Healthcare -Operational policy for Independent Review 30 November 2016. • Who Pays? Determining responsibility for payments to providers August 2013 • NHS England - NHS Continuing Healthcare Refreshed Redress Guidance (April 2015) • Consent form • Questionnaire • Checklist • Decision Support Tool revised 2016 • NHS Continuing Healthcare and Funded Nursing Care Appeal Review Procedure – including Previously Un-assessed Periods of Care (PUPoC)

1. Introduction

1.1 Continuing Care refers to care provided over an extended period of time to meet physical or mental health needs that have arisen as a result of disability, accident or illness.

1.2 NHS Continuing Healthcare (NHS CHC) is a complete package of ongoing care funded by the NHS where an individual has been assessed as having a Primary Health Need; as indicated in the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (Revised November 2012) (National Framework).

1.3 NHS Northern, Eastern and Western Devon Clinical Commissioning Group (NHS NEW Devon CCG) has a duty to take reasonable steps to ensure that an assessment for eligibility of CHC is carried out. If this was not carried out then a review of the previously unassessed period of care (PUPoC) should be undertaken.

2. Purpose

2.1 The Purpose of this Policy is to:

- Ensure all applications for previously unassessed Continuing Healthcare are reviewed in line with the Department of Health's closedown deadlines indicated below and where the previously unassessed period of care falls after the close down timeframe.
- Ensure consistency is applied to recommendations made to NHS NEW Devon CCG by the multidisciplinary teams (MDT) following a retrospective review of a person's eligibility for NHS CHC.
- Ensure that robust governance arrangements are in place regarding reimbursement of care funds to patients or their representatives following a review of a Previously Unassessed Period of Care (PUPoC).

3. Scope

3.1 On 15 March 2012 the Department of Health announced the introduction of deadlines for individuals to request an assessment of eligibility for NHS CHC for cases during the period 1st April 2004 – 31st March 2012.

3.2 The agreed closing dates for requesting an assessment of a 'Previously Un-assessed Period of Care' are as follows;

- Claims for periods before 1 April 2004 were required to be raised prior to 30November 2007
- Claims for periods between 1 April 2004 and March 2011, the closing date was 30 September 2012;

and

- Claims for periods between 1 April 2011 and March 2012, the closing date was 31 March 2013.

3.3 It should be noted that a period may be considered if exceptional circumstances can be identified as to why an earlier claim was not made.

3.4 Only in very exceptional circumstances will an earlier period be considered outside of the agreed Department of Health's timeframe.

3.5 Current claims, post the deadlines quoted above, will also be considered when the NHS has failed to complete an assessment or follow the process as set out in the National Framework and where NHS NEW Devon CCG has been notified of a health need.

3.6 Claims will not be considered where assessments have been completed and no appeal has been made within the 6 month timeframe. This is detailed in department of Health Guidance 2012 'NHS Continuing Healthcare: Guidance for Strategic Health Authorities and Primary Care trusts on the time limits for individuals to request a review of an eligibility decision for NHS Continuing HealthCare'.

3.7 This local policy has been developed based on the NHS England Policy guidance.

4. Implementation

4.1 On receipt of a request, NHS NEW Devon CCG will acknowledge the request and send out a questionnaire, consent form and request proof of authority, which will help establish whether or not they are the responsible commissioner (see Who Pays? establishing the responsibility for payments to providers August 2013), that the claimant has the correct authority to act for the individual and has consent to share information. The request and all future contact with the applicant, assessments and outcomes will be recorded on the NHS NEW Devon CCG administration system. If the requested documents have not been returned within 3 months NEW Devon CCG will send a reminding follow up letter. If these documents are then not returned within 1 month of the reminding letter no further action will be taken and the case closed.

4.2 NHS NEW Devon CCG will establish whether it previously fulfilled its responsibility to ensure a previous assessment was completed. If the individual had been previously assessed and the assessment was robust, clinically sound and was completed following the National Framework or previous tools used by NHS NEW Devon CCG's predecessors then NHS NEW Devon CCG will decline to consider the request.

4.3 If the client is alive and has never been assessed, NHS NEW Devon CCG will refer the client to the appropriate team in order for an assessment initially using a Checklist to take place as soon as possible as per the National Framework.

4.4 If NHS NEW Devon CCG agrees to consider the application, they will request all available documentation required to help establish whether the individual may have had a Primary Health Need. This may include all relevant notes, for example but not exclusively, hospital records, GP records social care records, care home records and domiciliary care records.

4.5 NHS NEW Devon CCG has commissioned an independent expert organisation to

complete some of the assessments. Permission to use this organisation will be sought from claimants at the earliest opportunity. A 'no response' will be considered consent to use the organisation and the letter will be worded accordingly. Claimants who refuse consent to use the organisation will have their cases reviewed by NHS NEW Devon CCG, however it may be in a longer timeframe.

4.6 If the claim period spans a number of years, the Checklist and Decision Support Tool (DST) will be used to review needs either in individual years or as the needs changed. The Checklist is a national screening tool used to help practitioners identify people who require a full assessment for NHS CHC. A positive Checklist leading to a DST is not an indication of the outcome of the eligibility decision. A Health Needs Portrayal (HNP) document may be used to collate all available evidence of health needs. The DST is the national tool used to bring together evidence and information drawn from a variety of sources to facilitate consistent, evidence-based decision- making regarding NHS CHC eligibility. It provides a framework to record needs in 12 'care domains' capture the nature, complexity, intensity and/or unpredictability of care needs which may indicate a Primary Health Need and eligibility for NHS CHC funding.

4.7 A Checklist should be completed for each period. If the client is assessed as not meeting the Checklist criteria and therefore no referral for further assessment is required, the claimant will be notified in writing and sent a copy of the Checklist with rationale as to why the claim has been declined and how to access the complaints procedure if they disagree with the process taken. If the claimant has additional information and is able to provide further evidence the declined checklist can be reviewed and this will be detailed in the correspondence.

4.8 If the client is assessed as fully or partially meeting the criteria for further assessment for the period under review the claimant will be informed in writing with a copy of the Checklist and the rationale for the decision and arrange for a HNP and / or DST to be completed.

4.9 An HNP and the DST are approved documents which enables the individuals care needs to be summarised throughout the claim period and to aid discussion regarding those care needs and whether there is a Primary Need for Health. The HNP and DST support the determination of eligibility using the Primary Health Need approach.

4.10 For a claim period of under six months or for a claim relating to care received at end of life which would have met the eligibility criteria for a fast track decision NHS NEW Devon CCG has agreed that at this stage the completed Checklist / DST and supporting documentation can be considered locally by the Quality Assurance Leads (QALs) within NHS NEW Devon CCG. If the QALs agree that the individual met the criteria for NHS CHC, for the whole period, the claimant will be informed in writing with a full rationale for the decision and reimbursement will be arranged in line with the NHS England NHS Continuing Healthcare Refreshed Redress Guidance (April 2015).

4.11 The HNP and/or the DST will be completed by experienced staff who are fully trained and conversant with the National Framework. This will include clinical transcribers as well as clinicians.

4.12 The claimant should be encouraged / supported to 'contribute' to the HNP - This can be achieved by either a meeting with the claimant or sending them a copy of the HNP by post or email and then discussing it over the telephone (if requested). The comments made by the claimant about the HNP will be considered alongside and at the same time as the completion of the DST.

4.13 The Checklist and DST processes are summarised on flowcharts at Appendix 1 and 2.

5. Recommendation

5.1 An indicative recommendation of eligibility will be made by the independent commissioned organisation's multidisciplinary team (MDT) or by NHS NEW Devon CCG's in-house team (this is subject to availability), which will be quality assured and include the four key indicators to determine evidence of a Primary Health Need.

5.2 The MDT will consist of a minimum of two professionals, at least one of whom will be a health professional, other members of the MDT should be experienced in health and/or social care and have a good knowledge of the National Framework. Additional professional input may be required as indicated by the needs of the case.

5.3 The MDT will review all the documentation (including comments from the claimant) and apply the principle of the National Framework and the Primary Health Need approach.

5.4 The MDT's discussions will be recorded and the levels of need in each domain on the DST will be agreed.

5.5 The MDT will then agree a recommendation using the four key indicators of a Primary Health Need – Nature, Intensity, Complexity and Unpredictability, clearly indicating if and where the care needs are.

6. Decision

6.1 The MDT's indicative recommendation and the claimant's comments will be considered by two NHS NEW Devon CCG senior CHC clinicians or Manager to ratify the decision. The NHS NEW Devon CCG senior clinicians or Manager can accept the recommendation or they may defer for further information.

6.2 Once a recommendation has been accepted by NHS NEW Devon CCG, a copy of the HNP and the DST and a letter will be will be sent to the claimant confirming the outcome, giving a clear rationale for the decision and requesting that they confirm that they accept the decision by returning the acceptance slip.

6.3 Information detailing how to dispute the outcome of the DST will be included in the letter where appropriate. This will include the option of a local resolution meeting, where claimants will have the opportunity to discuss the decision.

6.4 The outcome of the local resolution will be sent to the claimant giving a clear rationale for the decision. If the claimant does not accept the decision they will be given

information about how to refer to NHS England for Independent Review Process (IRP). This is detailed in the NHS Continuing Healthcare and Funded Nursing Care Appeal Review Procedure.

6.5 If the claimant accepts the decision, they are requested to return the acceptance slip and the case can be closed.

7. Approval of Payments

7.1 The NHS NEW Devon CCG administration system will be updated within 24 hours of acceptance of the eligible decision together with the eligible period. Finance will provide a monthly report from NHS NEW Devon CCG administration system identifying all new eligible cases enabling CCG awareness of the potential financial implications of these decisions.

7.2 The payment will be approved in accordance with the NHS NEW Devon CCG's Standing Financial Instructions.

7.3 NHS NEW Devon CCG will request proof of expenditure. Acceptable forms of evidence include invoices, bank statements or nursing home receipts.

7.4 Once all relevant proof has been received these will be passed to the finance team to arrange re-imbursement and calculate any compound interest in line with Retail Price Index (RPI) as per the NHS Continuing Healthcare Refreshed Redress Guidance (April 2015). (Appendix 3).

7.5 Payments should be made to the established legal claimant unless that individual nominates another to receive the funding due.

7.6 Where proof of expenditure is not available NHS NEW Devon CCG will advise the applicants that the case will be closed unless the individuals wish to complain setting out the reasons why the case should be considered in the absence of a total lack of financial information. This will also need to consider that when the request for retrospective review was first made the CCG notified the applicants that proof of payment would be required.

8. Complaints

8.1 If a patient or their families/carers are unhappy with an aspect of processing their claim, based upon this policy then the Patient Advice and Complaints Team within NHS NEW Devon CCG will manage and investigate their complaint in line with the CCG's concerns and formal complaint handling policy. For further detail on how to provide feedback or raise a formal complaint can be found of the Patient Advice and Complaints Team webpage: http://www.newdevonccg.nhs.uk/information-for patients/pals-and-complaints-team/100081

9. Distribution

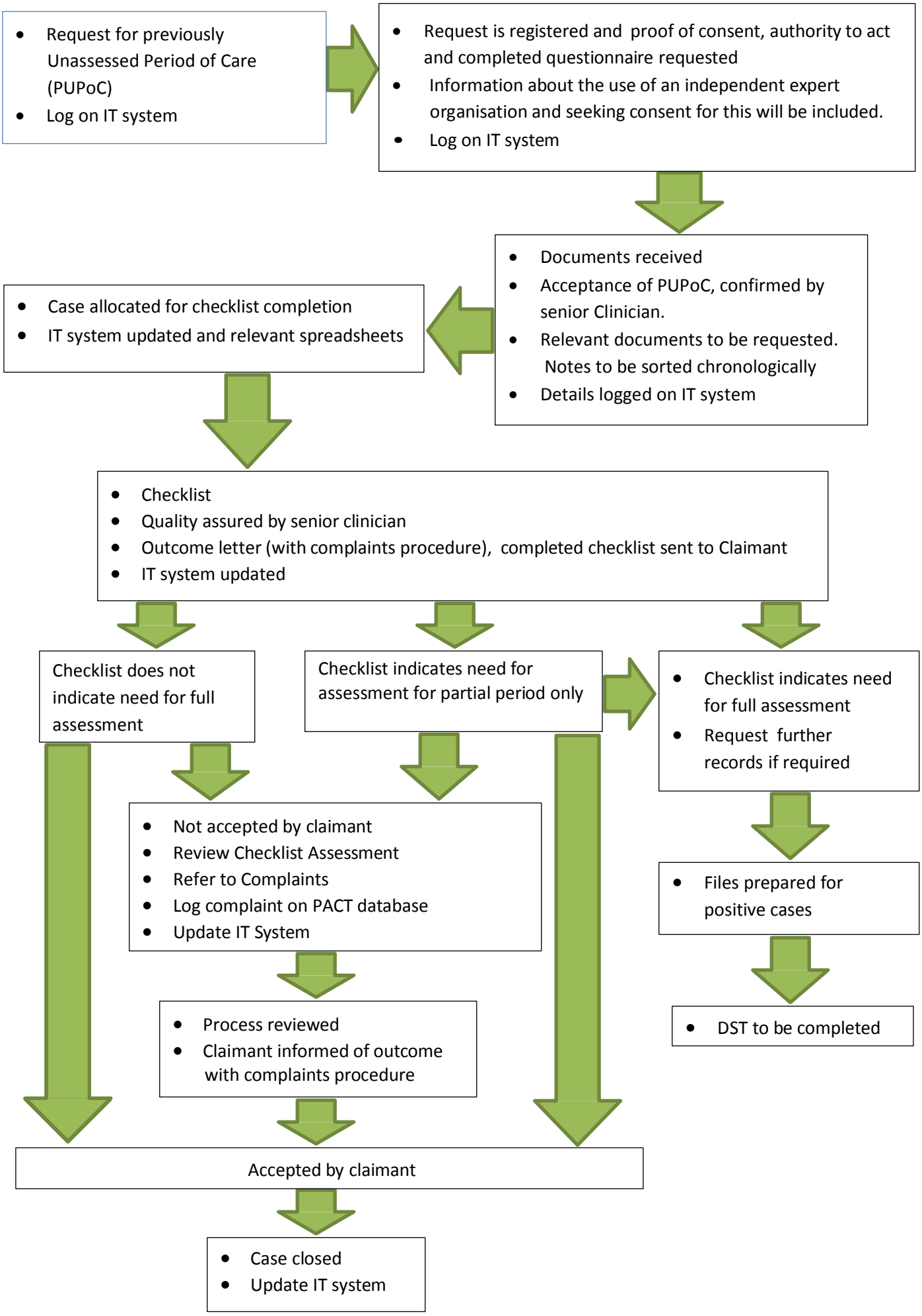
9.1 Staff will be advised of this policy through NHS NEW Devon CCG's electronic newsletters and NHS NEW Devon CCG website.

9.2 Managers are responsible for ensuring that staff read and are aware of how to access this policy.

9.3 The policy will be widely available to all staff and volunteers via their line manager and NHS NEW Devon CCG website www.newdevonccg.nhs.uk

APPENDIX 1

CHECKLIST PROCESS FLOW CHART



APPENDIX 2 **DECISION SUPPORT TOOL PROCESS**

- Case allocated for Health Needs Portrayal Positive or partially positive checklist

- More than one DST may need to be completed

Draft Health Needs Portrayal to be sent to claimant to comment on – via face to face meeting or in writing or telephone.

Completed DST to be quality assured by Quality Assurance Lead Nurse prior to MDT meeting

- DST and all supporting documents to be reviewed by Multidisciplinary team (MDT) consisting of at least of 2 people of different professions).
- The MDT will consider the level of need for each domain and give the recommendation taking into consideration the 4 key indicators and whether these indicate a primary health need.
- Details of the deliberations and the recommended level of needs to be recorded on the DST

Completed DST including MDT deliberation ratified by two senior CCG clinicians

- Completed CCG ratification, final DST(s) and reply sent to claimant.
- If recommendation is eligible (fully or partially) – invoices /proof of payments are requested.
- If recommendation is not eligible (fully or partially) - details of how to dispute this decision in the letter.

<u>ELIGIBLE OR PARTIALLY ELIGIBLE OUTCOME</u>

- Received invoices checked to confirm dates.
- Invoices passed to finance for final payment including interest as per redress guidance.
- Finance to record payment and process on IT system

Where no financial evidence is supplied:

- Outcome recorded and sent to claimant

Where financial evidence is supplied:

- Finance to inform PUPoC team when payment has been made

<u>DISPUTED NOT ELIGIBLE OUTCOME</u>

- A LRM will take place with the claimant and a CCG clinician.
- The outcome recorded and sent to claimant.

If no resolution, claimant will be given details of how to request an Independent Review by NHS England

CCG to abide by NHS England recommendation

<u>ALL CASES</u>

- All stages in the process are recorded on the NHS NEW Devon CCG IT system and once the final outcome has been agreed the case is closed

APPENDIX 3

NHS England

NHS Continuing Healthcare

Refreshed Redress Guidance

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03261**
Document Purpose	Guidance
Document Name	NHS Continuing Healthcare Refreshed Redress Guidance
Author	NHS England
Publication Date	01 April 2015
Target Audience	CCG Accountable Officers, CSU Managing Directors, Directors of Nursing, Directors of Finance, Heads of NHS Continuing Healthcare and their teams
Additional Circulation List	
Description	NHS England has published final refreshed Redress Guidance for NHS Continuing Healthcare for CCGs. This now reflects guidance from the Parliamentary and Health Ombudsman for all public sector bodies, on calculating interest on redress payments
Cross Reference	National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)
Superseded Docs (if applicable)	Department of Health NHS Continuing Healthcare: Continuing Care Redress (2007)
Action Required	For implementation
Timing / Deadlines (if applicable)	**This Guidance applies with immediate effect from date of publication**
Contact Details for further information	Continuing Healthcare Nursing Directorate Quarry House, Quarry Hill Leeds LS2 7PD http://www.england.nhs.uk/ourwork/pe/healthcare/redress-guidance-ccgs/

Document Status

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Contents

1 Executive Summary

This Guidance

1. This guidance is a refresh of "NHS Continuing Healthcare: Continuing Care Redress Guidance" published by the Department of Health on 14 March 2007[1] in response to the Parliamentary and Health Service Ombudsman's report "Retrospective Continuing Care Funding and Redress" published 13 March 2007. This guidance follows the principles set out in the Parliamentary and Health Service Ombudsman's "Principles for Remedy"[2].

2. The purpose of this guidance is to assist Clinical Commissioning Groups (CCGs) when settling claims for individuals arising from NHS Continuing Healthcare eligibility decisions or where an eligibility decision has been reached on a previously un-assessed period of care in respect of NHS Continuing Healthcare and the need for redress has been identified.

3. NHS England has responsibility for NHS Continuing Healthcare for specified groups, for example prisoners and serving members of the Armed Forces and their families. Throughout this document where CCG is referred to, the guidance will also apply to NHS England in relation to these specified groups.

4. This guidance also retains the previously established principle that "where maladministration has resulted in financial injustice, the principle of redress should generally be to return individuals to the position they would have been in but for the maladministration which occurred."

5. This guidance does not remove the requirement for CCGs to consider the specific circumstances of each individual case when determining the appropriate level of redress.

6. The guidance recommends that the Retail Price Index is the appropriate interest rate to apply to redress.

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[1] http://collection.europarchive.org/tna/20080107220102/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_073094

[2] http://www.ombudsman.org.uk/__data/assets/pdf_file/0009/1035/0188-Principles-for-Remedy-bookletweb.pdf

7. The guidance applies with immediate effect from the date of publication where:

    - an eligibility decision for NHS Continuing Healthcare has been made on or after the date of publication of this guidance; **and**
    - the need for redress has been identified by the CCG.

8. The Parliamentary and Health Service Ombudsman is aware that this guidance has been developed.

2 Background

1. NHS Continuing Healthcare is a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness. Where an individual has both health and social care needs, but they have been assessed as having a 'primary health need' under the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*[3] (the National Framework), the NHS has responsibility for providing for all of that individual's assessed health and social care needs. This care can be provided in a number of settings, including at home. Further information on the policy can be found in the National Framework.

2. This guidance has been developed to reflect the new NHS framework and structures which came into effect on 1 April 2013. This guidance details the appropriate interest rate which should generally apply to NHS Continuing Healthcare redress. This approach aims to achieve an outcome that is fair and reasonable to the individual and will demonstrate an appropriate use of public funds.

3. The Parliamentary and Health Service Ombudsman's report "Retrospective Continuing Care Funding and Redress"[4] was published on 14 March 2007. Subsequently, the Department of Health issued the *NHS Continuing Healthcare: Continuing Care Redress*[5] Guidance in 2007 to help Primary Care Trusts review the approach they had taken, and were taking, to settle cases arising from continuing care reviews since 1996.

4. The purpose of redress is solely to restore the individual to the financial position they would have been in had NHS Continuing Healthcare been

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf
[4] http://www.ombudsman.org.uk/__data/assets/pdf_file/0011/1118/Retrospective-continuing-care-funding-and-redress.pdf
[5] http://collection.europarchive.org/tna/20080107220102/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_073094

awarded at the appropriate time. As set out in “Principles for Remedy” “remedies should not lead to a complainant making a profit or gaining an advantage”. This principle also applies to the NHS.

3 Redress Guidance

Action

1. The guidance applies with immediate effect from the date of publication where:
   - an eligibility decision for NHS Continuing Healthcare has been made on, or after, the date of publication of this guidance; **and**
   - The need for redress has been identified. This is irrespective of the period of care for which NHS Continuing Healthcare funding is being paid.

   Therefore if the CCG is in the process of undertaking an assessment of a case and the decision on eligibility is made after publication of the guidance then, if appropriate for redress, this guidance applies.

Redress

2. CCGs are independent decision-making bodies. When making redress payments they should employ a transparent rationale and ensure they fully consider the individual circumstances of each case, taking legal advice where necessary. CCGs have the discretion to consider making ex-gratia payments, over and above the care costs and interest, however, these are expected to be exceptional and would need to be made in accordance with a CCG's own Standing Financial Instructions and any other pre-requisite guidance.

Interest rate

3. Redress is about placing individuals in the position they would have been in had NHS Continuing Healthcare been awarded at the appropriate time and not about the NHS or the public profiting from public funds.

4. CCGs are advised to apply the Retail Price Index for calculation of compound interest when considering redress cases. The index is calculated monthly, with an average for each calendar year. CCGs are advised to apply the average rate for the year for which care costs are being reimbursed. The rates of the

Retail Price Index are available from the Office of National Statistics at: http://www.ons.gov.uk/. The contact details for the Office of National Statistics are available here http://www.ons.gov.uk/ons/site-information.

5. It is important that once an eligibility decision for NHS Continuing Healthcare is reached, CCGs should promptly pay any redress sums owed to individuals or their representatives. Disputes about aspects of the redress payment or other aspects of a case should be dealt with subsequently.

Legal costs and complaints

6. The Parliamentary and Health Service Ombudsman has indicated that it is rarely appropriate to receive a refund of legal and professional costs in bringing forward an NHS Continuing Healthcare dispute.

7. Individuals do not need to seek legal advice in order to request an assessment of eligibility for NHS Continuing Healthcare and there is also a mechanism to request a review of a decision on eligibility. CCGs and third sector services will help and advise individuals or their representatives on the process that will be followed in line with the '*National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care'*.

8. If an individual is dissatisfied with the CCG's redress offer, they can pursue the matter via the CCG's complaints process. However, CCGs should not delay payment in respect of undisputed elements.

Deferred payment agreements

1. CCGs are reminded that under section 55 of the Health and Social Care Act 2001, effective since 1 October 2001, people in care homes who are responsible for paying all or part of their fees may be able to avoid having to sell their home to pay the fees by entering into a Deferred Payment Agreement with their local authority. The duties on local authorities to offer deferred payments are strengthening and being expanded from April 2015 (as a result of the Care Act 2014) so more people will be eligible than previously. Those already in residential care could now qualify for a deferred payment under the new rules, even if they have not previously been eligible.

2. If offering a deferred payment was omitted in a particular case, the CCG should ensure that the individuals are directed to the local authority who provided or arranged the accommodation, usually this will be the local authority for the area where the house is situated. Complaints about this aspect of policy should be raised with the local authority and, if not resolved, with the Local Government Ombudsman's Office.