HFMA briefing
May 2019

How it works

NHS continuing healthcare

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Contents

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- **Continuing Healthcare Strategic Improvement Programme, NHS England and NHS Improvement**
- **HFMA Commissioning Technical Issues Group**
- **HFMA Policy and Research Committee**
- **Liaison**
- **NHS Tameside and Glossop CCG**
- **Oxford Health NHS Foundation Trust**
- **Personalised Care, NHS England and NHS Improvement**

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Introduction

NHS continuing healthcare (NHS CHC) is an area of significant expenditure for clinical commissioning groups (CCGs), supporting some of the most vulnerable people in the population. It is an area of health and social care where the distinction between the two services is blurred and the legislation governing who is responsible for what can be confusing.

This briefing gives an overview of the NHS CHC rules and process, picking up some of the terms that are commonly used, but may not be fully understood. This guide is intended to give a basic understanding for those working in NHS finance teams. It should not be used to administer NHS CHC processes. Links to further reading and guidance are provided in the final section.

What is NHS continuing healthcare?

NHS continuing healthcare (NHS CHC) is the commissioning of an ongoing package of health and social care that is arranged and funded solely by the NHS where an individual is found to have a primary health need.

The NHS is responsible for providing for all of that individual's assessed health and associated social care needs, including accommodation, if that is part of the overall need. Such care is provided to an individual aged 18 or over to meet needs that have arisen as a result of disability, accident or illness.

Statutory roles and responsibilities

Under the *Care Act 2014*, local authorities have a duty to assess any person who appears to be in need of care and support. If the assessment shows that the person has needs that meet the national eligibility criteria in the *Care Act 2014*, then the local authority must consider how it will address them. It is also possible for the local authority to choose to meet needs that do not meet the eligibility criteria, if they have the ability to do so.

However, the *Care Act 2014* limits the care and support that can lawfully be provided to individuals. A local authority may not meet needs that should be provided under the *National Health Service Act 2006*, unless they are incidental to something else being provided, classified as ancillary support to the primary care activity or are of a nature that the local authority could be expected to provide. Further, local authorities are prohibited from providing, or arranging for the provision of, nursing care by a registered nurse.

If the local authority needs assessment identifies that the person has a health need, then the person must be referred to the relevant clinical commissioning group (CCG). Equally, if a health needs assessment identifies potential social care needs, the NHS should notify the relevant local authority.

There are no legal definitions of a health need or a social care need in the context of NHS CHC. However, the eligibility criteria in the *Care Act 2014* provide a basis for determining how a need should be classified. It is essential that people do not fall down the gap between the two sets of legislation with neither body providing funding for care.

It should be noted that NHS England, rather than a CCG, has responsibility for NHS CHC for specified groups – for example, prisoners and serving members of the armed forces and their families.

Determining eligibility for NHS continuing healthcare

Primary health need

The concept of a primary health need enables the CCG and local authority to distinguish between needs that should be met under the *Care Act 2014* and the *National Health Service Act 2006*. Where a person has been assessed to have a primary health need, they are eligible for NHS CHC.

A primary health need relates to the level, type, quality and quantity of the person's day-to-day care needs. It is not linked to diagnosis; rather the nature, intensity, complexity and unpredictability of their needs.

Eligibility is based upon need, not the setting of care, so a person may be eligible for NHS CHC in their own home or in a residential care setting.

Screening

Initial screening for NHS CHC eligibility can be carried out using a national CHC checklist before a full assessment is carried out. This enables the full assessment resources to be directed to those who are most likely to be eligible. Only the approved NHS CHC checklist can be used for this purpose. The checklist covers the 11 care domains and considers whether there is a high, medium or low level of need for each.
The care domains are:

- Breathing
- Nutrition
- Continence
- Skin integrity
- Mobility
- Communication
- Psychological and emotional needs
- Cognition
- Behaviour
- Drug therapies and medication
- Altered states of consciousness.

There is a 12th domain, which covers any other significant care needs. The checklist is a quick and straightforward exercise which does not require detailed evidence to support it. The outcome of the checklist then determines whether a person goes through the full assessment process for NHS CHC.

Health or social care professionals are able to carry out this initial screening, but only if they have been trained in the use of the tool. These include nurses, clinicians and GPs, as well as social workers and care managers. It is not possible for somebody to self-refer for a full assessment, but they can request this be completed on their behalf by the CCG.

NHS continuing healthcare assessment process

A positive checklist leads on to the full assessment process to determine NHS CHC eligibility.

The full assessment should be carried out in a community setting, rather than an acute hospital, so that long-term needs are properly understood. The assessment must be undertaken by a multi-disciplinary team (MDT) which includes, as a minimum, two professionals from different healthcare professions or one healthcare professional and one person who can assess under the *Care Act 2014*.

Standing rules for CCGs state that, as far as is reasonably practicable, the CCG must consult with the relevant local authority before making an assessment decision. If the local authority is consulted, then they are required to provide advice and assistance. The involvement of the local authority in the MDT makes the process of care-planning and decision-making more effective.

The evidence and rationale for the assessment decision must be accurately and fully recorded. To this end, the approved national decision support tool (DST) must be used to ensure consistent, evidence-based assessment. The tool covers the same 12 domains as the checklist and must be carried out with the full involvement of the individual and, where appropriate, their representative.

Decision-making by the CCG

At the conclusion of the assessment process, the MDT makes a recommendation to the CCG as to whether they consider the individual to be eligible for NHS CHC. The CCG must ensure consistency and quality of decision-making and can ask for further clarification if necessary. However, it is expected that the CCG will follow the MDT's recommendation in all but exceptional circumstances.

Validation of the MDT's decision can be carried out by a panel or an individual. The framework is clear: the validation process must not be used for gatekeeping or for financial control, and finance officers should not be part of the decision-making process.

Timescales

From receipt of a positive checklist, the whole process of assessment and eligibility decision should not exceed 28 days. It is expected that CCGs will respond to MDT recommendations within two working days (48 hours). These timescales do not apply in all circumstances, for example fast track NHS CHC or during transition from children and young people's continuing care.

Reviews

The review process is designed to ensure that the care plan and the arrangements in place continue to be appropriate to meet the person's needs. An initial review should take place three months after the eligibility decision is made, with further reviews at least annually.

If the local authority is responsible for any part of the care, then they should be involved in the review process. It can be beneficial to involve the local authority in any case, as the review may indicate a need for a care and support assessment or a carer's needs assessment.

Ongoing eligibility

Eligibility for NHS CHC is not indefinite as needs could change. The review process enables identification of significant changes that may require a reassessment of eligibility.

Neither the CCG or the local authority should withdraw from an existing arrangement without first consulting one another and the individual. No funding should be withdrawn without first ensuring that alternative arrangements have been put in place to enable continuity of care.

Delivery of care

When a person is eligible for NHS CHC, the CCG becomes responsible for all elements of care planning, commissioning services and case management. In this context, these include all aspects of care, not just the health elements.

A person-centred approach should be taken, ensuring that the individual has an active role in developing a personalised care and support plan that takes their preferences into account. Where the person has needs outside the remit of NHS CHC, these should be considered and, where possible, a single personalised care and support plan should be developed, covering all aspects.

Commissioning NHS continuing healthcare

The CCG is responsible for commissioning services for NHS CHC and can use a wide range of providers to meet people's assessed needs. CCGs and local authorities should work in partnership to share information and avoid duplication, leading to more cost-effective solutions for the whole population.

While the CCG is responsible for commissioning the services that those in receipt of NHS CHC require, it is likely that the local authority already commissions some of those services for other parts of the population, thus working together can optimise use of public funds. This integrated approach also ensures that the care market can be responsibly managed, developed and sustained. Changes of provider that have an adverse impact on the individual should not occur just because the responsible commissioner has changed.

People in receipt of NHS CHC continue to be entitled to the full range of primary, secondary, community and other health services. When commissioning services under NHS CHC, the specification for the services to be supplied should be clearly set out to ensure clarity of what is being commissioned.

The benefits of working in partnership with the local authority are clearly evident in **case study 1**.

Case study 1: Working in partnership

NHS Tameside and Glossop CCG has a single finance team comprising CCG and local authority finance staff operating as a strategic commissioner. The team manages an integrated commissioning pooled fund of £953m gross expenditure and £336m income (£617m net).

Integrated working between the CCG and local authority staff has played a key role in supporting the NHS CHC team to understand key cost drivers and subsequently deliver against an ambitious NHS CHC recovery plan.

The joint working has also resulted in more accurate forecasting and a robust budget setting process for what is acknowledged as a high-risk area.

The financial management of both NHS CHC packages at the CCG and residential and nursing care home placements at the local authority is the responsibility of the same management accountant. This means that where a package of care transfers between organisations – for example, where a person becomes eligible for NHS CHC – the finance team is able to quickly identify whether an appropriate package of care has been opened on the CCG's Broadcare management information system.

This ensures that there are no duplicate forecasts and reduces the risk of packages of care not being included in the financial plans.

On a monthly basis, CCG and local authority finance colleagues visit the NHS CHC nursing team together in order to review packages of care in detail to better inform forecasting and recharging between organisations. This visit includes a full reconciliation of those packages on the local authority care management system, Abacus, to the CCG's patient system, Broadcare.

Working closely with the NHS CHC team in this way also helps to resolve queries – for example, regarding an individual's assessed hours versus actual hours invoiced by providers. This ensures that the appropriate levels of care and support are being paid for and that providers are invoicing in line with the assessed needs identified by the NHS CHC nurses.

This also gives both the NHS CHC nursing team and finance support colleagues a detailed awareness of the wider system requirements and interdependencies.

Determining the financial envelope

The individual's preferences, as set out in the personalised care and support plan, should be the starting point for agreeing the package of funding. CCGs can take comparative costs and value for money into account but must consider the following factors:

- Any cost comparison with providing support through a care home, should be a genuine comparison for somebody with the person's specific needs, not an average cost.
- Cost must be balanced against other factors in each case, such as a person's desire to remain in their own home.
- Actual costs should be identified of supporting someone in their own home, based upon their assessed needs. CCGs can consider whether alternative models of support can be employed, such as assistive technology rather than 24-hour nursing.
- CCGs should not make assumptions about any individual, group or community being able to care for an individual, but should take any family support offered into account.
- The funding must be sufficient to meet the assessed needs in the personalised care and support plan. NHS care is free at the point of delivery and individuals must not be asked to contribute towards it.
- 'Top-up' or enhanced payments in care homes cannot be charged for individuals who are eligible under NHS CHC unless the top-up payment is unrelated to the provision of care. In these cases, the individual/family/representative may negotiate or agree to pay a top-up. However, the CCG will not be responsible for this fee.

Personal health budgets

Since October 2014, people in receipt of NHS continuing healthcare or continuing care for children and young people, have had the 'right to have' a personal health budget in law. Since 1 April 2019, a personal health budget should be offered as the default option to provide NHS CHC for people living in their own homes. **Case study 2** sets out how one health and care economy has approached this requirement.

A personal health budget, often referred to as a PHB, is an amount of money to support a person's identified healthcare and wellbeing needs. It is based on a personalised care and support plan, which is planned and agreed between the person, or their representative, and the CCG. It is not new money, but a different way of commissioning and spending health funding to better meet a person's needs.

Case study 2: Offering personal health budgets as the default for community-based NHS CHC

Personal health budgets (PHBs) are widely acknowledged as beneficial for the individual, but the reality of offering and implementing them can be a challenge. Many organisations see PHBs as something different to mainstream care, provided by a separate team and not part of the day job. This was largely true for **Oxford Health NHS Foundation Trust** where, despite being one of the original pilot sites, changes in staff at all levels, service reorganisation and competing pressures had led to a reduction in the offer to patients.

However, the announcement that PHBs were to become the default offer for community-based NHS CHC gave the trust an opportunity to rejuvenate the programme.

The NHS CHC team was a mix of those who had been involved before and had good experience of delivering PHBs, and those who had joined the team more recently so knew very little about the concept. The administrative support staff for NHS CHC had very little involvement previously and also needed to understand more. The relaunch of PHBs began with an away day for the whole team, to explain what PHBs were and how they worked. It was also an opportunity to raise any concerns.

The recent reorganisation of the service had introduced many efficiencies into the NHS CHC processes, but it was recognised that case management was not working as well as it could. This, together with concerns around how to deal with those who had complex existing arrangements, coupled with the time required for support planning, led to a new approach for the trust.

The new approach introduced a complex case manager into each locality team. These roles were filled by volunteers from current clinicians who effectively became the PHB champion in each locality. These posts enabled the individuals to step away from their normal caseload – joint assessor /case manager – and focus on the more complex cases, giving them the time necessary to implement the approach well.

At the same time, those in the roles act as mentors, offering support to clinicians in the service to effectively implement PHBs for less complex clients on their caseload. The three complex case managers are also reviewing existing PHB processes and documentation, benchmarking with other areas and developing a robust and simple process that can be used by everybody at the very beginning of the NHS CHC journey.

The process ensures that everybody has a good care and support planning conversation regardless of the ultimate setting of their care. Where residential care is identified as the most appropriate approach, the PHB element of the process does not have to be followed. However, it is not necessary to determine PHB applicability at an early stage, thus making the process very straightforward for practitioners.

The healthcare managers in the service are responsible for the end-to-end process: carrying out the assessment, arranging the care and setting up the PHB, where applicable. However, they have an option of referring the case to the complex case manager if it is not something that can be easily dealt with, or where they need support.

Over time, it is expected that all clinical staff will rotate through the complex case manager role, ensuring that all staff have the opportunity to develop the necessary knowledge to effectively case manage and implement PHBs for all levels of complexity.

The PHB approach will also be added to the trust NHS CHC staff induction, so that all new staff work in that way from day one.

A personal health budget can be used to pay for a broad range of goods and services that have been agreed to meet health and wellbeing outcomes through the personalised care and support planning process.

Personal health budgets can be made available in three ways; all three options must be available to the person who can choose one, or a combination, of methods. In all cases, the CCG retains responsibility for the provision of appropriate support for the individual, although delivery may be delegated.

1. **Notional budget** The NHS holds the money on behalf of the individual. The person knows how much their budget is and discusses with the NHS the care and support they require to meet their needs. The NHS purchases the agreed care and support.

2. **Third-party budget** An organisation independent of the NHS commissioner and the person manages the budget and arranges the care and support for the person, working in partnership with the person to achieve the agreed outcomes. This organisation is often from the third sector but could also be an NHS provider, if conflicts of interest are appropriately managed. Some CCGs choose to offer third-party budgets through a framework agreement where the contract of supply is between the CCG and the third-party provider, but the person can choose which provider to use. Other CCGs do not enter into these arrangements and the contract of supply is between the individual and the third-party provider. Third-party budgets are particularly helpful when a person:

    a. does not want to manage a direct payment
    b. does not wish to take on employer responsibilities for personal assistants
    c. lacks capacity or is otherwise not in a position to manage their own budget.

3. **Direct payment** The person, or their representative, has the money in a bank account or on a pre-paid card and takes responsibility for organising their own care and support. Payments to the account are usually made monthly, in advance. A CCG can delegate delivery of direct payments to another organisation, such as a local authority who has the processes already in place to carry out this task, but the CCG retains responsibility for the payments.

More information about personal health budgets can be found in the HFMA's publication *How it works – personal health budgets and integrated personal budgets*.[1]

Calculating the financial envelope for a personal health budget can be challenging. One method of determining the budget level is discussed in **case study 3** on the following page.

[1] HFMA, *How it works – personal health budgets and integrated personal budgets,* November 2018

Case study 3: Calculating the financial envelope

Overview

The Liaison Care Calculator has been developed to produce indicative budgets for both NHS CHC and for jointly funded packages of care. It uses information from the health and social care assessment to calculate the indicative budget and split, providing an accurate, sustainable and defensible method of resource allocation.

The Calculator can be integrated with existing NHS CHC and social care processes. It is based on the two key legal frameworks - the *Care Act 2014* and the *National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care 2018*.

It also considers the levels of needs that are currently being met through support from family and friends or are already met by other services. It has been developed as a national model with the ability for local configuration to reflect CCG policy decisions and local costs of care. This ensures that indicative budgets that are calculated using the Liaison Care Calculator will be sufficient for individuals to purchase the care that they need in their local area.

Developing the model

The Liaison Care Calculator was developed with a CCG and council, based on the agreed principles and using the Liaison health and social care assessment as its method of recording needs.

There were eight social care related questions and 11 health related questions in the assessment. An optimal weighted score was applied to each of the levels of need for each domain.

Informal support and support provided by universal commissioned health and social care, which included needs already being met by a service – for example, behaviour support and continence – was included to ensure that only unmet needs were calculated. There were seven levels of support included, ranging from 0% to 100% of needs being met.

The 'complexity of care' was factored in to ensure that all budgets generated from the Calculator would reflect the complexity of care required for each individual.

There are 11 levels of complexity that allow the Liaison Care Calculator to be calibrated for all adults and still maintain its level of accuracy in care costs and split of responsibility.

The intended or current living situation is also included in the Calculator, as this has a direct impact on costs, particularly in supported living environments where aspects of the costs of care can be shared.

It also has an impact where residential or nursing homes are an option, as there is often a contract in place for the costs of these services on a per bed per week basis.

Testing and validation

The Liaison Care Calculator was tested against the calculated budget for a cohort of individuals. The cohort was defined as adults with a learning disability, who had a current care package above £1,000 per week. The sample of 35 used for this phase were chosen based on being the most recently assessed in an area. No other selection criteria were applied.

An additional validation was used in this testing phase to include an evaluation of the accuracy of the assessments that were completed by Liaison on all 35 individuals. This was completed with representatives from health and social care, where at least one person knew the individuals well.

The outcome of this validation was that the assessments were 99.1% accurate, based on the information provided. There were two cases where breathing had not been scored when it should have been, and two cases where epilepsy was a need and had not been recorded. There were also two cases where the intended living situation was recorded incorrectly.

Once these corrections had been made, all assessments were agreed as reflecting the needs of the individuals.

Based on the sample of 35 cases tested by the Liaison Care Calculator, there is strong evidence to claim that it can predict the costs of care within +/- 1%.

The correlation of this sample between the costs produced by Liaison Care Calculator and the actual cost of care is 0.998. This is a very strong correlation.

Of the 35 cases in the sample, only three were above 1% and the maximum deviation was 2.77%. This represents a correlation of 0.978, which is still considered very strong.

NHS CHC strategic improvement programme

The national NHS CHC strategic improvement programme (SIP) was launched on 1 April 2017. Phase one of the programme concluded at the end of March 2019, paving the way for the transformational space of phase two.

The programme is triple-aimed and seeks to provide fair access to NHS CHC in a way which ensures better outcomes, better experience and better use of resources[2]. The programme goals include:

- Reducing the variation in patient and carer experience of NHS CHC assessments, eligibility and appeals
- Working with CCGs across the country to identify best practice that can be adopted by other CCGs
- Setting national standards of practice and outcome expectations
- Making the best use of resources – offering better value for patients, the population and the taxpayer
- Strengthening the alignment between other NHS England work programmes which have an NHS CHC component, such as personalisation and choice.

The programme has developed, and continues to develop, various products for use by NHS CHC systems to aid transformation, with key areas of focus including workforce development and planning, improved commissioning, a move towards digital NHS CHC and an online resource to aid standardisation of NHS CHC process across the country.

Liaison has been working in partnership with the NHS England strategic improvement programme to support the standardisation of the delivery of continuing healthcare across England and Wales.

As part of this partnership, Liaison has developed a NHS CHC audit to assess the performance and effectiveness of the delivery of the NHS CHC services that each CCG offers. This is described in **case study 4** on the following page.

Redress payments

Redress guidance[3] has been issued to assist CCGs when settling claims for individuals. Claims may relate to disputed eligibility decisions or a retrospective decision on a previously unassessed period of care.

The purpose of redress is solely to restore the individual to the financial position they would have been in, had NHS CHC been awarded at the appropriate time. It is not intended to result in a profit for any party involved and so does not usually cover legal or professional fees.

However, the CCG does have the power to make an ex-gratis payment over and above the care costs and interest, should they consider it appropriate and in line with their standing financial instructions.

Fast-track NHS continuing healthcare

The fast-track pathway tool for NHS CHC is intended for use with individuals who have a rapidly deteriorating condition that may be entering a terminal phase. There is no requirement to complete a decision support tool and an 'appropriate clinician' can determine that the person has a primary health need. An appropriate clinician is a person who is responsible for the diagnosis, treatment or care of the individual in question, and is a registered nurse or registered medical practitioner.

A CCG must accept and immediately action a fast-track pathway tool, where it has been properly completed. Care packages should be agreed and commissioned within 48 hours.

CCGs should monitor care packages to consider when and whether a reassessment of eligibility is appropriate. Where it is apparent that the individual is nearing the end of their life and the original eligibility decision was appropriate, it is unlikely that a review of eligibility will be necessary. NHS CHC funding would not be removed without their eligibility being considered via completion of a DST by a multi-disciplinary team.

[2] NHS England, *NHS CHC strategic improvement programme,* April 2019

[3] NHS England, *NHS continuing healthcare- refreshed redress guidance,* April 2015

High-cost packages

The funding identified for the care package must be sufficient to meet the assessed needs in the personalised care and support plan. NHS care is free at the point of delivery and individuals must not be asked to contribute towards it. However, an individual may express a preference for higher cost accommodation or services. Where this is related to an assessed need, then the cost should be funded.

People may become eligible for NHS CHC while they are living in a care home where the fees are higher than those that would normally be covered by the CCG. The CCG must consider whether moving the person to a new setting would be significantly detrimental to their health. If there is no justification for the CCG to fund the higher rate, any decision about changes to accommodation or service provision must be taken in consultation with the individual and a transition care plan developed.

Case study 4: Auditing the CHC process

The **West Sussex CHC** service incorporates Coastal West Sussex, Horsham and Mid Sussex and Crawley Clinical CCGs and is managed in-house and hosted by Coastal West Sussex CCG.

Following a review of the NHS CHC service in 2016, the West Sussex NHS CHC service implemented a service improvement plan, this included the restructuring of the team, engaging external support and developing new processes for the service. With much of the improvement plan implemented the senior leadership team wanted to ensure it had achieved measurable and notable improvements to the service.

The CCG engaged the Liaison CHC team to carry out a NHS CHC audit to assess the performance and effectiveness in the delivery of their services, against the NHS CHC national framework, using the NHS maturity matrix.

The NHS CHC audit assessed the service in all 18 dimensions of the end-to-end delivery of the service (as set out in the box below).

Prior to the audit, the Liaison CHC team agreed an agenda and structure of the audit to ensure that the appropriate staff were available for each of the sessions, and to ensure that the audit made as little impact on the delivery of the service as possible.

In advance of the audit, Liaison also provided the service with a list of documentation that was required as evidence to allow some time for preparation.

The audit was conducted over two days by two CHC consultants from the Liaison team and involved interviewing a variety of staff including the head and deputy head of CHC, CHC operations managers, contracts manager, senior management accountant, lead nurses and nurse assessors.

Following the audit, a full report was provided, detailing the scores for each dimension, with the evidence justifying each score. The report highlighted weaknesses and strengths, and provided the CCG with short-, medium- and long-term recommendations. The report included a scorecard and a graph of the scores, benchmarked against other CCGs.

A follow-up meeting was arranged with the NHS CHC team leads to discuss the report, detailing the findings and providing the team with an opportunity to clarify any questions and provide feedback. During this meeting Liaison were able to highlight the areas that were in need of improvement and what could be done to improve their levels of maturity in order to further improve the service.

The CCG felt that reviewing every aspect of the end to end service allowed them the opportunity to consider areas of the service that may have been overlooked, highlighting where improvements could be made to the service to improve compliance with the national framework plus patient experience. They were able to use the findings from the audit in their business plan and set priorities for the service.

West Sussex CHC Service commented: ‘Evaluating the end to end service with the Liaison team helped us recognise areas of improvement we had not necessarily considered before. We were able to easily identify and prioritise areas requiring improvement, relaunch our mission statement and align with our NHS CHC business plan 2019-21.’

- **CHC strategy and leadership**
- **Governance**
- **Invoicing and payment**
- **Full assessment**
- **Fast track**
- **Review and case management**
- **Patient and family**
- **Technology and systems**
- **Market management**
- **Verification**
- **Personal health budgets**
- **Appeals**
- **People and skills**
- **Data and information**
- **Screening**
- **Funded nursing care**
- **Brokerage**
- **Retrospective assessments**

NHS continuing healthcare and section 117 aftercare funding stream

CCGs and local authorities are jointly responsible for the provision of aftercare under section 117 of the *Mental Health Act 1983*, for those individuals who have been detained under certain provisions of the Act. This duty applies from discharge until such time as the CCG and local authority are satisfied that the person no longer needs the services. The after-care services provided are for needs arising from, or related to, their mental disorder.

Services that are provided in this context, must be provided under section 117. Section 117 aftercare services are jointly funded by the NHS and local authority, and the responsibility for provision of such services is held by both organisations. All services are provided free of charge, regardless of whether they are provided by the NHS or the local authority.

If the individual has needs that are not related to, or do not arise from, their mental disorder, then NHS CHC may be applicable, subject to the assessment of eligibility previously described. NHS CHC must not be used to meet section 117 needs.

Funded nursing care

If an individual is not eligible for NHS CHC, the need for care by a registered nurse may need to be determined. Eligibility for NHS-funded nursing care is determined by whether a person has that need and that their overall needs would be best met in a care home with nursing. This addresses the limitation on local authorities under the *Care Act 2014* that prohibits them from arranging such care.

Eligibility for NHS CHC should always be assessed via a checklist prior to assessing for NHS-funded nursing care. Once the need for NHS-funded nursing care is identified, supported by a clinical/nursing needs assessment and agreed, the CCG will pay a flat-rate contribution to the care home. This supports the provision of a nurse; it does not cover accommodation costs.

Joint packages of health and social care

If an individual is not eligible for NHS CHC, they may potentially receive a joint package of health and social care, which is funded by both the NHS and local authority. This may arise from completion of the decision support tool that identified needs beyond those that could be met by the local authority.

The CCG and local authority should work in partnership to develop the personalised care and support plan with the individual. Responsibilities for each party need to be agreed and a lead commissioner is identified.

Joint packages of care can support an individual in their own home who has both health and care needs. These packages can also support people in care homes, where they have needs over and above the scope of NHS-funded nursing care or where they do not require nursing but have specific health needs that require interventions not usually provided by core NHS services.

It is advisable that individuals who receive their care via a joint-funded care package are informed that they may need to contribute to the local authority proportion of funding.

Transition from children and young people's continuing care

Children and young people who have health needs beyond that routinely available from the NHS are supported by continuing care. Eligibility for children and young people's continuing care does not automatically mean that the person will be eligible for NHS CHC when they turn 18, as the legislation and associated criteria are quite different.

Where it is anticipated that NHS CHC may be appropriate in adulthood, children's services should notify the responsible CCG when the child reaches the age of 14. A formal referral for screening for NHS CHC will be made when the person reaches 16, with a full assessment of eligibility after their 17th birthday. This timescale ensures that packages of care can be commissioned and in place by the time the individual reaches their 18th birthday.

During transition, the normal 28-day timescale for assessment does not apply.

Conclusion

NHS continuing healthcare links the services that support people across a range of functions, providing the integration at an individual level that many systems seek to replicate for a population. However, navigating the rules and complying with the many aspects of legislation that touch vulnerable people's lives, is complex.

It is important that NHS finance staff have an understanding of the complexity of NHS CHC and what it seeks to achieve, rather than just seeing it as an, often large, figure in the financial statements to be managed downwards. Having a basic knowledge can allow finance staff to ask questions of those involved and assist the service to deliver the care and support that people need, while making the most effective use of resources.

Further information

- This briefing has made extensive use of the Department of Health and Social Care *National framework for NHS continuing healthcare and NHS-funded nursing care,* which can be found at **www.england.nhs.uk/healthcare** This website also contains information about the NHS CHC strategic investment programme and links to the redress guidance.

- Further detail about children and young people's continuing care can be found in the Department of Health *National framework for children and young people's continuing care* at **www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework**

- The CHC Strategic Improvement Programme has established a useful website for CHC practitioners to support implementation of the *National framework for NHS continuing healthcare and NHS-funded nursing care*. The website is currently in a beta user testing phase and can be accessed by individuals with an NHS or .gov e-mail address. Registration to access the CHC delivery model (beta version) can be found at **www.nhschc.co.uk**

About the HFMA

The Healthcare Financial Management Association (HFMA) is the representative body for finance staff in healthcare. For nearly 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

HFMA

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Healthcare Financial Management Association (HFMA) is a registered charity in England and Wales, no 1114463 and Scotland, no SCO41994.
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Liaison Care Calculator

The **Liaison Care Calculator** has been developed to assist CCGs in calculating indicative budgets to support the personalisation of care - offering individuals more choice and control by providing them with a personal health budget (PHB).

The Liaison Care Calculator achieves this by accurately predicting the cost of care based on the needs and complexity of the individual. The Liaison Care Calculator has been developed to produce indicative budgets for both CHC and for jointly funded packages of care. It can also accurately calculate the split of responsibility and funding between health and social care.

The Liaison Care Calculator

- Is an accurate, sustainable and defensible method of resource allocation.
- Is Integrated within existing CHC and social care processes.
- Uses already available information - Health and Social Care Assessment - to calculate the indicative budget and split.
- Uses an assessment which is based on two legal frameworks - The Care Act 2014 and The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care 2018.

It also considers the levels of needs that are currently being met through the support from family and friends or are already met by other services. It has been developed as a national model with the ability for local configuration to reflect your CCG's policy decisions and the costs of care in your area. This ensures that indicative budgets that are calculated using the Liaison Care Calculator are sufficient for individuals to purchase their care in your area that meet their needs.

Study and Evidence

In a recent study conducted with a health and social care organisation the Liaison Care Calculator was able to predict the costs of care within +/- 1%.

The correlation of the sample used in the study between the indicative budget produced by Liaison Care Calculator and the actual cost of care was 0.998. This is a very strong correlation. It also accurately predicted the split between health and social care.

To find out more about how the Liaison Care Calculator can support your CCG to implement personal budgets that are accurate and sustainable for either CHC or jointly funded packages of care please contact:

0845 603 9000

Email: info@liaisonfs.com

Web: www.liaison.co.uk

Other services provided by Liaison Care

Liaison Financial Reviews

We have identified and recovered million of pounds of duplicate and overpayments for CCGs which have been reinvested back into the NHS.

Liaison CHC Audits

A baseline assessment for measuring the maturity of the delivery of CHC. Identifying areas of strength and weakness to support the CCG to develop an effective improvement plan.

Liaison CHC Consultancy

We support CCGs to improve all aspects of their CHC delivery. This can include; improving process, supporting them with PHBs, reviewing and implementing technology etc.