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CCG decision-making and care planning

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Overview of the role of the CCG in the decision-making process

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- Next step after the MDT/DST is that the CCG makes a decision on whether the individual is eligible for NHS Continuing Healthcare.

- It is important to remember that, legally, the ultimate decision-maker is the CCG (usually a CHC panel acting as a decision-maker on behalf of the CCG)

- The decision is a matter of clinical judgment for the CCG and must reach its own decision on the tests set out in the 2012 Regulations.

- HOWEVER, the panel's decision must be informed by the outcome of the DST as reported by the MDT, and their recommendation.

Overview of the role of the CCG in the decision-making process

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- Regulation 21(5)(b):

(b) the relevant body makes a decision as to whether that person has a primary health need in accordance with paragraph (7), **using the completed Decision Support Tool to inform that decision.**

Regulation 21(6):

6) If a relevant body decides that a person has a primary health need in accordance with paragraph (5)(b), it must also decide that that person is eligible for NHS Continuing Healthcare.

Overview of the role of the CCG in the decision-making process

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- Regulation 21(7)

(7) In deciding whether a person has a primary health need in accordance with paragraph (5)(b), a relevant body must consider whether the nursing or other health services required by that person are—

(a) where that person is, or is to be, accommodated in relevant premises, **more than incidental or ancillary** to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or

(b) of a nature **beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide**,

and, if it decides that the nursing or other health services required do, when considered in their totality, fall within sub-paragraph (a) or (b), it must decide that that person has a primary health need.

Who within the CCG should be responsible for the eligibility decision?

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- The decision can be made by a person OR a committee authorised under the CCG's standing orders to take the decision on behalf of the CCG.

- This is typically a nominated officer or a panel which is constituted to review the assessments and reach a decision.

Who within the CCG should be responsible for the eligibility decision?

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- The Framework suggests the following potential arrangements, or combinations of them
- *appoint (or jointly appoint) an employee (or employees) to work within the organisation carrying out the assessment functions such that this member of staff has authority to make eligibility decisions as an employee of the CCG with clear lines of authority and accountability within the CCG for undertaking this role*
- *identify an employee (or employees), or Governing Body Member(s), within the CCG to make eligibility decisions regarding NHS Continuing Healthcare having received the completed assessments and recommendations from the organisation carrying out the NHS Continuing Healthcare assessment function on behalf of the CCG*
- *bearing in mind the guidance in Practice Guidance, use a verification committee or 'panel' as a formal sub-committee of the CCG with delegated responsibility for decision making in relation to NHS Continuing Healthcare eligibility*

Who within the CCG should be responsible for the eligibility decision?

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- **Potential legal pitfalls:**
- Remember that CCGs remain legally responsible for all eligbility decisions about a patient for whom they are responsible, even where they have delegated the function of assessment to another authorised body such as a Commissioning Support Unit for a number of CCGs.

- If there is a panel, ensure that the membership, terms of reference and decision-making powers of the panel are approved by the CCG governing body.

- Furthermore, it is not appropriate to set up the decision-making process of the any committee/panel with delegated authority in such a way that members from outside the CCG have a right to veto or constitute a majority for a vote on the issue of eligibility.

- I.e. CCG is in a position where its own staff are unable to take a decision that a patient is not eligible for CCG – could be open to legal challenge

How should the CCG's decision be made? Question 1: primary health need

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- The key question for the CCG is **whether the patient has a primary health need.** If it considers that it does, under Regulation 21(6) then the CCG must also decide that the patient is eligible for NHS CHC.

- The CCG should form this judgment in part by looking at the medical support the patient requires on a day-to-day basis to meet his or her needs using the assessment produced by the DST. Is the patient's **predominant** need for healthcare support, with a subsidiary need for accommodation and social care – more likely to indicate eligibility.

- The CCG should make a decision based on the patient's clinical condition as it is at the date of the decision. NB previous presentation on "well-managed need"

- Like the DST, the CCG should consider: the nature, intensity, complexity and unpredictability of the patient's needs.

- NB lots of guidance on this in the Framework, particularly the Practice Guidance

How should the CCG's decision be made? Questions 2 and 3: *Coughlan* grounds

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- Regulation 21(7) reflects the tests set out in the seminal CHC case, *Coughlan.*

- They **must** be considered when considering whether the patient has a primary health need.

- (7) In deciding whether a person has a primary health need in accordance with paragraph (5)(b), a relevant body must consider whether the nursing or other health services required by that person are—
- (a) where that person is, or is to be, accommodated in relevant premises, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or
  (b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide,
- and, if it decides that the nursing or other health services required do, when considered in their totality, fall within sub-paragraph (a) or (b), it must decide that that person has a primary health need.

How should the CCG's decision be made? What weight to be given to MDT assessment?

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- Regulation 21(5)(b) of the 2012 Regulations provides that the DST must be used to ”inform” the CCG's decision as to whether the patient has a ”primary health need”.

- Therefore, it is clear that legally the CCG is not bound to adopt the recommendation of the MDT.

- HOWEVER, the Framework is quite explicit that:

- ***Only in exceptional circumstances****, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed.*

How should the CCG's decision be made? What weight to be given to MDT assessment?

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- PG 39 in the Framework provides further guidance:

- *Exceptional circumstances where these recommendations may not be accepted by a CCG include:*
  - *where the DST is not completed fully (including where there is no recommendation)*
  - *where there are significant gaps in evidence to support the recommendation*
  - *where there is an obvious mismatch between evidence provided and the recommendation made*
  - *where the recommendation would result in either authority acting unlawfully.*

39.2 In such cases the matter should be sent back to the MDT with a full explanation of the relevant matters to be addressed. Where there is an urgent need for care/support to be provided, the CCG (and LA where relevant) should make appropriate interim arrangements.

How should the CCG's decision be made? What weight to be given to MDT assessment?

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- Is the Framework correct? Arguably, this is an (incorrect) gloss on the statutory framework. It does NOT refer to exceptional circumstance and instead the requirement is that the DST "informs" the CCG's decision.

- The correct legal position is likely to be that the CCG is **NOT** required to have exceptional reasons not to depart from the MDT's recommendation.

- But in any event, the CCG should still give **considerable weight** to the DST and its contents as the basis for their decision, have **good reasons** to depart from the MDT's recommendation, which they should **clearly record**.

- It cannot amend the DST or go back in to the document and re-score on the domains. It must take it into account but reach its own conclusions.

Consultation with the Local Authority

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- Regulation 22 (1) A relevant body must, insofar as is reasonably practicable—
  (a) consult with the relevant social services authority **before** making a decision about a person's eligibility for NHS Continuing Healthcare, including any decision that a person receiving NHS Continuing Healthcare is no longer eligible to do so;

- This stage should occur after the completion of the DST but before the eligibility decision is made by the CCG

- Duty on social services departments to provide advice and assistance to CCGs where they are consulted, including disclosure of any assessment that the LA has conducted to assess need for community care services

Communicating the eligibility decision

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- *159. Once the eligibility decision is made by the CCG, the individual should be informed **in writing** as **soon as possible** (although this could be preceded by verbal confirmation where appropriate). This written confirmation should include:*
- ***the decision** on primary health need, and therefore whether or not the individual is eligible for NHS Continuing Healthcare;*
- ***the reasons** for the decision;*
- *a copy of **the completed DST**;*
- ***details** of who to contact if they wish to seek further clarification; and*
- ***how to request a review** of the eligibility decision.*
- *160. Where an individual is not eligible for NHS Continuing Healthcare, the outcome letter may also include, where applicable and appropriate, **information regarding NHS- funded Nursing Care or a joint package of care.***
- *161. Where an individual is eligible for NHS Continuing Healthcare, **an indication of the proposed care package, if known**, could be included within this communication, or if not known at that stage, information on what the **next steps** are. Eligibility for NHS Continuing Healthcare is not indefinite, as needs could change. This should be made clear to the individual and/or their representative.*

Care Planning

- If the CCG decides that the patient is eligible for CHC, it comes under a legal duty to offer an appropriate package of services to meet the patient's needs for health services, social care services and accommodation (where that is part of the need)

- *165. Where an individual is eligible for NHS Continuing Healthcare, the CCG is responsible for care planning, commissioning services, and for case management. It is the responsibility of the CCG to plan strategically, specify outcomes and procure services, to manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare The* ***services commissioned must include ongoing case management*** *for all those eligible for NHS Continuing Healthcare, including* ***review and/or reassessment*** *of the individual's needs.*

- *166. CCGs should operate a* ***person-centred approach*** *to all aspects of NHS Continuing Healthcare, using models that maximise personalisation and individual control and that reflect the individual's preferences, as far as possible, including when delivering NHS Continuing Healthcare through a* ***Personal Health Budget****, where this is appropriate (refer to paragraphs 296-300).*

- *171. The care planning process is central to the commissioning and provision of care to meet an individual's needs. Responsibility for care planning lies with the CCG.*

- *172. Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is **appropriate to meet all of the individual's assessed health and associated care and support needs**. The CCG has responsibility for ensuring this is the case, and determining what the appropriate package should be. In doing so, the CCG should have **due regard to the individual's wishes and preferred outcomes.** Although the CCG is not bound by the views of the local authority on what services the individual requires, any local authority assessment under the Care Act 2014 will be important in identifying the individual's needs and in some cases the options for meeting them. Whichever mechanism is used for meeting an individual's assessed needs, the approach taken should be in line with the principles of personalisation (refer to paragraphs 296-300).*

- *173. Care planning for needs to be met under NHS Continuing Healthcare should **not be carried out in isolation from care planning to meet other needs**, and, wherever possible, a single, integrated and personalised care plan should be developed.*

The relevance of financial considerations in care planning and commissioning?

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- While the Framework states that a decision on eligibility should not be based on financial considerations, once a patient is deemed eligible, it is perfectly proper that the decision on the package of services and how those services will be commissioned will be informed by cost-effectiveness considerations.

- Typical scenario that a model of support preferred by individuals will be more expensive than other options – this could be a package of services provided at home versus in a care home.

- The Framework makes clear that CCGs can take comparative costs and value for money into account but should consider the following factors:

The relevance of financial considerations in care planning and commissioning?

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- a) The cost comparison has to be on the basis of the genuine costs of alternative models.

- b) Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual's assessed needs and agreed desired outcomes.

- c) Cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment

The relevance of financial considerations in care planning and commissioning?

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- Worth taking particular care when financial considerations relate to choice/location of accommodation .
- Arguably engages patient's Article 8 rights under the ECHR so take care when making these decisions.
- Sensible for CCGs to adopt a clear policy as to how they will approach these situations to ensure equity.
- Must take into account patient preferences but no legal requirement on CCG to spend significantly more of its resources to support a patient in his or her own home than offering to fund an appropriate package of care in a suitable care setting.
- Cost is a legitimate factor.

Top up fees or fee sharing? Is this lawful?

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- Framework:

- *180. NHS care is free at the point of delivery. The funding provided by CCGs in NHS Continuing Healthcare packages should be sufficient to meet the needs identified in the care plan. Therefore it is not permissible for individuals to be asked to make any payments towards meeting their assessed needs*

- However, it is permissible for patient or relatives to agree a package of **additional** services (i.e. beyond the assessed needs) with, for example, care home owners: chiropodist, hairdresser, or to pay for a larger room.

- But the CCG should be able to enter into contract with the home which is capable of standing on its own without support of others.