All Age Continuing Healthcare Operational Policy

NHS Devon

Version	1.1
Policy Sponsor	Chief Nursing Officer
Policy Lead	Head of Quality Assurance
Approved by	Chief Nursing Officer and Chief Medical Officer
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Document change history			
Date	**Change**	**Version number of policy**	**Comments**
05/09/2022	New Policy	0.1	Review of Previous Policy documents by Head of Quality Assurance and Nursing
05/09/2022	New Policy	0.2	Transfer of previous policy documents onto new NHS Devon branded template. This included updating with the updated national CHC framework guidance.
03/04/2023	New Policy	0.4	Drafting of new policy to include both children and adult's processes and procedures.
07/08/2023	New Policy	0.4	Clarification on points of difference between the children's and the adult's policy.
07/08/2023	New Policy	0.5	Amended from feedback from the CHC team and Beacon Advisory service.
04/12/2023	New Policy	0.6	Final Draft approved by Chief nursing Officer and Chief Medical Officer
29/04/2024	New Policy	1.0	Finalisation and approval of policy, following a QEIA and implementation plan being completed.
16/04/2025	New Policy	1.1	Review of policy, date changed for Who Pays Guidance

Equality, diversity and inclusion statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672
Email: d-icb.patientexperience@nhs.net

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1. Introduction

1.1 NHS Devon Integrated Care Board (ICB) has a statutory responsibility to deliver NHS Continuing Healthcare (CHC) and Children and Young People's Continuing Care (CYPCC) for the population of approximately 1.2 million people registered with a General Practitioner (GP) within the ICB's boundaries.

1.2 This Policy recognises the statutory differences between CHC and CYPCC but also confirms an overarching series of fundamental value statements and core principles common to both; encompassed here as a single entity.

2. Purpose and objectives

2.1 The aim of this policy is to ensure that high-quality, cost-effective care is delivered, and to support consistency and equity of access to services for individuals assessed as eligible for NHS Continuing Healthcare, a health contribution to a joint package of health and social care and Children and Young People's Continuing Care.

2.2 This policy will ensure that:

- NHS Devon meets its statutory duties, to operate within financial frameworks and parameters which must be considered in addition to the Human Rights Act. The ICB also has an obligation of equality under the Public Sector Equality Duty.
- This policy should be read in conjunction with the National Framework for Continuing Healthcare and NHS Funded Nursing Care (2022 and the National Framework for Children and Young Person's Continuing Care (2016).
- The principles of this policy apply to the provision of Personal Health Budgets (PHB). All individuals who are eligible for NHS Continuing Healthcare or Childrens Continuing Care funding and have home based care will have their support as a PHB. All guidance in relation to personal health budgets and integrated personal budgets (for joint funded support) can be found in the ICB's PHB guidance.
- This policy sets out the principles and processes for implementation of the National Framework for Continuing Healthcare and NHS Funded Nursing Care (July 2022) and the National Framework for Children and Young People's Continuing Care (2016), hereinafter referred to as the National Framework(s).
- It is expected that readers of this policy will already be familiar with the content of the relevant National Frameworks and Responsible Commissioner Guidance

National framework for NHS continuing healthcare and NHS-funded nursing care - GOV.UK (www.gov.uk)

National Framework for Children and Young People's Continuing Care (publishing.service.gov.uk)

https://www.england.nhs.uk/wp-content/uploads/2022/06/B1578_i_who-pays-framework-final.pdf

3. Scope

3.1 This Policy applies to NHS Devon ICB workforce for the AACC operational teams, whether in the Business Unit or at Place (including the sub delegated duties of Torbay and South Devon Foundation Trust – the 'FT'.

4. Definitions

Term	Acronym	Definition
All-Age Continuing Care	AACC	A combined approach to the delivery of NHS CHC and CYPCC.
Accessible Information Standard	AIS	The Accessible Information Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of individuals, service users, carers and parents with a disability, impairment or sensory loss.
Best Interests	BI	A statutory principle set out in Section 4 of the Mental Capacity Act. It states that 'Any act done, or a decision made, under this Act or on behalf of a person who lacks capacity must be done, or made, in his best interests'.
Care Quality Commission	CQC	The independent regulator of all health and social care services in England.
Checklist		A screening tool designed to indicate whether or not full assessment of eligibility for NHS funding is required.
CHC Competency Framework		The NHS CHC Maturity Framework was designed to support the NHS in its local service design, to include workforce development programmes, supervision, appraisal and job descriptions.
Children and Young People's Continuing Care	CYPCC	Continuing Care may be provided for children and young people whose health needs cannot be met by existing universal, targeted or specialist health services. The aim of the care package is to support the child/young person's parent (s) and/ or carers to manage their child/young person's care at home and/or in

Term	Acronym	Definition
		other settings. It may require the provision of services from the NHS, social care, education, or other organisations to enable the child/young person's parent (s) and/ or carers to be appropriately supported in their community.
Continuing Healthcare	CHC	A package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in this National Framework (July 2022). Such care is provided to an individual aged 18 or over.
Court of Protection Deputy		An authorisation by the Court of Protection to make decisions on behalf of a named individual if they 'lack mental capacity' to make a decision for themselves at the time it needs to be made.
Decision Support Tool	DST	A document designed for recording the MDT assessment for CHC/CYPCC eligibility.
Deprivation of Liberty Safeguards	DoLS	An amendment to the Mental Capacity Act 2005 which ensures people who cannot consent to their care arrangements in a care home, hospital, or own home (per 2014 amendments) are protected if those arrangements amount to a deprivation of liberty.
Domiciliary Care		Care, including clinical care, delivered in the individual's own home.
Do Not Attempt Resuscitation form	DNAR	A document agreed between the individual (or approved representative) and their responsible medical clinician, instructing that in the event of a cardiac arrest, the individual's wishes to not be resuscitated will be respected.
Education Health and Care Plan	EHCP	An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs
Funded Nursing Care	FNC	Funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse.
Fast Track	FT	An AACC funding stream that can be implemented without full assessment for a person who is rapidly deteriorating and may be in the terminal stage of their life / life-limiting condition; together with the need for urgent care support and delivery.

Term	Acronym	Definition
Gillick competence		It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. If a child passes the Gillick test, he or she is considered 'Gillick competent' to consent to that medical treatment or intervention
Health Needs Assessment	HNA	An assessment to accurately reflect a person's needs, aimed at promoting physical and mental health (and to inform the child's Individual Health Plan), as well as supporting the multi-disciplinary team in their recommendations to the ICB
Independent Mental Capacity Advocate	IMCA	A legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.
Independent Review Panel	IRP	An expert panel with an independent Chair, to enable individuals and/or their representatives to look at the primary heath need decision by a NHS Body and / or the procedure followed in reaching a decision about eligibility to NHS Continuing Healthcare; and to make a recommendation to NHS England in the light of its findings. https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/our-services/continuing-health-care-independent-review-panels/
Integrated Care Board	ICB	Integrated Care Boards (ICB s) are statutory organisations that bring NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Integrated Care System	ICS	Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

Term	Acronym	Definition
		Following the passage of the Health and Care Act (2022), 42 ICSs were established across England on a statutory basis on 1 July 2022.
Integrated Discharge Team	IDT	An integrated multi-disciplinary team who triages individuals who have ongoing care needs, planning and facilitating discharge from hospital.
Joint Funding	JF	CHC: Where the NHS identifies health needs for an individual out with those core NHS services applicable to all. The person has been found not eligible for fully funded NHS CHC. CYPCC: This may include joint or Tri part funding with Education/social care
Lasting Power of Attorney	LPA	A legal document that lets the 'donor' appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf if they lack mental capacity.
Liberty Protection Safeguards	LPS	The replacement for DoLS, announced in a Mental Capacity (Amendment) Bill which passed into law in May 2019. Key features will include starting at 16 years of age, and deprivations of liberty having to be authorised in advance by the 'responsible body'. The LPS process has not currently been lawfully enacted as at 16.04.25 .
Local Resolution Meeting	LRM	A meeting with the individual / family aimed at transparently reviewing and explaining the process taken to come to the eligibility decision. The LRM also has a responsibility to listening to the individual's concerns and offering resolution to those concerns where possible.
Multi-Disciplinary Team	MDT	For AACC, an MDT is defined as at least two care professionals from different disciplines. These should be practitioners who know the individual and are knowledgeable about their specific care needs. The MDT will make a joint recommendation to the NHS over NHS CHC / Children's CC eligibility, following a comprehensive assessment of needs.
Mental Capacity Act (2005)	MCA	The Mental Capacity Act 2005 is an Act of the Parliament of the United Kingdom applying to England and Wales only. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves.

Term	Acronym	Definition
Needs Portrayal Document	NPD	A document used to collate information and reflective of a person's needs spanning a defined period of time (restricted to those periods beyond 01.04.2013), to assist the NHS in deciding whether an individual may have presented with health needs warranting NHS CHC eligibility at any point.
Outsourcing		This is where to support the CHC processes, a proportion of the work is contractually outsourced to another company. The company applies the same standards and principles of the CHC framework. All recommendations from the outsourcing company are verified by the ICB
Parliamentary and Health Services Ombudsman	PHSO	A formal body which makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations.
Personal Budget	PB	A budget given to the individual to purchase care independently to meet their assessed needs and personal preferences. This may be for a joint / tripartite funded package of care
Personal Health Budget	PHB	Funding provided for a NHS CHC package to be delivered in a highly personalised approach, commissioned either by the ICB, via a third party, or directly by the individual / their legal representative via a direct payment.
Previously Unassessed Period of Care	PUPoC	A time period during which the individual had not been considered for NHS CHC eligibility.
Primary Care Network	PCN	A group of GP Practices grouped together to enhance delivery of primary care services to a local population.
Primary Health Need	PHN	A concept central to deciding whether the entirety of someone's care needs should be met by the NHS or the local authority. An individual has a primary health need if, having taken into account all their health and social care needs, it can be said that needs for healthcare outweigh those needs for social care and accommodation. The "test" of whether someone has a primary health need emerges from the Coughlan court judgment (R v North & East Devon Health Authority ex parte Coughlan [1999] EWCA Civ 1871). The test focused on the concepts of the "nature" of the needs (whether they were of a type that a local authority could be expected to provide), and the extent of those needs (whether any

Term	Acronym	Definition
		health needs were incidental and ancillary to legitimately provided social care needs)
Quality Innovation Productivity and Prevention	QIPP	An NHS scheme aimed at improving quality, encouraging innovation, delivering preventative activities to reduce demand on health services and to improve use of resources.
Shared Business Services	SBS	A provider of corporate, often financial services to the NHS, including invoice management.
SPINE		The system supporting the IT infrastructure for health and social care in England, allowing information to be shared securely between over 20,000 organisations.

5 Operational Policy and Enablers

5.1 Commissioning

5.1.1 The ICB will undertake collaborative commissioning with Devon County Council, Plymouth City Council and Torbay Council, wherever possible, identifying efficiencies in planning and delivery to include integrated systems of work.

5.1.2 We will promote individual health, well-being, and independence.

5.1.3 We will share responsibility for maintaining the health and well-being of people in our communities with family, carers, friends, and other organisations.

5.1.4 We will achieve better outcomes by promoting independence and building on the strengths of individuals.

5.1.5 We will promote choice and control so people can receive support in ways that are meaningful to them but will balance this against the effective and efficient use of our resources.

5.1.6 We will, wherever possible, support people to live at home or in the community through aligning and developing our community resources.

5.1.7 We will work to ensure people are protected from significant harm whilst allowing people to take risks.

5.1.8 We will always seek the most cost-effective way to provide support, in order to ensure we can continue to meet the needs of all people eligible for health and social care support.

5.1.9 To note to enable efficiencies and to support the delivery of the CHC function, that the CHC assessment and review processes a proportion of the service is contractually outsourced.

5.2 Principles

5.2.1 When commissioning services for people, we will place greater emphasis on the achievement of outcomes and value for money over the level of choice available. The ICB will aim to operate a person-centred approach to care planning and commissioning, using models that maximise personalisation and individual control and that reflect the individual's preferences.

5.2.2 The funding made available to support an individual will be determined by the most cost-effective care package, based on the local care market, the availability of local care providers and the cost of community based and residential or nursing care.

5.2.3 All individuals living at home will have their care delivered through a person-centred care plan reflecting clear outcomes which is funded by a PHB or notional PHB (held by the ICB) aiming to maximise independence and control over their health and care outcomes.

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

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

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

5.2.7 It is the responsibility of the NHS to make reasonable offers of services to individuals eligible for Continuing Healthcare and Children's Continuing Care to meet their assessed needs. If offers of reasonable services are made to individuals to meet their assessed needs and refused, the ICB has discharged its legal duty to those individuals.

5.2.8 We will always aim to integrate commissioning with partners across the Integrated Care System (ICS).

5.3 Safer Patients, Safer Cultures and Safer Systems

5.3.1 The ICB is continuously working to improve patient safety. Patient safety will always remain paramount in planning a care package and will not be compromised.

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

5.3.3 It is vital that the personalised care and support plan and any undertaken assessments capture the complexity of the individual's needs, providing the necessary evidence that the needs are of such a level which warrants the requested care package. This will enable the ICB to better understand, better commission and effectively manage the needs of individuals within the population they serve.

5.3.4 For assessed needs to be approved by the ICB, they must be identified and detailed in the personalised care and support plan and must be:

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

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

5.3.4.3 **Affordable**: All costs have been identified and can realistically be met within the budget. In deciding whether the support plan is affordable it must show that it is within the indicative budget or, if the indicative budget is exceeded, a clear and reasoned explanation is provided to justify the additional spend.

5.3.4.4 **Appropriate:** The personalised care and support plan should not include the purchase of items or services that are inappropriate for the state to fund or that would bring the NHS into disrepute. Or where funded already through universal services. The plan must have clear and strong links to a health or social care outcome.

5.3.5 There may be circumstances where concerns are raised about the quality of care from a provider. The ICB will work with individuals and their

families to address those concerns to improve quality or commission where appropriate an alternative package of care.
In all cases, the ICB will work with individuals to ensure that the personalised care and support plan is managed on an individual basis and responsive to their changing needs and circumstances.

5.3.6 The ICB is committed to ensuring that a high quality, person-centred approach is at the heart of everything it does, whilst remaining focused on safe and effective care.

5.4 Strategy and Leadership

5.4.1 The ICB will appoint a dedicated accountable lead for AACC, sponsored by the Chief Nurse and Accountable Officer to steer the direction of operations and provide leadership.

5.4.2 The AACC service will have a comprehensive list of QIPP schemes in place, all of which achieve or exceed the QIPP target expected. All QIPP schemes are closely monitored and opportunities to expand or extend schemes are maximised. This will include a rolling programme of improvement, monitoring and evaluation.

5.4.3 The ICB will ensure that clear lines of accountability are present in AACC services, well-defined and well documented for all processes and that there is proportionate governance architecture in place to support the delivery of a fair and sustainable, high-quality service.

5.4.4 The ICB will operate an organisational climate that is positive, resilient, and progressive. The AACC team will be supported in their decision making and understand the wider positioning of the AACC service within the ICB and be clear as to the objectives of their role(s) and that of the AACC service as a whole.

5.5 Individuals and Families

5.5.1 The AACC service will work proactively to involve the individual and/or their family/representatives in referral and assessment processes and to formally acknowledge, record and consider their views, through attendance at meetings (face to face, video/teleconference) or through submission of written statements for consideration throughout the process of assessment, case management and review.

5.5.2 To manage expectations and to provide further understanding of the patients journey in NHS CHC / Children's and young people's Continuing Care, national and local information leaflets will be provided together with:

5.5.2.1 Information provided on the ICB website (including a copy of this policy). This will also include detail of the Beacon national CHC and Advice service.

5.5.2.2 Information provided by Council websites.

5.5.2.3 Signposting correspondence to NHSE websites and document folders.

5.5.2.4 Open access to the service via telephone, where a citizen is able to speak directly to a subject matter expert from the team via the service Single Point of Access line.

5.5.3 The AACC service will utilise templated letters communicating the outcome of referrals and decisions relating to assessment / eligibility, sent to the individual and/or their representative (where applicable) **within 48 hours of decision together with a copy of the Decision Support Tool (DST) and the reasons for those decisions.**

5.5.4 The AACC service will have due regard to the ICB's statutory duty to follow the Accessible Information Standard in its operations and to support implementation of the Standard in its commissioned services. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of individuals, service users, carers and parents with a disability, impairment or sensory loss.

https://www.england.nhs.uk/publication/accessible-information-standard-specification/

5.5.5 Any other adjustments required to meet individual communication support needs will also be facilitated as far as practicable, relating to any protected characteristic under the Equality Act 2010.

5.5.6 A named coordinator/ Specialist Nurse Assessor will be assigned to each individual and the individual/family/representatives will be formally advised of the coordinator's contact details.

5.5.7 Individual and family feedback will be collected and utilised to improve the service, through proactive information gathering via surveys and recording of compliments; the outcome of investigations into complaints; cases reviewed by the PHSO; the outcome of resolution meetings and appeals; and will be used alongside feedback from NHS England's Independent Review Panels (IRP).

5.5.8 The AACC service will ensure that elements of the service are developed through co-production with individuals (including experts by experience) and families and partner organisations.

5.5.9 For CYPCC the National Framework for children is followed. Given the elements common to both the EHC plan assessment, and the continuing care process commissioners and local authorities should consider how the two processes can be brought together, to articulate a single set of needs and outcomes. There are many children and young people with special educational needs or disability without a continuing care need, and their health needs should of course be reflected in the EHC plan.

5.5.10 Local authorities and ICB must work together to make EHC plans work, and their joint arrangements should include an agreement as to how continuing care fits with the EHC process. Although the processes are

different, the same information and professionals across disciplines should be involved, in order to result in a coherent package of care across health, education and social care for children and young people who are eligible for continuing care.

5.6 Zero Tolerance

5.6.1 The AACC service will follow the NHS and ICB's strategy and policy on Zero Tolerance of abuse.

https://onedevon.org.uk/download/persistent-and-unreasonable-members-of-the-public-policy/?hilite=persistent+and+unreasonable

5.6.2 The policy extends to our partner service –

https://www.torbayandsouthdevon.nhs.uk/uploads/25420.pdf

5.7 People and Skills (Workforce Development)

5.7.1 AACC documentation will be completed by staff who have received training in the principles of the National Framework and are trained in the use of the published tools. NHS England and NHS Improvement has developed an **NHS Continuing Healthcare (NHS CHC) Workforce Development Programme**.

This programme aims to:

- Develop clinical assessors and administrators who are already familiar with NHS CHC or are currently working in NHS CHC; and
- Introduce new clinical assessors and new administrators to NHS CHC
- Support the training and development of social care practitioners in the field of NHS CHC.
- The programme is specifically focused on achieving competency for the NHS CHC

5.7.2 The programme will describe the minimum levels of development and competence necessary to operate within the sphere of AACC services.

5.7.3 The AACC service will actively identify other provider services involved in NHS CHC / CYPCC and ensure that an effective, rolling training programme is in place to ensure that these identified groups complete education that confirms skills and knowledge in the subject area, commensurate with role and function.

5.7.4 Education will be delivered collaboratively wherever possible, led by the ICB AACC team as part of a planned annual programme. The AACC team will proactively seek feedback from delegates and adjust delivery to satisfy need.

5.7.5 The AACC service will ensure that staff are supported through effective training and supervision and have protected time for learning & development. Staff will be supported to take opportunities forward in

developing senior leadership, patient management and administrative skills and in developing resilience, supported by the workforce plan and senior management. Training uptake will be monitored and utilised to proactively inform where further support may be required.

5.7.6 The AACC service operates caseload review on the basis of clinical priority, commencing with patient safety, including timely case reviews of commissioned care.

5.7.7 The underlying principle of the AACC service is to ensure that the Right Care is delivered at the Right Time, in the Right Place to the Right Person.

5.8 Governance

5.8.1 The AACC service has a fully implemented governance schedule that monitors decision-making processes to enable a consistent and fair application of National Frameworks and in accordance with the Standing Rules (2012/13).

5.8.2 These arrangements will include regular audit of process and decision-making, the aim to ensure Statutory / regulatory compliance and consistency of process across the ICB. External peer review is provided via NHS England's IRPs, 'deep dives' into performance data.

5.8.3 The AACC workforce are required to ensure that procurement sits within the national systems of good governance to include considerations of (not exhaustively):

- Standing Financial instructions
- Contractual guidance and limitations
- Local procurement policy

5.8.4 Clear oversight of provider performance will be maintained, requiring regular reporting from providers against their contractual obligations and monitoring KPIs, with a plan in place to address provider quality and also to share best practice and compliments where appropriate.

5.8.5. Joint Local Authority governance processes are in place and are actively utilised to manage the transfer of responsibilities between ICB and the Local Authority , proactively meeting the 28-day target.

5.8.6. Given the elements common to both the EHC plan assessment, and the continuing care process commissioners and local authorities should consider how the two processes can be brought together, to articulate a single set of needs and outcomes. There are many children and young people with special educational needs or disability without a continuing care need, and their health needs should of course be reflected in the EHC plan.

https://www.devon.gov.uk/education-and-families/send-local-offer/

This to include stakeholder responsibilities for those young persons deemed Looked After (Children Act 1989)

https://www.scie.org.uk/publications/introductionto/childrenssocialcare/lookedafterchildren.asp

5.8.7. The AACC service will ensure clarity and agreement with all stakeholders on ways of working, organisational obligations, and performance management processes. This includes agreement with any organisations commissioned to deliver AACC on the ICB's behalf and extends to other providers and delivery partners in the AACC landscape for example (non-exhaustive) LAs, Education, acute trusts and care homes/residential schools.

5.9 Technology and Systems

5.9.1 The AACC service will work with software providers to develop fully interoperable caseload management software for use across the end-to-end AACC process, which facilitates a single source of evidence (where possible), fully meeting NHS digital expectations (to include the Patient Level Data Set Programme)

5.9.2 Notification of both upcoming and overdue assessments and reviews is available live within the system. Clerical procedures and scheduling are supported by the use of the caseload management database and / or other customisable software. Individuals requiring assessment or review are flagged by the integrated technology platform through the production of reports that can be run at any time and demonstrate progress in pathway against a countdown clock.

5.9.3 Equipment and technology to support remote working over a secure connection, enabling access to individual level data has been made widely available to the AACC team and is the default expectation.

5.9.4 Workflow(s) are fully structured and/or addressed using software, with assessments carried out electronically and automatically directed to the relevant team member.

5.9.5 Invoice processing and validation is supported by a high level of automation with governance workflows built in.

5.9.6 Referrals are submitted via a digital platform.

5.10 Data and Information

5.10.1 There is a central repository of information that integrates all data across the end-to-end AACC process, is actively maintained and audited for data quality and is accessible remotely.

5.10.2 Regular data quality checks are in place as a matter of routine. This includes an external and annual data Health check through the existing service provider.

5.10.3 AACC insights are shared between Place-based Alliances to share best practices and lessons learnt.

5.11 Invoices and Payment

5.11.1 Invoices from domiciliary care providers must be accompanied by evidence in the form of timesheets confirming staff attendance, which will be validated by the ICB against the funding agreement / contract prior to payment being approved.

5.11.2 Invoices must include the individual unique individual identifier number to facilitate payment process. Invoices will be rejected at source where GDPR is deemed to have been breached.

5.11.3 Providers are expected to have due regard to the ICB's policy regarding Initiation, Suspension and Cessation of Funding when an individual in receipt of funding is admitted to hospital, dies, or is not in receipt of the commissioned package of care for any other reason.

5.11.4 The ICB recognises that there will be individual circumstances (including the retention of familiar workforce) where payment suspension is not possible. Such instances will be managed on a case-by-case basis and defined as extenuating circumstances.

5.11.5 Robust financial arrangements between the ICB, Local Authorities and providers will be facilitated through 'Care Package Agreements' and quarterly financial monitoring.

5.11.6 The ICB will ensure that all valid invoices are paid in a in accordance with scheduled payment runs.

5.12 Market Management

5.12.1 Proactive and long-term support and management of the provider market, including strategic commissioning and procurement will be in place via a clearly articulated strategic commissioning plan, which is understood by commissioners, clinicians, suppliers and individuals.

5.12.2 Clear contracting routes will be in place for all providers, with up-to-date care specifications. To include consideration of the uplift in the price of commissioned services to ensure any such discussions are facilitated via the ICB and to ensure that providers do not attempt to impose third party top-ups on individuals.

5.12.3 The ICB will adopt a collaborative commissioning process alongside Local Authorities and across neighbouring ICS, ensuring that specifications and associated costs are subject to benchmarking in accordance with agreed commissioning arrangements.

5.12.4 A market engagement plan will be implemented which will proactively communicate and receive feedback in a structured way and to ensure

consistent messaging across the ICB, as a true partner with the Local Authorities

5.13 Consent, Mental Capacity, Safeguarding, and Deprivation of Liberty Safeguards (DoLS)

5.13.1 In our work with vulnerable individuals and groups, the AACC service will comply with local safeguarding policy and legislation. The Children Act 2004 places a duty on all agencies to safeguard and promote the welfare of children and young people.

5.13.2 NHS AACC activity must include valid consent (Data Sharing process only), or if an adult (age 16 and over) lacks capacity, be formally assessed to be in their best interests.

5.13.3 Note – the assessment and review process for the purposes of NHS CHC is a statutory duty of the ICB. Consent then to undergo the process is not required, but it is essential that the person (and / or representative) are fully engaged from the outset in order that they are supported in making informed decisions over their involvement in said assessment / review.

5.13.4 For CYPCC, consent of the CYP or their parents, when necessary, for referral and assessment must be sought. If consent is not given, the potential effect this will have will be explained to them. Where there are concerns that an individual may have significant ongoing needs, and that the level of appropriate support could be affected by their decision not to give consent, the ICB will discuss with the local authority the implications, as in any other case where consent for treatment is withheld. If the young person is 16 or over, the Mental Capacity Act may apply. Where there is evidence that a person being referred for assessment lacks capacity to consent to the assessment, MCA assessment must be undertaken, in accordance with the MCA (2005) and local Safeguarding Board policy and procedure. This includes the appointment of an IMCA if the person is un-befriended.

5.13.5 The AACC service will use the NHS England presented consent document (2022)

5.13.6 Consent (data sharing) will cover the entire process from referral, through screening and full assessment, and include reviews, although consent for review will always be reaffirmed at the time of those reviews taking place.

5.13.7 The AACC service will work closely with colleagues from Safeguarding and LAs in relation to developments and implementation plans for the introduction of the Liberty Protection Safeguards (LPS). Policy will be updated accordingly as plans progress for this implementation Deprivation of Liberty orders known as Community DoLs currently remain in place to ensure the lawful authorisation of arrangements for care or treatment that deprives an individual of their liberty.

5.14 Initial screening

5.14.1 For CHC, an individual can refer themselves for initial screening to ascertain if a full eligibility assessment for AACC is required. A request will be accepted from non-professionals via email, letter or in exceptional cases, a referral can be initiated by telephone. Health & Social Care Professionals including care providers must have received the training and can make referrals electronically. In all cases, valid consent is required.

5.14.2 When an individual is referred for screening, the AACC service will first take steps to ensure that the individual's long-term needs are clear, and they are in the correct location for their needs to be assessed.

5.14.3 Receipt of Checklists will be recorded in the case management system, with formal recording of the outcome of those screening assessments and appropriate adjustment of the record to reflect the contemporaneous.

5.14.4 The process for decisions about eligibility for AACC will be transparent for individuals and their families and for partner agencies. All AACC practitioners will confidently and proactively communicate the consistent message to individuals, families and relevant professionals (e.g., District nurses, social care, discharge teams), that screening via the AACC Checklist is not an indication of eligibility; that the threshold to progress to full assessment is appropriately set to ensure that all possibly eligible individuals are identified for full assessment.

5.14.5 The outcome of referral screening will be made in writing to the individual, with next steps outlined in the letter, including, in the case of a negative Checklist, information relating to how to request a review of the process and the NHS Complaints process, which is the next step if the individual / representative wishes to dispute the outcome.

5.14.6 Where the referral comes from an individual, family, representative or any professional who has not completed a AACC screening tool (Checklist), the AACC service aims to complete the screening within 14 days of receipt of that referral.

5.14.7 For CYPCC, the ICB ensures that referrals can be made by a variety of professionals, and this should include professionals working in primary, secondary and tertiary care, Child and Adolescent Mental Health Services, community nursing teams, local authority commissioned public health, school nursing and also education and social care.

5.14.8 Where a child or young person is eligible for continuing care and the young person is aged 14 years or over, adult CHC are requested to become formally involved in the young person's continuing care so that eligibility for Adult NHS CHC can be determined immediately following the individual's 17th birthday. This negates the need for a formal referral to adult CHC.

5.14.9 The framework for CYPCC (2016) supports ICBs in determining if a child's needs are such that they require a package of continuing care. It provides

advice based on existing practice across the country on undertaking a holistic assessment of the child or young person's needs. ICBs have autonomy as to how they fulfil this function, and what process they adopt.

5.14.10 The ICB should ensure that referrals can be made by a variety of professionals, and this should include professionals working in primary, secondary and tertiary care, Child and Adolescent Mental Health Services, community nursing teams, local authority commissioned public health, school nursing and also education and social care.

5.14.11 When an individual is referred for screening, the AACC service will first take steps to ensure that the individual's long-term needs are clear, and they are in the correct location for their needs to be assessed.

5.14.12 Receipt of Checklists will be recorded in the case management system, with formal recording of the outcome of those screening assessments and appropriate adjustment of the record to reflect the contemporaneous pathway stage and decisions reached. Regular quality audits are performed, with data and information routinely used to identify practitioners and/or organisations requiring targeted support to improve the quality of screening.

5.14.13 Receipt of a referral / Checklist will be triaged and acknowledged to the referrer within 5 working days. Referrals will be rejected if incomplete or if the ICB is not the responsible commissioner.

5.14.14 This framework supports ICBs in determining if a child's needs are such that they require a package of continuing care. It provides advice based on existing practice across the country on undertaking a holistic assessment of the child or young person's needs. ICBs have autonomy as to how they fulfil this function, and what process they adopt.

5.15 Full Assessment

5.15.1 The National Frameworks provide a consistent approach to establishing eligibility for NHS CHC or CYPCCC. For CHC This is achieved using the revised (2022) National Tools and guidance developed to assist in making decisions about eligibility for NHS CHC. It clarifies that the decision-making process should sit as closely to the individual as possible and should, wherever possible, involve the patient and their representative.

5.15.2 Considering the National Framework's recommendations, the assigned CHC/ Specialist CYP Health needs assessor will act as lead coordinator and may undertake pre-assessment information gathering. They will make every effort to engage the individual and their representatives. The assessor will engage with appropriate professionals to comprise the MDT and liaise with them to complete the assessments and the Decision Support Tool (DST).

5.15.3 Assessments for CHC/ CYPCC will be undertaken by an appropriately trained, constituted MDT in accordance with the National Framework and

the NHS Commissioning Board and CCG (Responsibilities and Standing Rules) Regulations 2012 (Part 6, Regulation 21, Paragraph 13). For CHC All members of MDT must be knowledgeable about the individual's needs. Where possible, at least one member of the MDT must know the individual. The practitioners will have a strong understanding of their respective roles within the MDT and of the wider system pressures.

5.15.4 For CYPCC, parents/ representative/MDT members are contacted and will be involved in supplying information and their views, but not necessarily all at the same time via and MDT meeting.

5.15.5 Where the individual has a specific condition or diagnosis that requires a specialist understanding of their presentation and needs, the AACC service will ensure that a relevant subject clinical specialist has been consulted or is also part of the MDT.

5.15.6 For CHC the individual or representative will be invited to be present, and a minimum of ten working days' notice will be given to an individual and/or their representative to be present and fully involved in the assessment process and the completion of the DST. It should be noted that the assessment process should not be unduly delayed.

5.15.7 The lead coordinator will explain the DST process to the individual or representative and support them in playing a full role in contributing their views on their needs.

5.15.8 Where the involvement of a Local Authority representative on the MDT has not been possible, as far as is reasonably practicable NHS Devon ICB will consult with the relevant Local Authority before making any decision about an individual's eligibility for NHS CHC/ CYPCC, particularly around consideration of the local authority's legal limits.

5.15.9 In CHC, the MDT should apply the principles of the 'primary health needs test', by describing the four key characteristics of a primary health need, as detailed in the National Framework, when making its recommendation regarding an individual's eligibility for NHS CHC.

5.15.10 Assessments are scheduled by the AACC team administrators at the appropriate point in an individual's rehabilitation and in an appropriate care setting. The team will request, collate and share any relevant individual records required to support the MDT and for CHC will invite attendance and/or a written submission from the individual / family / representative for the meeting.

5.15.11 For CYPCC, assessments are scheduled by the specialist nurse assessor or Children's Community Nurse (CCN) (if applicable), who will also collate any individual records required to complete the assessment.

5.15.12 The default methodology for meetings involving individuals and families remains 'remote': online via videoconference. Should the default

methodology not be considered appropriate due to individual or family request, face to face assessment may be offered by exception only.

5.15.13 The time taken from receipt of a positive checklist to eligibility decision will very rarely extend beyond 28 days for adult cases and (as guidance) 42 days for CYPCC cases. Where there is a delay, referrers and individuals will be kept advised of the situation and anticipated revised timelines, and welfare checks will be undertaken by the AACC service to ensure ongoing individual safety.

5.15.14 Assessments for CYPCC will be undertaken via a holistic and objective Health Needs Assessment completed by the CYPCC Specialist Nurse Assessor/ CCN, after meeting with the child/young person and family and ensuring transparency of process by explaining how a decision on eligibility is made. Where relevant, joint visits with social care and education representatives are undertaken in the assessment planning stage, to minimise duplication and promote joint working.

5.15.15 There are four key areas of evidence that should be considered in the CYPCC assessment:

- The preferences of the child or young person and their family.
- A holistic assessment of the needs of the child or young person and their family.
- Reports and risk assessments from a multidisciplinary team or evidence collated during the Education, Health and Care plan assessment, and;
- The Decision Support Tool for children and young people.

5.15.16 The CYP specialist nurse assessor will also obtain and collate all pertinent assessments and information relating to the child/young person's needs. The continuing care assessment draws on earlier assessments that the child/young person may have already undergone, and focuses on the needs of the child / young person mainly in the preceding 3 months, however, a longer period can be considered if appropriate.

5.15.17 For CYPCC, the specialist nurse assessor undertakes a visit / phone call with family, contacts members of the MDT, writes the DST according to information gathered, makes recommendations then the completed DST along with Specialist Nurse Assessors recommendation is placed on the agenda for the ICB CYPCC verification panel, consisting of ICB QA Lead (Chair), QA Nurse, representative from social care and any other relevant professionals involved in their care. The panel will then make the decision if eligible or not. The outcome of the assessment is a recommendation from the specialist nurse assessor as to whether or not the child or young person has continuing care needs and is eligible for CYPCC support.

5.15.18 If eligibility is recommended, Social Care, Education professionals (as appropriate) may also be asked to provide a professional assessment report and the child/young person and family will be given the opportunity

to review the DST and contribute further to the report prior to the subsequent panel stage.

5.15.19 DSTs will be completed digitally and uploaded to the case management system. Supporting evidence will be scanned and uploaded electronically.

5.15.20 For CHC The MDT will consider all evidence collated for the assessment, including written submissions from the individual / family / representative if unable to attend in person. The assessment draws on earlier assessments that the individual may have already undergone, where relevant. All domains of the DST will be discussed in full against the documentary and verbal evidence and the discussion recorded in the DST documentation.

5.15.21 The MDT will allocate levels of need in each domain of the DST. Where there is disagreement from any party during the MDT process, this will be clearly recorded in the documentation. Where the MDT are unable to agree the level of need for a domain against the domain descriptors (including where needs sit between two levels), the higher level will be selected, and narrative recorded to reflect that decision.

5.15.22 Following the MDT discussion and family/representatives' submissions against the DST domains, the MDT will consider and record their deliberations relating to the PHN test in closed session without the individual / family / representative present.

5.15.23 The MDT will make its recommendation to the ICB with regard to the eligibility decision. The MDT is able to recommend full eligibility for CHC or no eligibility, the latter of which can be accompanied by a further recommendation for Funded Nursing Care, or a jointly funded package of care or placement where appropriate.

5.15.24 For CHC, Where the MDT is unable to unanimously agree the outcome of the PHN test, this will be clearly recorded in the DST document. Each MDT stakeholder representative (Health and Social Care) will be invited to provide their written submission over eligibility and attend a peer review meeting to try and agree an outcome. If no agreement can be reached, the ICB decision will be recorded in the individual's record.

The case will then be considered at the Stage One Interagency Dispute Panel as per the agreed policy.

5.15.25 Receipt of DST assessments will be recorded in the case management system, with formal recording of the outcome of those assessments and appropriate adjustment of the record.

5.15.26 The ICB AACC service will provide quarterly audit reports over trends in MDT recommendations, disputes and appeals progression, which will inform current and future practice and workforce development.

5.15.27 For CYPCC and families, ICBs must have complaints procedures in place to respond promptly to any request to review disagreements voiced by the

child or young person or their family or carer about any aspect of the continuing care process.

5.15.28 For local authorities, ICBs and local authorities should agree a local dispute resolution process to resolve cases where there is a dispute between NHS organisations, or between a health commissioner and a local authority, over a child or young person's continuing care needs and/or over responsibility for the funding of a package of continuing care, in a robust and timely manner.

5.15.29 At present, families and local authorities can dispute the decision and they will be asked on what basis they are disputing, if they have any further information they feel was not taken into account when the decision was made. The CYP team will then look at it the decision again, taking into account any new information provided – if decision upheld, the case will be heard by Head of Quality Assurance and equivalent in the local authority.

5.16 Verification

5.16.1 The vast majority of verifications of MDT adult eligibility recommendations will be undertaken via peer review or manager review within the AACC service, with the application of the standard NHS Devon ICB Quality Assurance Tool confirming practice, decision making and providing an audit trail for such decisions.

5.16.2 CYPCC cases will be peer reviewed internally as required, to confirm eligibility or escalated to the service lead if there are any concerns relating to the eligibility decision. DSTs should rarely be returned for additional supporting evidence, as all relevant documentation will have been requested in advance. The DST decision is then presented at the respective Joint Agency Verification Panel for ratification and approval.

5.16.3 For CYPCC – a biweekly multi agency verification panel is in place to discuss completed DSTs, recommendations made by Specialist Nurse Assessors or CCN completing the DST and jointly agree a decision on eligibility. This Panel comprises of QA Lead Nurse for CYP (Chair), CYP QA nurse, Representative from CYP Local Authority Area, Specialist Nurse Assessor/ CCN and any other relevant professional if required.

5.16.4 It is expected that only a limited number of adult DSTs will require a panel review for verification. Each locality will follow local arrangements with local authorities. Place-based AACC team will have arrangements with the Local Authority to convene a Joint Agency Verification Panel comprising a senior social worker and senior nurse, to verify MDT recommendations by exception.

5.16.5 For CHC verification should always be achieved within two working days of the DST, where panel review is not required. However, in cases requiring Joint Agency Verification Panel, there will be a maximum of 5 working days between DST and a joint verification panel decision.

5.16.6 MDT recommendations will be accepted by the ICB unless there is a clear breach of process or lack /mismatch of evidence to support the recommendation made by the MDT. This will be confirmed in the application of the NHS Devon ICB Quality Assurance Tool. Where there is such a case, the DST will be referred back to the assessors for further consideration of the contents.

5.16.7 Outcome letters advising the individual of the ICB or Multi-Agency CYPCC panel's decision as to eligibility will be issued within 5 working days of verification of the MDT recommendation. Outcome letters contain the information relating to the decision and relevant dates of eligibility, information on how and by when to dispute against a decision and will be accompanied by a copy of the fully completed DST document.

5.16.8 Regular quality audits are performed, with data and information routinely used to share best practice and trends to advise continuous quality improvement. There is an arrangement for reciprocal quality review of a sample of DSTs across the AACC Place-based teams to ensure consistency of the application of the PHN test.

5.17 Funded Nursing Care (FNC)

5.17.1 NHS FNC is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse.

5.17.2 FNC can be recommended, following full consideration for CHC, either via a negative Checklist and subsequent Nursing Needs Assessment, or via a full MDT eligibility assessment.

5.17.3 Where an individual is receiving services under Section 117 of the Mental Health Act 1983, they will nonetheless be eligible for NHS-funded nursing care as a universal service, discrete from any Section 117 provision, if they meet the relevant criteria and reside within a Care Home with Nursing accommodation. This arrangement will be considered as part of the NHS contributions to the overall costs of care under a joint funded agreement per NHS Devon ICB Policy.

5.17.4 It would be preferable if FNC eligibility is considered prior to an admission to a care home facility. However, the ICB appreciates the climate of care and so commits to confirming FNC eligibility within two weeks of a care home notifying the AACC service of the individual's admission / need for assessment (with NHS CHC assessment being carried out, where relevant, in the first instance and where nursing needs have been identified following submission of the care homes care plan). These referrals must be made via the electronic referral portal, to enable the assessment timeframeto be activated.

5.17.5 The ICB has an integrated strategy and infrastructure which supports and manages individuals in Care Homes with Nursing. This operates via the Primary Care Networks (PCNs) and prevents deterioration and avoidable

hospital admissions in line with the principles of 'Ageing Well', as outlined in the NHS Long Term Plan. There is evidence of improved outcomes through this strategy and the strategy is regularly reviewed.

https://www.devon.gov.uk/care-and-health/disabilities/health-and-happiness/aging-well/

5.18 Fast Track (FT)

5.18.1 Fast Track applications should be by exception and not the standard approach to requesting funding of care for people at end of life. The ICB will commission sufficient provider capacity in the community to proactively identify and support most people who are in their last year of life, to ensure that the required care and support is put in place and contingency / deterioration plans are in place, thus reducing the need for FT funding applications, except in exceptional circumstances.

5.18.2 There will be circumstances where an individual not previously determined eligible for NHS CHC or CYPCC has a rapidly deteriorating condition, and the condition may be entering a terminal phase. The person may need NHS CHC/ CYPCC funding to enable their needs to be urgently met (e.g., to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in another care setting).

5.18.3 In such circumstances, the fast-track tool should be used by an appropriate clinician to outline the reasons for the fast-track CHC eligibility decision, which should include adequate information to describe the 'primary health need' as evidenced by the assessed individual having a rapidly deteriorating condition and the condition may be entering a terminal phase.

5.18.4 The fast track tool bypasses the requirement to complete a checklist and DST. The National Framework is clear that it can only be completed by an appropriate clinician. The fast track tool defines "appropriate clinician" as follows: "*Those who are, pursuant to the National Health Service Act 2006, responsible for an individual's diagnosis, treatment or care and are registered medical practitioners (such as consultants, registrars, GPs) or registered nurses. These can include senior clinicians employed in voluntary and independent sector organisations that have a specialist role in end of life needs (for example hospices) where the organisation's services are commissioned by the NHS."*

5.18.5 FT applications will only be made for any age individuals who are:
- Rapidly deteriorating (and may be entering the terminal stage of life)
- In need of urgent care package to support them in their Preferred Place of Care.

5.18.6 Upon receipt of a completed fast track tool and care plan, all relevant information is reviewed by an appropriate CHC / CYPCC clinician, on behalf of NHS Devon ICB, who will confirm provided information is

sufficient to support the referring clinician's decision about eligibility for fast-track NHS CHC funding.

5.18.7 Where the provided information supports the eligibility decision, this will be communicated to the referrer and the relevant local health and social care providers, who will arrange the care as directed by the holistic care plan to ensure care and other support, such as appropriate equipment, is commissioned and in place within 48 hours of receipt of the fast track tool.

5.18.8 For CHC, where the provided information does not adequately meet the criteria for a fast-track application, the CHC clinician will contact the referring clinician to request additional information and provide advice as needed.

5.18.9 This may be by email where care provision is already in place and the referral simply relates to a change in funding or by telephone where an urgent change in care provision is required.

5.18.10 The AACC service will ensure a package of care is sourced and commissioned to meet the individual's identified needs without delay, prioritising such cases over standard brokerage/commissioning activity.

5.18.11 Clinicians making referral via a FT application must explain to the individual / their representative that their needs will be subject to periodic review and that the funding stream may change following such a review.

5.18.12 Receipt of a FT application will be recorded in the case management system, with formal recording of the outcome of the application and appropriate adjustment of the record to reflect the contemporaneous pathway stage and decisions reached.

5.18.13 A review of the FT care plan will commence with a telephone outreach to the patient (or representative) 12 weeks following verification. If there is a change in need or the individual is no longer rapidly deteriorating or in a terminal phase, the AACC Case Coordinator will consider the option of convening a full NHS Consideration at this stage, or to confirm an additional period of FT eligibility (this being case dependent). In all such cases, the case coordinator will provide a written rationale for their conclusion, before uploading all relevant evidence, rational and decision making to the Patient Management database.

5.18.14 The case coordinator will require a second senior level verification to progress a Fast Track case to full MDT consideration. This should only occur in exceptional circumstances and for clearly articulated reasons.

5.18.15 If the ICB AACC service applies a robust process of referrals management and workforce education, the ICB would expect that full case reconsiderations would be the exception rather than the rule, and the ICB will expect the AACC service to maintain an effective reporting, audit

and improvement system which clearly monitors and controls such processes.

5.18.16 The ICB will require assurance on a quarterly reporting framework which clearly articulates the activity of the FT system by component function.

5.19 Personal Health Budgets (PHBs)

5.19.1 PHBs are the default mechanism for delivering AACC care packages in the community.

5.19.2 Adults eligible for NHS Continuing Healthcare and children in receipt of continuing care have had a right to have a personal health budget since October 2014 has been the default option for these groups since 1 April 2019.

5.19.3 There is a well-established local PHB offer for AACC that is supported by the local health and social care system, with an over-arching ICB PHB Policy and comprehensive information available for people and families on the ICB website and in paper form on request. Please refer to that policy for further detail on the PHB process.

https://devonccg.nhs.uk/health-services/continuing-healthcare/personal-health-budgets

http://fis.torbay.gov.uk/kb5/torbay/fsd/service.page?id=V7WUOJbJ98Q

5.19.4 There are clear, well documented, and comprehensive PHB processes in place, with detailed guidance and support available to aid practitioners with all parts of the process, including routine and complex decision making and providing timely, person-centred advice; this includes access to expert points of contact within the ICB and in third party PHB providers.

5.19.5 All front-line AACC staff will have the skills, confidence, and resilience to manage complex cases and decisions and to deliver PHBs in a timely and sustainable way. All staff members have access to training and senior support and where necessary have a clear competency and development plan in place which is reviewed regularly.

5.19.6 The AACC service will ensure consistency, equity, and transparency in how PHBs are offered to all those eligible for AACC funded home care packages.

5.19.7 The ICB works with local authorities to use the same support providers and has set up consistent processes for paying individual personal health budgets. This means that people who have a personal budget from both the council and ICB, or who move from the council to ICB funding, will have a better experience.
https://new.devon.gov.uk/adultsocialcareandhealth/assessments-for-care/after-your-assessment/personal-budgets/

http://www.plymouth.gov.uk/personalbudgets

5.19.8 The AACC service will have a focus on proactive management of clinical and financial risks in PHBs, with strong governance in place. Financial audits and clinical reviews are carried out in line with assessed risk.

5.20 Brokerage and commissioning

5.20.1 The AACC service will operate a clear policy to support practitioners when determining an individual's care package and placement. The policy allows for exceptionality and provides clear and concise practice guidance. For CHC, exceptional decisions outside of the standard brokerage and commissioning arrangements are clearly recorded for the audit trail on the electronic case management system. To support this the ICB follows the individual's package of care policy.

5.20.2 Provision of a care package to meet the specified outcomes for the individual and support them to achieve their potential should occur as soon as possible after the eligibility decision is verified. Individuals and families should be kept appraised of progress, anticipated timelines and any delays should be promptly notified.

5.20.3 Clinicians in the AACC service will determine, in partnership with the individual and family, the best option for placement or domiciliary care provision, dependent on level of needs and associated risk. Sensitive conversations may be required to ensure that choices made reflect the assessed clinical needs and risks as well as the equity and sustainability of the requested care package, within scope of the ICB limitations and procurement guidance.

5.20.4 Individuals and family members will be made aware of all available options at the outset of eligibility, including the ICBs procurement protocols.

5.20.5 For CHC, the Care Plan produced by the case manager will guide brokerage and Procurement within local policy standards.

5.20.6 Wherever possible, the ICB will enable an agreed balance of the individual's aspirations, and clinical need within the boundaries of procurement protocols.

5.20.7 CYPCC case funding arrangements and agreements will be fed back to local authority led Multiagency panels (held at least monthly) comprising representatives from Health, Social care and Education. Assessed recommendations and respective costed care package options are presented and considered to determine an appropriate multi-agency package of support.

5.20.8 For CYPCC a brokerage system for placements is not in place, if a CYP requires a residential placement outside of the family home, the local authority will retain responsibility for leading on sourcing a suitable placement with involvement with the CYP QA team to provide assurance that their health needs can be met in the proposed placement.

5.20.9 If a commissioned package of care is chosen by the family to support them to care for their CYP, a Needs and Outcomes form will be completed by the Specialist Nurse Assessor or CCN and send to ICB Framework Providers. If Framework providers are unable to accept the request, or quote above the agreed Framework rates, then the request is made to a list of SPOT purchase Providers. A Decision is then made by the CYP QA Team as to the most appropriate provider to award the package to, based on lead time to put the package in place, speciality of the provider and costs.

5.20.10 The fundamental principle for agreeing a CYPCC care package is the full participation of the parent/carer and the individual at all times. This includes involvement in the recruitment and appropriate training of the team Aaound the child to ensure the package can be safely and sustainably implemented.

5.20.11 Individuals and families are made aware of their rights to have care (and accommodation in a care home) fully funded by the NHS if eligible for CHC. 'Lifestyle choice' charges levied by care homes for additional services that are outside of an individual's assessed care and accommodation needs will not be funded by the ICB. Further guidance is available within the Framework.

5.20.12 The ICB will not enter arrangements with any provider currently inspected by the CQC as Inadequate, or any provider subject to existing s42 Safeguarding enquiries except by exceptional circumstances. Decisions will be made via the IPOC panel to meet clinical need and keep an individual clinically safe.

5.20.13 Where a Provider is inspected as 'Requires Improvement', the ICB will reserve the right to suspend placement on a case-by-case basis.

5.21 Equity and choice

5.21.1 The ICB has a duty to meet the needs of an individual eligible to NHS CHC / CYPCC, whilst considering the best use of resources for the population it serves. Care options will be considered to meet the assessed health, social and wellbeing needs of an individual who is eligible for health funding and the ICB will always consider the most cost-effective option to meet the individual's needs, taking into account the safety, welfare and any potential risks to the funded individual or others and care providers in the care commissioned.

5.21.2 Personalisation and choice are central to decision making, balanced with the principles above and the lawful duties of the ICB. The individual's wishes and expectations of how and where care is delivered should be documented and taken into account, along with the risks of different types of provision and access to resources.

5.21.3 The ICB's starting point will always be to take into consideration an individual's views and preferences, including those relating to

cultural/religious beliefs. However, there may be situations where an individual's choice cannot be agreed or met.

5.21.4 AACC can be provided in any setting. Where an adult is living in their own home, it means that the NHS funds all the care and support that is required to meet their assessed health and care needs. Such care may be provided either within or outside the person's home, and includes primary healthcare and community nursing services, as appropriate to their assessment and care plan. For CYPCC health and care support may be funded by health in partnership with social care and/or education.

5.21.5 The ICB will not be responsible for the upkeep and maintenance of any residential / domestic property. This to include any tenancy agreements. Unless by exception agreed via the IPOC panel.

5.21.6 For CHC where an individual has been assessed as needing a care home placement the ICB will work with the individual /representative to identify a choice (where possible) of suitable accommodation.

5.21.7 Individuals with a primary health need are strictly prohibited in law from privately commissioning any service related to their assessed health or care. The only acceptable privately commissioned services are those which are clearly not related to the individual's assessed health / care needs (for example hairdressing) and are not a condition of entering the chosen residential placement.

5.21.8 Safety will be determined by risk assessment to include contingency planning, which will include the availability of equipment, the appropriateness of the physical environment and the availability of appropriately trained workforce to deliver the care.

5.21.9 For CHC, the following should be considered before the ICB agree to commission a package of care in the individuals own home, to include those decisions made via the IPOC panel:

- The Key Benefits to the individual, their wishes, and preferences (and Best Interests in the instance of Lack of capacity to engage in decisions over place of care
- Parental responsibility for young people under 18 years of age, and other relationships if adults
- The individual's current and likely future needs
- The individual's GP agrees to provide primary care support
- The suitability and availability of alternative care options, and impact of alternative arrangements on their overall wellbeing
- The cost of the package required to meet the assessed needs and the relative costs of providing the package of choice considered against the relative benefit to the individual.

5.21.10 In the event that the ICB 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 be neither condoned nor accepted and the ICB will take any action necessary including immediate withdrawal of

services. Where, in exceptional circumstances it is necessary to withdraw services, the ICB will urgently consider how else (if at all) services can be offered.

5.21.11 For CHC, respite care, defined as the provision of short-term, temporary relief to those who are caring for family members, who might otherwise require permanent placement in a facility outside of the home, by replacing that care with a temporarily commissioned care package. Respite can be arranged, with suitable notice to the AACC service. Respite may be arranged for the individual in a placement if this is deemed the safest option, through a temporary enhancement to the home care package.

5.21.12 For CYPCC – respite care is responsibility of Local Authority based on their assessments for eligibility. The ICB may consider funding towards a respite provision if there are health needs being met whilst accessing respite provisions.

5.21.13 If a person who has mental capacity to make decisions about their care refuses to accept any of the options offered by the ICB, the ICB will consider that it has fulfilled its legal duty toward the person. The ICB will inform the person in writing that they will need to make their own arrangements for ongoing care within 28 days of the date of the letter. The letter will explain the risks of refusing the care and advise who they can contact if they change their mind in the future. The risks will also be documented in the person's care record.

5.21.14 An individual retains the right to decline NHS services and make their own private arrangements. However. if an individual chooses to decline support from CHC, they should be advised of the impact of such a decision upon their ability to source any support from the Local Authority. The individual will be determined eligible but at zero cost.

5.21.15 Where no locally suitable provider is identified, the ICB may be required to engage with those providers known as Out of Area providers. In such cases, the AACC service will contact the ICB in the locality of the proposed placement, and request placement / package of care within the local arrangement, following existing local protocols.

5.21.16 Where an individual already in receipt of a care package or Personal Budget funded by social care or jointly with the NHS becomes fully eligible for CHC, the AACC service will consider the absorption of the package in situ. This maintains service continuity for the individual. However, this is on the provision that the package remains appropriate to safely meet the individual's assessed needs.

5.21.17 All decisions with regard to funding of packages of care will be approved according to the ICBs standing financial instructions and ceiling for sign off by management levels for packages of care and placements.

5.21.18 Governance is in place and is actively used to ensure brokerage of all placements is in line with market management strategy and represents

value for money. The multidisciplinary AACC team actively supports its brokerage team to identify viable placement options to meet complex care needs.

5.22 Safe and supportive observations

5.22.1 A number of service users, such as the vulnerable older person, those at risk of extending physical injury, people with cerebral injury, learning disabilities, children and/or those lacking the mental capacity to support safe decision making, may require enhanced levels of observations and support.

5.22.2 Supportive observations are there to ensure the safe and sensitive monitoring of the service user's physical and psychological well-being. This monitoring should support staff members to quickly identify changes in the service user's condition and/or well-being to enable a rapid and appropriate response to minimise the risks or potential harm to self or others.

5.22.3 Supportive observations should always be set at the least restrictive level, this includes for the least amount of time, within the least restrictive environment. Regular review and early reduction in restrictive practices is the expected approach.

5.22.4 The Standing Nursing & Midwifery Advisory Committee (SNMAC) Proactive guidance on the Safe and Supportive observation of Individuals at risk (1999) recommends four levels of observation to be adopted throughout provision of NHS care to ensure consistent practice.

5.22.5 The guidance relates to individuals who are 18 and over. For CYPCC all domiciliary packages are delivered as Close Supportive Observation (Level 4) unless exceptionality is determined. Safe and supportive observations within Residential and/or residential school placements are based on bespoke need and robust individual risk assessments.

5.23 Review and Case Management

5.23.1 For CHC anamed Case Manager will be assigned to each AACC eligible case and their contact details shared with the individual / representative. Case manager details will be recorded on the individual record on the case management system. The best means by which to contact case managers will be agreed with the individual/family.

5.23.2 For CYPCC, a Specialist Nurse Assessor will be allocated to each CYP who is eligible for CCC funding for oversight of the CYPCC process, with case management being undertaken by the CYP CCN Team.

5.23.3 The service lead is responsible for allocating and rotating case management responsibilities where required, ensuring that individuals / representatives are kept informed of changes.

5.23.4 Reviews are undertaken at 3 months following a new decision on eligibility and at 12 monthly intervals (as a minimum, case dependent) thereafter.

5.23.5 Where an individual is funded under 'Fast track' arrangements, at the point of the 12 week review, if there is reasonable clinical judgement that the individual may continue to rapidly deteriorate and / or the individual is nearing end of life, the assessor is able to recommend extension of the FT eligibility for up to an additional 12 weeks, when a further review will take place.

5.23.6 Where an individual is funded under 'Fast track' arrangements, at the point of the 12-week review of the care plan, if the clinical judgement is that the individual has stabilised and/ or improved in their presentation, then a full NHS CHC/ CYPCC assessment will be required. Patients, families and representatives are informed of this at the outset of eligibility.

5.23.7 Proactive case management of AACC eligible individuals will enable review to be undertaken efficiently via regular reviews of care provision in meeting assessed needs and safety of the commissioned care plans, in accordance with the National Frameworks.

5.23.8 Reviews are prioritised using risk stratification, with Safeguarding always taking priority. Ongoing case management will enable continual review of risk factors and re-prioritisation according to triage.

5.23.9 AACC individual files, previous DSTs, supporting evidence, current contract and provision cost is available within the ICBs case management system. This information is accessible by all relevant practitioners and is proactively used within reviews and referred to if reassessment is required.

5.23.10 Reviews should primarily focus on whether the care plan or arrangements remain appropriate to meet the individual's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility.

5.23.11 The outcome of an NHS Continuing Healthcare/ CYP Continuing Care review will determine whether:
(a) the individual's needs are being met appropriately, and
(b) whether eligibility should be reconsidered through reassessment for NHS Continuing Healthcare.

5.23.12 Re-assessment of eligibility following review of the care plan is triggered only where the reviewer suggests that, in the face of evidence viewed, heard and / or read, the individual may no longer require the support of the NHS under NHS CHC/ CYPCC eligibility.

5.23.13 Care provision is adjusted in line with the outcome of the care review, with due consideration given to whether the change may impact on the equity, safety and sustainability of the package of care / placement.

5.23.14 The individual and family will be fully informed and engaged in the process of review and are informed of the outcome of the review and

supported to understand reasons for and implications of any need for reassessment.

5.23.15 Review outcomes will be clearly documented, with supporting evidence, in the case management system. Clear documentation will be recorded relating to any change in need and subsequent changes to the care plan.

5.23.16 For CHC, there is an agreed process in place for the transfer of responsibility between the ICB and Local Authority's , where individuals are stepped up / down from social care into healthcare and vice versa. The process is comprehensive, widely understood and accepted practice, followed appropriately and reviewed at regular intervals.

5.24 Requests for reviews of eligibility decisions

5.24.1 Due to the low threshold of the national tool Checklist tool, the ICB makes no provision for appeal in such instances. The patient and/ or representative however, does reserve the right to request the ICB reconsiders the outcome and/or to make a formal complaint to the ICB following the ICB complaints policy –

https://devonccg.nhs.uk/contact-us/patient-advice-and-complaints

5.24.2 Where a child/young person and their family have a dispute over an Education, Health and Care Plan, the AACC service may be required to provide appropriate representation. This should be in line with the respective SEND mediation Pathway.

https://www.devon.gov.uk/educationandfamilies/guide/ehcp-tribunals/

http://fis.torbay.gov.uk/kb5/torbay/fsd/service.action?id=ifcbuRs7a6U&localofferchannel=7&slaction=ADD&itemid=gT1nreQ8PTqryCPnH7R3n_rCWhOM

5.24.3 For CHC - requests for reviews of eligibility decisions from full assessment processes will be invited via the outcome letter following a full assessment for AACC funding eligibility. Individuals / families are given 6 months from the date of the outcome letter to notify the AACC service of their intention to appeal the decision, outlining their reasons for such appeal.

5.24.4 The AACC service will acknowledge the request for a review of the decision regarding a full eligibility assessment decision, within 5 working days, providing clear and timely communication and explanation of the process to the individual requesting the review.

5.24.5 The AACC service aims to undertake all requested reviews of eligibility decisions within a maximum of 3 months from the date of receipt of the request.

5.24.6 For CHC only - Stage One Local Review Process –

A key principle of local resolution is that the ICB does not change its decision and that the individual / representative has had a clear explanation of the rationale for the ICB's decision.

To this end, the ICB will offer a case coordinator to meet directly with the appellant. The meeting will be minuted, with a final report and recommendation being sent to the appellant within 28 days of the meeting.

5.24.7 The purpose of the Stage One Local Review Process is:

- to listen carefully to the concerns of the individual and the reasons that they have requested a review of the eligibility decision, and to then agree a plan for resolving those concerns wherever possible.
- To discuss the appeal and the content of the decision support tool.
- To discuss how the decision on CHC funding eligibility was met.
- For the Case coordinator to provide clarification on anything not understood regarding the process.
- For the appellant to provide additional evidence to be considered at the next stage.

5.24.8 For CHC, all individuals requesting a review will initially be offered a Stage One local review process within 28 days of making their request. The invitation letter / email will advise of the process followed which will include a review meeting. The process will consider:

- Levels of need in disputed care domains
- Application of the Primary Health Needs Test (CHC only)
- Any concerns relating to the process

5.24.9 In some CHC cases, such as those with a legal representative making the appeal, an informal review may not be beneficial to resolving issues and the decision of the ICB may be to progress to the Stage Two Local review process.

5.24.10 Prior to the review meeting, provided there is the appropriate consent, the ICB will ensure all attendees will be provided with the original DST and the relevant information to support the recommendation.

5.24.11 The review meeting will be held with a CHC or Case Coordinator (as appropriate) who was not involved in the original decision and an AACC administrator, with the aim for the individual to:

- Receive clarification of anything that they have not understood.
- Have an explanation of how the MDT/Case Coordinator arrived at the recommendation of 'not eligible' using as a reference the evidence used to complete the DST and the 4-part PHN test (CHC only).
- Describe additional information that has not been obtained by the MDT/Case Coordinator that the individual believe needs to be considered; and

- Describe additional information that was available to the MDT/Case Coordinator that the individual believes was not given due consideration.

5.24.12 At the conclusion of the review meeting, the Case Coordinator conducting the meeting will summarise the findings of the meeting and determine if the appellant is satisfied with the explanations given.

5.24.13 Minutes will be taken for review meeting. They will not be verbatim but will be a summary of the conversations.

5.24.14 In cases where the appellant has identified evidence that had not been considered in the full assessment process, or where the correct assessment process has not been followed, the Case Coordinator may recommend that the full assessment process is repeated, with a new MDT.

5.24.15 If the outcome of the review meeting does not find issue with process or evidence and the appellant is satisfied with the explanations given, the Case Coordinator will confirm the ICB's decision and advise the appellant that the local review process outcome will be forwarded to them in writing.

5.24.16 If the outcome of the local review process for CHC does not find issue with the assessment process or evidence and the appellant is not satisfied with the explanations given, the Case Coordinator will confirm the ICB's decision and advise the appellant that the next steps will be to set a date for a formal stage two local review process.

5.24.17 Invitation to the CHC stage two local review meeting will contain details of the attendees in terms of roles, not individuals' names, as identities of representatives may change prior to the meeting date. The ICB aims as far as is possible, for those representatives to have not had prior involvement in the assessment/decision-making process of that particular case to ensure impartiality The attendees will comprise of a Chair, who will be a senior clinical ICB manager (not necessarily from the AACC service), a clinical representative from the AACC service, a subject specialist (if relevant to the case), a Social Worker and an administrator. The appellant is invited to provide a written statement pertaining to their concerns.

5.24.18 The stage two local review process will be conducted in the same manner as an NHS England IRP:

- Introductions
- CHC case presenter invited to give a verbal summary portrait of the individual and relevant history to frame the case
- Appellant / representative invited to give a verbal summary portrait of the individual and relevant history to frame the case.
- All present will then collectively review each domain of the DST against the evidence and the level descriptors, allowing discussion and the opportunity for each attendee to provide their views, which will

be recorded for the minutes. All agreements and disagreements will be documented for the meeting record.

- Following review of the DST, the appellant / family / representative will leave, after being advised of the next steps.
- The panel will undertake a new PHN test (CHC only) and agree a recommendation.

5.24.19 The outcome decision of the stage two local review process will be confirmed in the form of a report to the individual / family / representative within 6 weeks. The outcome letter will include information of how to make further request for review of the decision direct to NHS England Regional Leads (The Independent Review process) should they not agree.

5.25 Retrospective assessments (CHC only)

5.25.1 Claims for retrospective assessment of eligibility for NHS CHC funding can no longer be made for any period of care prior to 31 March 2012.

NHS Devon ICB has prepared a separate policy detailing process in such applications.

5.26 Disputes with Local Authority

5.26.1 The ICB has agreed a Disputes Policy with the relevant Local Authorities for AACC. This is a jointly agreed policy requiring governance approval from the health and social care bodies and will be published on the AACC service web pages.

5.27 Transition from Child to Adult Services

5.27.1 Transition is recognised to be a crucial stage for young people who have complex ongoing health needs and/or life-limiting conditions. Child and adult service provision is often very different, and it can be a stressful time for families navigating the pathway.

5.27.2 A key aim of transition is to ensure that a consistent package of support is provided during the years before, during and after the transition to adulthood. The nature of the package may change because the young person's needs or circumstances change. However, it should not change simply because of the move from child to adult services or because of a change in the organisation with commissioning or funding responsibilities. Where change is necessary, it should be carried out in a planned manner, in full consultation with the young person and family. No services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place.

5.27.3 Individual literature regarding transition will be developed and accessible to all, to promote autonomy in decision-making.

5.27.4 All staff will be fully aware of the AACC transition pathway and work together to achieve a high-quality and safe transfer of responsibilities.

5.27.5 In acknowledgement that the CYPCC threshold is set very high CHC will accept the CYPCC DST as the referral document in place of a checklist.

5.27.6 The AACC service will ensure that it learns from the experience of families, staff and providers using a co-design, co-production approach to service development. Feedback/monitoring will be designed with the focus on improving individuals' experience of transition.

5.27.7 The AACC service will adopt Key Performance Indicators (KPIs) for CYPCC transition:

- Evidence in the case management record of notification to CHC at 14 years of age for whom it is likely that adult NHS Continuing Healthcare will be necessary.
- Evidence of discussions around transition needs, linked to Year 9 Transition Planning and as part of the Education, Health and Care Planning (EHCP).
- Evidence of formal referral for screening for CHC at 16 years of age.
- At 16-17 years of age, there is agreement in principle at the CYPCC annual review that there is evidence of a primary health need.
- Eligibility for CHC is determined within 28 days after a young person's 17th birthday.

5.27.8 Where a young person remains in Education beyond the age of 18 years, there should be continued partnership working to ensure the continued implementation of an individual's EHCP with each partner contributing funding according to their statutory responsibilities.

5.27.9 If a young person who receives CYPCC has been determined by the relevant NHS Commissioner not to be eligible for a package of CHC, the AACC service will continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care.

5.27.10 The Children and Families Act (2014) requires a young person accessing education to have an Education, Health and Care Plan up until the age of 25 years where an individual needs more support than is available through special educational needs support. This change in practice requires partner agencies to acknowledge their continued responsibility for the extended transition period and require funding streams to continue. For example, where a young person at 18 has been assessed as eligible for CHC funding but is in receipt of education this remains a jointly funded care package thus should be noted as continuing care funded within adult services.

5.27.11 Where a young person receives support via a placement outside the ICB's boundaries, it is important that, at an early stage in the transition planning process, there is clear agreement between NHS Commissioners as to

who the responsible commissioner presently is, and whether this could potentially change in accordance with NHS England's 'who Pays? Determining responsibility for NHS payments to providers' (2024). All parties with current or future responsibilities should be actively represented in the transition planning process. A dispute or lack of clarity over commissioner responsibilities must not result in a lack of provision or risk an individual's placement. Due consideration must be given by the ICB and LA where a child is 'looked after 'by the LA, to ensure appropriate placement and funding responsibilities.

5.28 Joint Funding

5.28.1 Where a joint or triparte or joint package of care is agreed for CYPCC a care package funding agreement is signed by all parties following award of the commissioned care package and a lead commissioner is identified.

5.28.2 Joint Funding for an adult is not CHC funding. However, the AACC service is the appropriate team to facilitate such arrangements for adults. Where an individual has been assessed as not eligible for CHC but has identified health need(s) that in the opinion of the MDT are outside of the LA's legal ability to provide under the Care Act 2014, it may be appropriate for the NHS to fund that care element as part of a jointly funded package of care.

5.28.3 Verification of the joint funding recommendation will be managed through the Joint Agency Verification Panel. The panel will firstly verify the MDT recommendation.

5.28.4 For CHC, the Local Authority will be invited to present a Care and Support Plan, used by the panel to identify the exact care provision required to meet need, and to consider what health contribution is identified out with those core NHS services already commissioned across the ICB landscape.

5.28.5 The panel will then request to the AACC team to seek costings for those elements of care provision to be NHS-funded and to set up a funding flow to the LA to cover this cost.

5.28.6 Where a joint funded package of care is identified, NHS and LA bodies must agree a contractual relationship to ensure robust governance and responsibility.

5.28.7 Joint/tripart Funded cases should be reviewed in the same way as for all NHS-funded care packages. The review should be undertaken under a Trusted Assessor arrangement, with one Key Worker nominated.

5.29 Discharge to Assess (CHC only)

5.29.1 Discharge to Assess is not a specific AACC responsibility, until the individual's long-term needs are known, and they are ready for NHS CHC consideration.

https://www.torbayandsouthdevon.nhs.uk/uploads/25398.pdf

https://www.devon.gov.uk/providerengagementnetwork/coronavirus-advice/discharge-to-assess-pathway-changes/

5.29.2 Discharge to Assess commissioning and case management will be clearly and comprehensively recorded on the case management database and cases tracked until the individual is clinically optimised. At this stage, the case moves onto the 28-day referral to decision timeframe for CHC consideration.

5.29.3 It is expected that, in most cases, the individual will be optimised for assessment within 4 weeks of hospital discharge. However, some individuals may take several weeks to become ready for assessment. In these cases, D2A funding will continue until assessment is feasible.

6 Accountability, Duties and Responsibilities

Chief Executive Officer	The Chief Executive Officer has ultimate accountability for the strategic direction and operational management of NHS Devon, including compliance with all legal, statutory and policy requirements.
Policy Sponsor	The Policy Sponsor is responsible for: • ensuring that policy is appropriate for consideration for approval; • endorsing this policy ahead of submission for approval; • with the Policy Lead, maintaining and updating procedures/protocols and other supporting documents for this policy;
Policy Lead / Author	It is the responsibility of the Policy Lead / author to: • ensure as far as possible that the policy is in line with Department of Health and Social Care guidance, legal requirements and advice from clinical bodies; • to complete a QEIA and Implementation Plan where required • undertake a fair and proportionate consultation period with the relevant stakeholders as part of the document's development • to ensure that the policy is in alignment with NHS Devon's strategy and values • ensure that the policy is developed, approved, disseminated and monitored as set out in the document; with Policy Sponsors, maintaining and updating procedures / protocols and other supporting documents for this policy.
Title of any other relevant Officer	CHC and EOL Programme Lead • To oversee production of the document • To liaise with the relevant stakeholders to ensure the content is appropriate, up to date and correct. • Ensure the policy follow the correct governance route. • To complete any other documentation as necessary.

Titles of any Committee	CHC Control Centre – to oversee policy production. To review and approve poly document relating to CHC processes and procedures. Make recommendations for onward approval.
Line Managers	Line managers have a responsibility to ensure their staff comply with NHS Devon policies and standards within their areas of responsibility.
All Staff	Employed or engaged staff have a duty to comply with NHS Devon policies and standards as outlined in their contracts of employment and codes of conduct.

7 Implementation

7.1 All staff will be informed of the approval of the Policy via the Staff Bulletin which will provide a link to the document on the NHS Devon Intranet.

7.2 NHS Devon Senior Managers, or their designated representatives, will implement this policy by:

- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.
- Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.
- Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
- Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.

7.3 Relevant staff Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.

- Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.
- Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
- Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.

8 Approval and Review

8.1 This policy will be reviewed approved by NHS Devon's CHC Control Centre meeting. This group will make recommendations for approval to the Chief Nursing officer and Chief Medical approval who will give final ratification.

8.2 This policy will be reviewed annually, or sooner if required, in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of NHS Devon.

9 Monitoring compliance and effectiveness

9.1 NHS Devon ICB recognises its statutory duty to exercise its function effectively, efficiently and economically. The general duties of an ICB include improving the quality of services, reducing inequalities, promoting patient involvement and patient choice, promoting innovation, research, education and training.

9.2 The ICB is required to contain expenditure within the limits directed by NHS England. This is each ICB's statutory duty as an organisation and is separate to the requirement to deliver system financial balance.

9.3 The Finance Committee is responsible for assuring the ICB of compliance with financial management and performance against national and locally set Key Performance Indicators (KPIs), through receipt of regular reports and escalations where required from the AACC services. https://onedevon.org.uk/download/nhs-devon-icb-finance-committee-tor/

9.4 The ICB has a statutory duty to ensure compliance with the Standing Rules (2012) relating to NHS CHC, and the 2013 Standing Rules in regard to CYPCC –

https://www.legislation.gov.uk/uksi/2013/2891/contents/made

9.5 The ICB will take due regard of the National Frameworks in its development of policy and process; and its delivery of NHS CHC and CYPCC.

9.6 The Quality and Patient Experience Committee is responsible for assuring the ICB of compliance with aspects of this Policy relating to quality of the AACC service and its application in practice of the National Frameworks, through receipt of regular reports and escalations where required from the AACC services.
https://www.torbayandsouthdevon.nhs.uk/uploads/quality-assurance-committee-terms-of-reference.pdf

9.7 The policy and compliance will be monitored for compliance through the following routes:

- CHC control centre meeting – meeting held twice a month.
- Quality Patient and Experience Group- Quarterly review update meetings on performance and individual and family experience. This is reported onward the NHS Devon's Board meeting.

- NHS England Quality Assurance meeting – held quarterly.

10 Quality and Equality Impact Assessment (QEIA)

10.1 A QEIA has been undertaken, with the overall outcome a positive improvement on the previous polices that were in place. Information and detail is clearer for individuals and families. The project sponsor has approved the QEIA.

11 References

Care Act 2014

Care Standards Act (2000) Domiciliary Care National Minimum Standards Regulations

NOTE - Whilst care in England is subject to the Health and Social Care Act 2008, the provision of adult social care in Wales is predicated upon the Care Standards Act 2000. ***This piece of legislation was superseded in England in 2008****, but in Wales it is still the foundation stone of their regulatory system.*

Children Act 2004

Children and Families Act 2014

Continuing Healthcare Competency Framework
https://nhschc.co.uk/docs/competency_framework.odt

Equality Act 2010

Health and Care Act 2022

Hospital Discharge and Community Support: Policy and Operating Model (Oct 2021)

How to manage discrimination from individuals and their guardians / relatives (British Medical Association, 2022)

Local Resolution Best Practice Guidance: NHS Continuing Healthcare (NHSE & NHS Improvement, March 2021)

Mental Health Act (1983; 2007)

National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (July 2022)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1087562/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care-July-2022-revised.pdf

National Framework for Children's and Young People's Continuing Care (2016)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499611/children_s_continuing_care_Fe_16.pdf

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012
https://www.legislation.gov.uk/uksi/2012/2996/contents/made

NHS Devon ICB – NHS Continuing Healthcare Financial Redress Policy

NHS Devon ICB Constitution
https://www.england.nhs.uk/wp-content/uploads/2022/06/39-nhs-devon-icb-constitution-010722.pdf

Proactive guidance on the Safe and Supportive observation of Individuals at risk (Standing Nursing & Midwifery Advisory Committee [SNMAC], 1999)

Violence prevention and reduction standard (NHS and Social Partnership Forum, 2020)
Violence against NHS staff: letter to the workforce (Secretary of State for Health, 18 February 2020).
Who Pays? Determining which NHS commissioner is responsible for making payment to a provider (NHS England, June 2022)
https://www.england.nhs.uk/wp-content/uploads/2022/06/B1578_i_who-pays-framework-final.pdf