NHS
Dorset
Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

Policy for NHS Continuing Healthcare and NHS-Funded Nursing Care

Supporting people in Dorset to lead healthier lives

PREFACE

This policy sets out how NHS Dorset Clinical Commissioning Group (CCG) implements The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care.

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

All CCG policies are published on the staff intranet and communication is circulated to all staff when new policies or changes to existing policies are released. Managers are encouraged to use team briefings to aid staff awareness of new and updated policies.

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

A	SUMMARY POINTS
This policy sets out how NHS Dorset Clinical Commissioning Group (CCG) implements The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.	

B	ASSOCIATED DOCUMENTS
• Continuing Healthcare Choice Policy 2016 • Governance for Personal Health Budgets 2016	

C	DOCUMENT DETAILS
Policy Number	ID 18
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2	January 2016	Angie Smith Senior Continuing Healthcare Support Services Manager David Palmer Senior Continuing Healthcare Operational Manager	N/A The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care is mandated by NHS England

E	VERSION CONTROL				
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February 2014	1	January 2016	New CCG document	February 2014	Directors
May 2016	2	May 2018	Document put into corporate format	16 May 2016	Directors/Performance

F	SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES	
Evidence	**Hyperlink (if available)**	**Date**
Access to Health Records Act 1990		1990
Community Care Act (delayed discharge) 2003		2003
Data Protection Act 1998		1998
Equality Act 2010		2010
Guidance for Access to Health Records Requests		2010
Health and Social Care Act 2012		2012

Human Rights Act 1998		1998
Local Authority Social Services Act 1970		1970
National Assistance Act 1948		1948
Local Authority Social Services Act 1970		1970
National Health Service and Community Care Act 1990		1990
National Health Service Act 2006		2006
NHS Continuing Healthcare, Continuing Care Redress, 14 March 2007 – Gateway 7976		2007
NHS England and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012		2012
The Delayed Discharges (Continuing Care) Directions 2009		2009
The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care – November 2012 (Revised)		2012
The National Health Service (Nursing Care in Residential Accommodation) Directions		2007
The NHS Constitution		2013
Who Pays? Determining responsibility for payments to providers		2013
The Care Act		2014
NHS England Operating Model for NHS Continuing Healthcare		2015
The Children and Families Act 2014		2014

G	**DISTIBUTION LIST**		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
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POLICY FOR NHS CONTINUING HEALTHCARE AND NHS-FUNDED NURSING CARE

1.0 RELEVANT TO

1.1 This policy is relevant to all staff employed by the CCG who undertake activities with regard to CHC.

2.0 INTRODUCTION

2.1 *The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)* is hereafter referred to as 'The National Framework'.

2.2 NHS England and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 set out the Standing Rules for NHS Continuing Healthcare and NHS-funded Nursing Care.

3.0 SCOPE

3.1 This policy sets out how staff employed by NHS Dorset Clinical Commissioning Group (CCG) implement *The National Framework for NHS Continuing Healthcare and NHS-funded nursing care.*

3.2 This policy does not include children's continuing care apart from transition from children's to adult services. There is a separate National Framework for children and young people.

4.0 PURPOSE

4.1 This policy sets out the processes and procedures for health and social care staff to implement The National Framework in the geographical County of Dorset.

4.2 Annexe G in The National Framework provides a best practice guide for local protocols and procedures regarding NHS continuing healthcare (CHC).

4.3 The policy also sets out the CCG processes in those situations where the CCG decides that an individual is not eligible for NHS continuing healthcare funding.

4.4 This policy describes the way in which the CCG will commission care in a manner that reflects patient choice and preferences of individuals but balances the need for the CCG to commission care that is safe and effective and makes best use of resources.

5.0 DEFINITIONS

5.1 This policy reflects legislation and the mandate from NHS England that all CCGs comply with The National Framework.

5.2 The policy guides standards, decision making and actions for staff.

5.3 A glossary of CHC terms and definitions is included in the Decision Support Tool (DST) for NHS Continuing Healthcare November 2012 (Revised).

5.4 A list of abbreviations is contained in Appendix B.

6.0 ROLES AND RESPONSIBILITIES

6.1 The Director of Quality is the designated lead for CHC within the CCG and is responsible for:

- Reporting compliance with The National Framework

6.2 CHC Managers in the CCG will be responsible for monitoring compliance with The National Framework.

6.3 All CHC members of staff in the CCG are responsible for compliance with The National Framework with regard to standards, decision making and actions.

7. KEY PRINCIPLES

7.1 NHS continuing healthcare means a package of care that is arranged and funded solely by the NHS. The services provided as part of that package should be seen in the wider context of best practice and service development for each individual group.

7.2 Eligibility for NHS continuing healthcare places no limits on the settings in which the package of care is delivered or on the type of service delivery. (The National Framework, Paragraph 13).

7.3 The NHS and Local Authorities (LAs) have a responsibility to ensure that the assessment of eligibility for NHS continuing healthcare and the provision of care take place in a timely and consistent manner. (The National Framework, Paragraph 15).

7.4 The principles underlying this policy support the provision of a consistency in assessing eligibility and fair and equitable access to NHS continuing healthcare funding. These principles are as follows:-

- health and social care professionals will work in partnership with individuals and their families throughout the process;
- all individuals and their representatives will be provided with information to enable them to participate in the process;
- the CCG will support the provision of advocacy to individuals throughout the process of assessment for NHS continuing healthcare funding;
- the process for decisions about eligibility for NHS continuing healthcare funding will be transparent for individuals, their representatives and for partner agencies;
- assessments of health and social care will be undertaken jointly by relevant agencies using local processes;
- assessments and decision-making about eligibility for NHS continuing healthcare funding will be undertaken in a timely manner to ensure individuals receive the care they need in the appropriate environment without unreasonable delay.

8. ELIGIBILITY FOR NHS CONTINUING HEALTHCARE

8.1 The National Framework provides guidance for establishing eligibility for NHS continuing healthcare and tools to assist in making decisions about eligibility for NHS continuing healthcare.

8.2 To assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the National Health Service Act 2006 and to distinguish between those and the services that LAs may provide under Section 21 of the National Assistance Act 1948, the Secretary of State has developed the concept of a 'primary health need' Where a person's primary need is a health need, they are eligible for NHS continuing healthcare. Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, the NHS is responsible for meeting all of that individual's assessed health and social care needs. (The National Framework, Paragraph 33).

8.3 Identification of a primary health need should include consideration of the nature of all needs; the impact of these needs and to determine whether the quantity or quality of care is more than the LA can lawfully provide (Coughlan Judgement).

8.4 Certain characteristics of need and their impact on the care required to manage them may help to determine whether the quality or quantity of care is more than the limit of a LAs responsibilities for service provision:

- nature;
- intensity;
- complexity;
- unpredictability.

Each of these characteristics may either alone or in combination demonstrate a primary health need because of the quality and/or quantity of care required to meet the needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered.

8.5 It is important that deterioration is taken into account when considering eligibility including where deterioration is reasonably likely to occur in the near future. (The National Framework, Paragraph 38).

8.6 The first step in the process in most cases will be the NHS continuing healthcare Checklist. It is important that the individual/their representative understands that passing the Checklist threshold does not indicate a likelihood that the individual will be eligible, but that a full assessment is needed using the DST. The threshold for proceeding to a DST has been set deliberately low to ensure that all those who require a full assessment have that opportunity.

8.7 Any one practitioner from health or social care can apply the Checklist to refer individuals for a full assessment of eligibility for NHS continuing healthcare. Whoever applies the Checklist should be familiar with and have regard to the Department of Health (DH) guidance.

Further guidance on the Checklist can be found. (The National Framework, Paragraphs 68–76 and PG 15-25).

8.8 To minimise variation in interpretation of the principles and to inform consistent decision making, the DST is used by practitioners to assist in identifying the needs and to indicate whether those needs could constitute a primary health need. (The

National Framework, Paragraph 40).

8.9 The DST must be completed by the multi-disciplinary team (MDT) which is a team of at least two professionals usually from both health and social care.

8.10 The assessment process should draw on those who have direct knowledge of the individual and their needs. It should also make use of existing specialist assessment and should make referrals for other specialist assessment whenever that is appropriate in light of the individual's care needs.

8.11 It is the responsibility of the MDT to make a recommendation on eligibility for NHS continuing healthcare eligibility.

Further guidance on the MDT and DST is at (The National Framework, Paragraphs 77–89 and PG26-38).

9. MENTAL CAPACITY ACT AND CONSENT

9.1 Hyperlink to the Mental Capacity Act.

http://www.nhs.uk/CarersDirect/moneyandlegal/legal/Pages/MentalCapacityAct.aspx

9.2 As with any examination or treatment, the individual's informed consent should be obtained before the start of the process to determine eligibility for NHS continuing healthcare. The consent form can be accessed on the CCG website.

9.3 It should be made explicit to the individual whether their consent is being sought for a specific aspect of the eligibility consideration process (e.g. completion of the Checklist) or for the full process. An individual may withdraw their consent at any time in the process.

9.4 If an individual does not consent to assessment of eligibility for NHS continuing healthcare, the potential effect this will have on the ability of the NHS and the LA to provide appropriate services should be carefully explained to them. If an individual does not consent this does not mean the LA has an additional responsibility to meet their needs, over and above the responsibility it would have had if consent had been given. Where there are concerns that an individual may have care needs and the level of appropriate support could be affected by their decision not to give consent, the appropriate way forward should be considered jointly by the CCG and the LA,

taking into account each organisation's legal powers and duties and safeguarding responsibilities.

9.5 If the individual may not have the capacity to give consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. All health and social care staff should be aware of the five principles of the Act.

- a presumption of capacity;
- individuals being supported to make their own decisions;
- unwise decisions;
- best interest;
- least restrictive option.

9.6 It is important to be aware that just because an individual may have significant difficulty in expressing their views this does not mean that they lack capacity. Appropriate support and adjustments should be made available, in compliance with the Mental Capacity Act 2005 and with disability discrimination legislation.

9.7 If the person lacks the mental capacity to refuse or to consent, a 'best interests' decision should be taken (and recorded) as to whether or not to proceed with assessment of eligibility for NHS continuing healthcare. Those making this decision should bear in mind the expectation that everyone who is potentially eligible for NHS continuing healthcare should have the opportunity to be considered for eligibility.

9.8 A third party (for example, a relative) cannot give or refuse consent for an assessment of eligibility for NHS continuing healthcare on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (Welfare) or they have been appointed a Welfare Deputy by the Court of Protection. (The National Framework, Paragraphs 45-51).

9.9 The completion of the Checklist and DST should be carried out with the knowledge and consent of the individual and/or their representative. They should be given every opportunity to participate in the assessment process. The individual should be

given the option of being supported or represented by a carer or advocate.

9.10 More detailed guidance on consent can be found at (The National Framework, Paragraphs 45–47 and PG5 & 8).

More detailed guidance on mental capacity can be found at (The National Framework, Paragraphs 48–51 and PG6).

10. CARERS

10.1 A carer who provides (or intends to provide) substantial care on a regular basis has a right to have their needs as a carer assessed (Carers and Disabled Children Act 2000, as amended by the Carers (Equal opportunities) Act 2004). The CCG should inform carers of their right to a carer's assessment by the LA. (The National Framework, Paragraph 54).

10.2 Further guidance on carers is available at PG89, which states that the CCG may need to provide additional support to care for the individual whilst the carer has a break for his/her caring responsibilities and will need to assure carers of the availability of this support when required.

11. ADVOCACY

11.1 The Mental Capacity Act 2005 created a new statutory service: the Independent Mental Capacity Advocate (IMCA) service. Its purpose is to help vulnerable people who lack capacity and who are facing important health and welfare decisions. The NHS and LAs have a duty under the Act to instruct and consult the IMCA if those concerned are people who lack capacity in relation to the relevant decision and who have no family or friends that are available (or appropriate) for consultation on their behalf.

11.2 Even if an individual does not meet the criteria for the use of the IMCA service, and regardless of whether or not they lack capacity, they may wish to be supported by an advocate. CCGs should ensure that individuals are made aware of local advocacy and other services that may be able to offer advice and support, and should also consider whether any strategic action is needed to ensure that adequate advocacy services are available to support those who are eligible and potentially eligible for NHS continuing healthcare. In addition, any person may choose to have a family

member or other person (who should be independent of the LA and the NHS) to act as an advocate on their behalf. (The National Framework Paragraph 52-53).

11.3 The CCG has commissioned an advocacy service from Dorset Advocacy. The purpose of this service is to provide support for individuals during the NHS continuing healthcare process. Additional guidance is found at (The National Framework, Paragraphs 52–53 and PG8-10).

12. RESPONSIBLE COMMISSIONER

12.1 *'Who Pays? Determining responsibility for payments to providers'* (2013) sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, helping to determine which CCG should pay for the individual's care.

Who Pays? sets out expectations when there is a dispute between CCGs as to responsibility. Section 1 Paragraph 6 states: 'The underlying principle is that there should be no gaps in responsibility – no treatment should be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual's healthcare provision.' CCGs should agree interim responsibilities for who funds the package until the dispute is resolved. (The National Framework, Paragraphs 159-160).

12.2 Where the patient is registered with a GP practice when they become eligible for NHS continuing healthcare funding, the responsible commissioner will be the CCG that holds the contract with that GP practice.

12.3 The exception is where the placing CCG has taken the preference of the individual on the location of the care home or independent hospital into account in making the placement. The placing CCG remains responsible for the NHS continuing healthcare funding.

12.4 Where a patient is not registered with a GP practice, the responsible commissioner will be the CCG in whose geographical area the patient is "usually resident".

13. MULTIDISCIPLINARY ASSESSMENT, COMPLETION OF THE TOOLS AND MAKING RECOMMENDATIONS

13.1 Hyperlink to DOH The National Framework and Tools.

http://www.dh.gov.uk/health/2012/11/continuing-healthcare-revisions/

13.2 The overall process for determining eligibility for NHS continuing healthcare is explained in (The National Framework, Paragraphs 62 – 107).

13.3 There are also guidance notes in the CHC Checklist, DST and Fast Track Tool.

13.4 Whatever the outcome of the Checklist this should be communicated in writing to the individual and their carers or representatives where appropriate by the Lead Health Coordinator.

13.5 Where the outcome is not to proceed to a full consideration of eligibility, the individual should be informed of the right to ask for reconsideration and details of their rights under the NHS Complaints Procedure.

13.6 Once an individual has been referred for a full assessment for eligibility the CCG has responsibility for co-ordinating the whole process until a decision on funding has been made. The CCG should identify an individual to carry out the coordination role, which can by mutual agreement be from an external organisation. (The National Framework, Paragraph 77).

13.7 The DST is not an assessment in itself; it is a way of bringing together and applying evidence (written and oral) in a single formal to facilitate consistent, evidence-based decision-making regarding eligibility for NHS continuing healthcare. The evidence and decision-making process should be accurately and fully recorded. (The National Framework, Paragraph 81).

13.8 The DST should be used following a comprehensive, multi-disciplinary assessment of an individual's health and social care needs and their desired outcomes. (The National Framework, Paragraph 79).

13.9 Assessment is the process of gathering relevant, accurate and up to date information about an individual's health and social care needs including any relevant risk assessments and applying professional judgement to decide what this information signifies in relation to those needs.

13.10 Assessment documentation should be obtained from any professional involved in the individual's care. It should be clear, well recorded, factually accurate, up to date, signed and dated.

13.11 MDT in the context of NHS continuing healthcare means either two professionals

from different healthcare professions or one professional from a healthcare profession and one person who is responsible for assessing individuals for community care services under Section 47 of The National Health Service and Community Care Act 1990. Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, The National Framework makes it clear that the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs.

Once the MDT has reached agreement, it should make a recommendation to the CCG on eligibility.

13.12 The principles contained within PG27 – 37 of The National Framework which explains multidisciplinary assessment, completion of the DST and making recommendations should be applied.

14. TIME FRAMES

14.1 The time that elapses between the Checklist (or other notification of potential eligibility) being received by the CCG and the funding decision being made should, in most cases, not exceed 28 days. In acute services, it may be appropriate for the process to take significantly less than 28 days if an individual is otherwise ready for discharge. CCGs can help manage this process by ensuring that potential NHS continuing healthcare eligibility is actively considered as a central part of the discharge planning process, and also by considering whether it would be appropriate to provide interim or other NHS-funded services. (The National Framework, Paragraphs 65 & 95).

15. ELIGIBILITY CONSIDERATIONS INCLUDING MANAGED NEED

15.1 NHS continuing healthcare may be provided by CCGs in any setting (including, but not limited to, a care home, hospice or the person's own home). Eligibility for NHS continuing healthcare is, therefore, not determined or influenced either by the setting where the care is provided or by the characteristics of the person who delivers the care. The decision making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or

removed an ongoing need will this have a bearing on NHS continuing healthcare eligibility, (The National Framework, Paragraph 56).

However, there are different ways of reflecting this principle when completing the DST. For example, where psychological or similar interventions are successfully addressing behavioural issues, consideration should be given as to the present–day need if that support were withdrawn or no longer available and this should be reflected in the behaviour domain, (The National Framework, DST user notes, Paragraph 28).

15.2 It is not intended that this principle should be applied in such a way that well-controlled physical health conditions should be recorded as if the medication support was not present. Where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain. (The National Framework, Paragraph 28-29).

Financial issues should not be considered as part of the decision on an individual's eligibility for NHS continuing healthcare.

The reasons given for a decision on eligibility should not be based on:

- the person's diagnosis;
- the setting of care;
- the ability of the care provider to manage care;
- the use (or not) of NHS employed staff to provide care;
- the need for/presence of 'specialist staff' in care delivery;
- the fact that a need is well managed;
- the existence of other NHS funded care;
- any other input-related (rather than needs-related) rationale.

16. ELIGIBILITY, DECISION MAKING AND PANEL PROCESSES

16.1 The National Framework makes clear recommendations for the decision making process to sit as closely to the individual as possible, with local multidisciplinary teams collating the relevant assessments, considering the health and social care needs of the individual, using the DST and professional judgement, and making recommendations to the CCG regarding eligibility. Further information can be found

at (The National Framework, PG 33-37).

16.2 The CCG will ratify multidisciplinary team recommendations that are appropriately supported by evidence. Only in exceptional circumstances and for clearly articulated reasons, should the MDT's recommendation not be followed. (The National Framework, Paragraph 91).

16.3 Where the CCG finds insufficient evidence to support the MDT's recommendation, the DST will be returned to the MDT for further work. However the CCG will not refer a case back, or decide not to accept a recommendation, simply because the MDT has made a recommendation that differs from the one that those who are involved in making the final decision would have made, based on the same evidence. (The National Framework, Paragraph 92).

16.4 Individuals with a rapidly deteriorating condition that may be entering a terminal phase and with an increasing level of dependency will require "fast tracking" for NHS continuing healthcare. Fast track procedures are set out in (The National Framework, Paragraphs 97-107).

17. PROCESS FOR COMMUNICATING DECISIONS

17.1 Decisions will be communicated to the individual or their representative and to relevant health and social care professionals by the CCG.

17.2 The CCG continuing healthcare team will communicate the decision in writing to the individual or their representative, either ratified or made by a multidisciplinary panel within the 28 day time scale from Checklist to decision being communicated.

17.3 The time that elapses between the Checklist (or where no Checklist is used the DST) being received by the CCG and the funding decision should in most cases not exceed 28 days.

17.4 The decision letter will contain:-

- name of the person who has been assessed;
- the date of the assessment, eligibility and/or the date of the period under review;
- the decision;

- who made the decision;
- a full rationale for each of the key indicators (nature, complexity, intensity and unpredictability);
- if eligible information of how to obtain reimbursement from the CCG or details of the options if not eligible;
- advocacy information;
- information about the right and how to request a review of the eligibility decision;
- contact numbers.

18. HANDOVER OF CARE BETWEEN CCG AND LA

18.1 A care transfer protocol needs to be agreed between the CCG and the Local Authorities to ensure a smooth transition of care when an individual becomes eligible, or ceases to be eligible, for NHS continuing healthcare.

18.2 **Case Management**

Once an individual has been found eligible for NHS continuing healthcare, the CCG is responsible for the case-management of the whole package, including monitoring and reviewing. CCGs should ensure arrangements are in place for on-going case management for all individuals eligible for NHS continuing healthcare. (The National Framework, Paragraph 108). This may be provided directly or commissioned from provider services.

There is a Multiagency Protocol for Case Management for individuals who are eligible for CHC.

The CCG's Responsibility for Provision of Services for those found eligible for NHS Continuing Healthcare

The CCG has financial responsibility for all health and personal care services and associated social care services to support assessed health and social care needs and identified outcomes for the individual, including the following:-

- equipment provision;

- routine and incontinence laundry;
- daily domestic tasks such as food preparation, shopping, washing up, bed-making;
- support to access community facilities;
- additional support needs for the individual whilst the carer has a break.

(The National Framework, PG85 & 89).

LA Responsibility for Provision of Services

The LA is not prevented from providing services to a person who is eligible for NHS continuing healthcare, subject to legal limits (The National Framework, PG79). Some examples include:-

- taking the lead in safeguarding investigations;
- Section 47 assessment and/or carer's assessment (but not necessarily needs identified in such assessments);
- welfare and benefits advice;
- general advice and signposting to service users and carers;
- leisure, education and access to work services if the Fair Access to Care Services criteria (FACS eligibility criteria for adult social care) are met;
- assistance with making Disabled Facilities Grant applications to the local housing authority for major adaptations;
- support with essential parenting activities.

Whilst LAs and CCGs have some overlapping powers and responsibilities in relation to supporting individuals eligible for NHS continuing healthcare in their own home, CCGs should be mindful that their responsibility under NHS continuing healthcare involves meeting both health and social care needs. Therefore in an individual case the CCG should first consider whether the responsibility to meet a specific need lies with them as part of their NHS continuing healthcare responsibilities. The LA will consider the provision of any additional services for individuals eligible for NHS continuing healthcare on a case by case basis.

18.3 There is a financial implication if an individual is not eligible for NHS continuing healthcare as LA services are means tested. This will be discussed with the individual or their representative when the DST is completed.

19. INDIVIDUAL CHOICE

19.1 The starting point for agreeing the care package and the setting where NHS continuing healthcare services are to be provided should be the individual's preferences. Those involved in working with individuals to plan their future support should advise them of the options and the benefits and risks associated with each one. (The National Framework, PG83).

19.2 The CCG has a Choice Policy.

20. FUNDED NURSING CARE

20.1 Determining the need for NHS-funded nursing care is in Annex D of The National Framework.

20.2 In all cases individuals should be considered for eligibility for NHS continuing healthcare before a decision is reached about the need for NHS-funded nursing care.

21. RESPITE POLICY

21.1 The CCG may need to provide additional support to care for the individual whilst their carer has a break from caring responsibilities. The CCG will need to inform carers of the availability of this support when required. (The National Framework, PG89).

22. CONFIDENTIALITY, INFORMATION SHARING AND INFORMATION GOVERNANCE

22.1 The following policies apply:-

- Access to Health Records Policy;
- The Data Protection Act 1998;
- CCG Email Policy;
- Confidentiality Code of Practice.

22.2 Both The CCG and the NHS E have roles in establishing and maintaining governance arrangements for NHS continuing healthcare eligibility processes and

commissioning. (The National Framework, Paragraphs 161-165).

23. LOCAL DISPUTES RESOLUTION PROCESS WITH THE LA

23.1 Directions state that CCGs and LAs in each local area should agree a local disputes resolution process to resolve cases where there is a dispute between NHS bodies, or between an LA and a CCG, about eligibility for NHS continuing healthcare and/or about the apportionment of funding in joint funded care/support packages. Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to LAs and CCGs in different geographical areas, the relevant LA and CCG should agree a dispute resolution process to ensure resolution in a robust and timely manner. This should include agreement on how funding will be provided during the dispute, and arrangements for reimbursement to the agencies involved once the dispute is resolved. (The National Framework, Paragraph 159).

23.2 There is an agreed local disputes resolution process between the CCG, Dorset County Council, Bournemouth Borough Council and the Borough of Poole.

23.3 If agreement cannot be reached on a 'not eligible' decision the local disputes process should be invoked. Current funding arrangements should remain in place until the dispute has been resolved. The local disputes process must have a stage which reaches a final conclusion.

24. REQUEST FOR REVIEW OF AN ELIGIBILITY DECISION PROCEDURE FOR INDIVIDUAL/REPRESENTATIVE

24.1 The CCG has an agreed local review procedure. This includes timescales and a copy is sent to anybody requesting a review of a decision.

24.2 Once the local CCG procedures have been exhausted the individual/representative can apply to NHS England for the case to be referred to an independent review panel (IRP).

24.3 All parties involved should be able to view and comment on all evidence to be considered under the review procedure. (The National Framework, Paragraph 154).

25. PERSONAL HEALTH BUDGETS

25.1 A Personal Health Budget helps people to get the services they need to achieve their

health outcomes by letting them take as much control over how money is spent on their care/support as is appropriate for them.

25.2 The CCG can offer direct payments for healthcare as approved by the Secretary of State.

25.3 There is further guidance on Personal Health Budgets. (The National Framework, PG 90-98).

26. HOSPITAL DISCHARGE POLICY AND INTERIM PROCESS

26.1 The CCG is committed to:-

- reducing the number of individuals who are delayed in hospital when they are fit to be discharged;
- working in partnership to ensure that individuals receive the care they need, when and where they need it, in accordance with the Community Care (Delayed Discharges etc.) Act 2003.

26.2 To ensure that unnecessary stays on hospital wards are avoided, the CCG can provide further NHS-funded services where appropriate. This can include an interim package of support in an individual's own home or a placement in a care home. The interim care package or placement will continue until the determination of eligibility for NHS continuing healthcare has taken place using a Checklist or, where indicated, a Decision Support Tool (The National Framework Paragraph, 65).

26.3 Eligibility for NHS continuing healthcare should be considered using a NHS continuing healthcare Checklist before an assessment notification (Section 2) is sent to Social Services.

26.4 Assessments for NHS continuing healthcare should not delay discharge.

26.5 NHS and Social Services staff will work together to ensure that the individual can move to the right type of care as soon as possible.

26.6 Safe discharge from hospital remains the responsibility of the discharging hospital.

26.7 Hospital staff must be sure that appropriate provision will be available to meet the person's needs after discharge, including:

- care provision;
- a safe environment;
- moving and handling equipment;
- medication;
- continence supplies;
- advance notice to the District Nurse and GP.

27. COMMISSIONING OF CARE PACKAGES, CONTRACTING ARRANGEMENTS

27.1 There is a commissioning strategy for NHS continuing healthcare.

27.2 There is a CHC Procurement Procedure for staff which includes authorisation limits.

27.3 There is a brokerage procedure for care packages.

27.4 The CCG is responsible for identifying, commissioning and contracting for all services to meet the needs of individuals who qualify for NHS continuing healthcare.

27.5 Care packages may be commissioned from care homes, from domiciliary care providers and from nursing agencies. When a care package is commissioned by the CCG, a contract will be issued in order to ensure robust governance and quality of service.

27.6 The individual will be supported in reaching a decision about their care package where possible and any package will be developed in conjunction with the individual's views, and that of their representative if appropriate, so that it reflects as far as possible the individual's needs and wishes. Where the LA was previously funding the care package the case transfer protocol will be followed.

27.7 The CCG will actively promote equity of access and personalised care and:-

- will not discriminate against an individual on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other non-medical characteristics;
- will assess the needs of an individual on the grounds specified above and will take this assessment into consideration when commissioning care;
- will provide appropriate assistance for an Individual who has communication

difficulties.

27.8 Where the CCG believes that the individual may be prejudiced or hindered in their ability to access care, whether on any of the grounds specified above or otherwise and may have an unmet need for care then the CCG and LA will make an assessment to determine what steps are required to be taken.

27.9 The CCG will request from care providers such information as the CCG may reasonably require:

- to monitor the equity of access to care;
- to fulfil its legal obligations.

27.10 The individual should be involved in all decisions affecting their life, unless there are demonstrable reasons, acceptable to the CCG, that this is not possible or appropriate. The individual should be able (so far as reasonably possible) to make independent choices in terms of options for care and other elements of the Care Plan.

27.11 The individual should be given the right to think and act without having to refer to others, including the right to say "no" to help. The individual should have the right to take risks. Risks should be fully assessed and reasons for actions clearly documented.

27.12 The CCG will require residential care providers to ensure that the individual is offered suitable accommodation, which meets the individual's requirements as specified in their Care Plan. Adequate information should be given to the individual to enable them to make the best choice available to meet their assessed care needs.

27.13 Where the individual is unable to express a preference for themselves, and a best interest assessment has been done, the CCG will act on the preferences recorded at the assessment.

27.14 The individual has a right to request a transfer to another care provider. Any such request should be referred to the CCG who will investigate the reasons for such a request and will if necessary serve notice.

28. OUT OF AREA PLACEMENTS

28.1 When the CCG places an individual who is NHS continuing healthcare funded in a residential establishment in the area of another CCG, the placing CCG is required to inform the receiving CCG about this placement.

28.2 A template letter is used to inform the receiving CCG.

28.3 Robust arrangements need to be agreed and in place to ensure monitoring of the provider and information regarding safe guarding alerts are communicated to the placing CCG.

29. AUDIT AND MONITORING

29.1 NHS Continuing healthcare processes and commissioning will be audited through:-

- reports to the Clinical Commissioning Group;
- reports to the Health and Well Being Board.

29.2 Care will only be commissioned from care providers who are registered with the Care Quality Commission.

29.3 The CCG will commission the provision of NHS continuing healthcare in a manner which:

- balances the need for the CCG to commission care that is safe and effective;
- makes best use of resources.

29.4 In circumstances where the quality of a care home is poor and the CCG cannot commission care in the home at that time, the CCG will work with individuals and their families to commission a more suitable package of care.

30. BENCHMARKING

30.1 The CCG is required to submit a quarterly bench marking return to NHS England on activity and cost.

31. EQUIPMENT

31.1 Where individuals who are eligible for NHS continuing healthcare require equipment to meet their care needs they are entitled on the same basis as other patients to joint equipment services. The CCG should ensure that this is taken into account in

the planning, commissioning and funding arrangements for these services. (The National Framework, Paragraph 172).

32. RETROSPECTIVE REVIEWS OF CARE AND NHS CONTINUING HEALTHCARE REDRESS

32.1 There may be circumstances where an individual not previously awarded NHS continuing healthcare believes that they were wrongly denied NHS funding.

32.2 In these circumstances the individual or their representative can request a retrospective review of the individual's care needs and eligibility for NHS continuing healthcare for any period after 1 April 2012. There is legal advice regarding whether a CCG is required to progress a retrospective application.

32.3 Any case involving retrospective claims prior to 1 April 2012 should no longer be accepted, except where there are exceptional mitigating circumstances.

32.4 On 15 March 2012, the Department of Health announced the introduction of deadlines for individuals to request an assessment of eligibility for NHS continuing healthcare funding, for cases during the period 1 April 2004 – 31 March 2012. The deadlines have now passed for applications for this period although their processing will continue for some time.

32.5 Where a retrospective review of eligibility for NHS continuing healthcare is approved, appropriate arrangements will be made for financial recompense in accordance with the Department of Health Guidance for Continuing Care Redress. Reimbursement of all care fees for the qualifying period of care approved will be made, together with interest payments if applicable.

33. TRANSITION – CHILDREN'S TO ADULT CHC

33.1 There is a separate National Framework for Children and Young Peoples Continuing Care.

Hyperlink to Department of Health, National Framework for Children and Young People's Continuing Care.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114784

33.2 The process for transition from children and young people's continuing care to adult continuing healthcare is contained in The National Framework, Paragraphs 124-138.

SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND)

33.3 The Children and Families Act 2014 introduces a new approach to securing the care needed by children and young people with special educational needs. The legislative framework around this Act states that joint commissioning arrangements and a joined up approach across education, health care must include arrangements for considering and agreeing the education, health and care provision reasonably required by children and young people (birth – 25 years). '*The Special Educational Needs and Disability code of practice 0 – 25 years'* outlines statutory guidance for organisations which work with and support children and young people who have special educational needs.

33.4 When an individual's needs cannot be met by resources available to mainstream early years providers, schools and post – 16 institutions, the local authority decides if an assessment for an Education Health and Care (EHC) Plan is required. The local authority will seek medical advice and information from health care professionals with a role in relation to the child/young person's health.

33.5 When requested, health care professionals should contribute to the EHC Plan, adopting a needs based/goals approach when working with the young adult and their carers within agreed timescales.

33.6 The Local Offer is the name given to the range of services which are locally available for an individual with specials educational needs or disability. The local authority is responsible for capturing the key health, social care and education services which it expects to be available for children and young people (0 – 25 years) with SEND and their families/carers. The CHC Team, as appropriate, will be required to contribute their element to the Local Offer and update information if it changes or when requested by the local authority.

33.7 Each CCG must appoint a Designated Medical/Clinical Officer (DMO). A key aspect of the role is to help facilitate the collaborative approach of the SEND reforms. The

DMO acts as a point of contact for enquiries related to the health component of the EHC Plan process.

34. TRAINING

34.1 All CHC staff are expected to complete the NHS England online CHC training within their induction period.

34.2 There is a CHC training plan in place which is reviewed annually. Joint training between CHC and the local authorities is delivered throughout the year according to an agreed timetable of dates, no less than bi-monthly.

35. PUBLIC INFORMATION

35.1 There are a number of information leaflets available to download from the CCG website.

36. ASSOCIATED POLICIES

36.1 Section 117 Mental Health Act

After care services under Section 117 of the Mental Health Act 1983 should be provided under that legislation. Only needs that are not Section 117 aftercare should be considered for NHS continuing healthcare eligibility using the DST (The National Framework, Paragraphs 118-122 and PG 64-66).

Services for needs that fall to be met as after-care services under Section 117 of the Mental Health Act 1983 should be provided under that legislation rather than as NHS continuing healthcare. Only needs that are not Section117 after-care needs should be considered for NHS continuing healthcare eligibility in the usual way. For example, the individual might have or develop physical health needs which are distinct from the section 117 needs, and which separately constitute a primary health need. Whether Section 117 services are being funded by a CCG or a LA there should be no charge to the individual.

Guidance states that LAs and CCGs should have agreements in place detailing how they will carry out their Section 117 responsibilities, and these agreements should clarify which services fall under Section 117 and which authority should fund them. LAs and CCGs use a variety of different models and tools as a basis for working out how Section 117 funding costs should be apportioned. However, where this results

in a CCG fully funding a Section 117 package this does not constitute NHS continuing healthcare.

It is preferable for a CCG to have separate budgets for funding section 117 and NHS continuing healthcare. Where they are funded from the same budget they still continue to be distinct and separate entitlements.

For patients in the DCC area Section 117 is subject to a separate agreement that means that those eligible for Section 117 do not require consideration under CHC even if their needs are now primarily related to their physical health.

36.2 **NO SECRETS**

Department of Health No Secrets Guidance.

Hyperlink to the DOH No Secrets guidance.

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003726

Hyperlink to The CCG the Pan Dorset Safeguarding policy.

http://www.dorset.nhs.uk/aboutus/policy-search.htm?sitekit=true&task=search&indexname=PD+Dorset+Policies&search=safeguarding

Hyperlink to the DOH role of Health Service Practitioners Guidance March 2011.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

36.3 **DEPRIVATION OF LIBERTY**

Hyperlink to the DOH Deprivation of Liberty Safeguards.

http://www.dh.gov.uk/en/SocialCare/Deliveringsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm

36.4 There may be situations when vulnerable individuals who are eligible for NHS continuing healthcare need to be deprived of their liberty for treatment or care because this is in their best interests to protect them from harm. The deprivation of liberty safeguards will be followed in all cases.

37. EQUALITY IMPACT ASSESSMENT

37.1 An Equality Impact Assessment has been carried out to ensure that this policy is anti-discriminatory.

All reasonable steps have been taken to ensure that this Policy reflects the:-

- NHS Dorset equality and diversity strategy;
- relevant articles of the Human Rights Act 1998;
- philosophy of clinical governance, providing evidence for compliance with the requirements of the Standards for Better Health of the Department of Health and the NHS Litigation Authority Risk Management Standards for CCGs;
- Health and Safety at Work Act 1974 and associated legislation;
- Freedom of Information Act 1998 (amended 2000);
- Equality Act 2010.

The equality considerations will also ensure that the policy is equitable, easily understood, culturally sensitive and widely communicated to 'hard to reach communities'.

38.0 CONSULTATION

38.1 There was a full consultation by the Department of Health with all stakeholders before the first National Framework was issued in 2007.

39.0 APPROVAL AND RATIFICATION PROCESS

39.1 The Policy will be approved by the Directors Meeting

40.0 COMMUNICATION/DISSEMINATION

40.1 The Policy will be communicated via the internal CCG intranet, the CCG internet website and the CCG communications bulletin.

41.0 IMPLEMENTATION

41.1 The policy does not contain any new aspects to be documented.

42.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THE DOCUMENT

42.1 Compliance with the policy will be monitored through quarterly benchmarking returns to NHS England and monthly management information and finance reports.

42.2 Any areas of concern or non-compliance identified are added as actions in the CHC Operating Model and Assurance Framework.

43.0 DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

43.1 The policy is reviewed annually to take account of any changes in national guidance. Necessary changes throughout the year will be issued as amendments to The National Framework. Such amendments will be clearly identifiable to the section to which they refer and the date issued. These will be clearly communicated via the CCG communications bulletin.

APPENDIX A

NHS
Dorset
Clinical Commissioning Group

EQUALITY ASSESSMENT FORM

Title of procedural document:	Policy for NHS Continuing Healthcare and NHS-funded Nursing Care
What are the intended outcomes of this work? Include outline of objectives and function aims	This policy sets out how NHS Dorset Clinical Commissioning Group (CCG) implements *The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*
Who will be affected? e.g. patients, staff, service users etc.	Staff, individuals and the individuals' representatives

Evidence
What evidence have you considered? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.
The National Framework is based on statutory responsibilities, case law, input from the Parliamentary and Health Service Ombudsman, and comments received from stakeholders. There was extensive consultation by the Department of Health prior to The Framework first being issued in 2007. CCGs are not required to report to NHS England on the protected characteristics for people who are eligible for CHC funding. If required, for example for a Freedom of Information request, the CCG could report on some of the protected characteristics i.e. disability, gender and age.
Disability Consider and detail (include the source of any evidence) on attitudinal, physical and social barriers
Section 1C of the National Health Service Act 2006 states that, in exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service. (*The National Framework paragraph 20).* Generally CHC eligibility has a positive impact as, once found eligible, the NHS funds all the individual's health and social care and they don't have to make a financial contribution. Reasonable adjustments are considered in terms of language barriers and comprehension, for example documents made available in 'easy read' format.

Gender Consider and details (including the source of any evidence) on men and women (potential link to carers below)
The policy does not impact differently on men or women. Section 1C of the National Health Service Act 2006 states that, in exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service. (*The National Framework paragraph 20).*
Race Consider and detail (including the source of any evidence) on different ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers
There will be no negative impact with the proviso that race issues are kept in consideration. Section 1C of the National Health Service Act 2006 states that, in exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service. (*The National Framework paragraph 20).*
Age Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare
Older people could be positively affected as older people are more likely to have health problems which meet the criteria of a 'primary health need'. Section 1C of the National Health Service Act 2006 states that, in exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service. (*The National Framework paragraph 20).*
Gender reassignment (including transgender) Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment
There will be no negative impact with the proviso that gender reassignment issues are kept in consideration. Section 1C of the National Health Service Act 2006 states that, in exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service. (*The National Framework paragraph 20).*
Sexual orientation Consider and detail (including the source of any evidence)on heterosexual people, as well as lesbian, gay and bi-sexual people
CHC delivers an equitable service regardless of sexual orientation. All staff involved with CHC are subject to the values in the NHS Constitution. Section 1C of the National Health Service Act 2006 states that, in exercising functions in

relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service. (*The National Framework paragraph 20).*
Religion or belief Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief
There will be no negative impact with the proviso that religious and belief issues are kept in consideration. Section 1C of the National Health Service Act 2006 states that, in exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service. (*The National Framework paragraph 20).*
Pregnancy and maternity Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities
Not applicable
Carers Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities
The policy will have a positive impact on carers as once eligible the CCG is responsible for funding all the individual's health and social care needs. Should the CCG identify a carer in the course of its assessment process, it should inform them of their rights to a carer's assessment and advise them to contact their LA or, with their permission, refer them for this purpose. CCGs and LAs should be mindful of the approaches set out in the national strategy for carers with reference to '*Recognised, valued and supported: Next steps for the Carers Strategy' 2010.*
Other identified groups Consider and detail (including the source of any evidence) on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access
Anyone who is eligible to NHS services may be eligible for NHS continuing healthcare.

Engagement and Involvement
Have you engaged stakeholders in gathering evidence or testing the evidence available? If not, what do you intend to do?
The Department of Health carried out extensive consultation with all stakeholders prior to the implementation of the first National Framework in October 2007. In line with The National Framework the CCG has the lead responsibility for CHC in the Dorset locality. The CCG needs to have clear arrangements with other NHS organisations and independent/voluntary partners.

- CHC information is available in appropriate formats at key locations e.g. acute hospitals;
- CHC information is available on the CCG website;
- There are bi-monthly training sessions for staff involved in CHC including LAs and other NHS organisations;
- The CCG has commissioned Dorset Advocacy to provide free help and support to individuals or their representatives in the CHC process, including appeals against eligibility decisions.

How have you engaged stakeholders in testing the policy or programme proposals? If not, what do you intend to do?

The National Framework gives the individual or their representative the right to request a review of an eligibility decision. If the individual or their representative is still not satisfied they can request an independent review by NHS England. The final stage of this process is an application to the Parliamentary and Health Service Ombudsman.

The individual or their representative can also make a complaint about process through the CCG's Complaints Procedure.

If you have engaged groups, please list below and include who was involved, how they were involved and the key outputs:

There is a pan Dorset CHC Steering Group and a pan Dorset CHC Implementation Group. Both groups meet bi-monthly. Their memberships consist of representatives from the CCG and the three local authorities. The Implementation Group is responsible for delivering the Steering Group's action plan.

Groups engaged	Date and type of engagement	Outputs from activity
Dorset CHC Steering Group	Bi-monthly meetings	Action plan
Dorset CHC Implementation Group	Bi-monthly meetings	Action plan

Summary on analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your proposals. Consider whether the evidence shows potential for differential impact; if so, state whether adverse or positive and for which groups. How will you mitigate any negative impacts? How will you include certain protected groups in services or expand their participation in public life?

The National Framework reflects the new NHS framework and structures created by the Health and Social Care Act 2012 effective from 1 April 2013. Standing Rules Regulations have been issued under the National Health Service Act 2006, and directions are issued under the Local Authority Social Services Act 1970 in relation to The National Framework.

Equality Act 2012
The CCG is bound by the Public Sector Equality Duty and is required to evidence how in its decisions is delivering the following. Please outline how your work and the service will contribute to these:
Eliminate discrimination, harassment and victimisation
The National Framework sets out the core values and principles for determining eligibility. Access to assessment should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation or belief, or type of health need (for example, whether the need is physical, mental or psychological). NHS England and the CCG are responsible for ensuring that discrimination does not occur and should use effective auditing to monitor this matter. '*The National Framework, paragraph 43'*
Advance equality of opportunity
The Decision Support Tool contains equality monitoring information to help the CCG understand whether everyone is receiving fair and equal access to NHS continuing healthcare. This equality information is submitted quarterly to NHS England as part of the benchmarking return.
Promote good relations between groups
The NHS continuing healthcare process is person centred and is not dependent on diagnosis or condition.

What is the overall impact of your proposals of decision? Consider whether there are difference levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?
The Policy will have no negative impact against the protected characteristics with some provisos that issues are kept in consideration. The CCG is benchmarked against other CCGs by NHS England.

Addressing the impact on equalities Please give an outline of what broad action you or any other bodies are taking address any inequalities identified through the evidence.
The CCG has commissioned Dorset Advocacy to provide free help and support to individuals or their representatives in the CHC process, including appeals against eligibility decisions.

Action planning for improvement
Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes needs to be summarised (An action plan is appended for action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.
N/A

Please give an outline of your next steps based on the challenges and opportunities you have identified.
N/A

Name and job title of person who carried out this assessment	Angie Smith Senior Continuing Healthcare Support Services Manager
Date assessment completed	23/12/2015
CCP Lead	Paul Rennie
Date assessment signed	

Action Plan Template

This part of the template is to help you develop your action(s). You might want to change the categories in the first column to reflect the specific actions needed for your procedural document.

Category	Actions	Target Date	Responsible Person and their Directorate
Involvement and consultation			
Data collection and evidencing			
Analysis of evidence and assessment			
Monitoring, evaluating and reviewing			
Transparency (including publication)			

Please return a copy to Ebi Sosseh, Stakeholder Development Manager: ebi.sosseh@dorsetccg.nhs.uk once completed who will review it and ensure that it is published on the website. A signed hard copy and electronic copy should be kept within your department for audit purposes.

APPENDIX B

LIST OF ABBREVIATIONS

CCG	Dorset Clinical Commissioning Group
CHC	Continuing Healthcare
C&YP	Children and Young People's
DCC	Dorset County Council
DOH	Department of Health
DST	Decision Support Tool
FNC	Funded Nursing Care
GP	General Practitioner
IMCA	Independent Mental Capacity Advocate
LA	Local Authority
MDT	Multidisciplinary Team
PHB	Personal Health Budgets
NHS E	NHS England
BOP	Borough of Poole
BBC	Bournemouth Borough Council