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NHS Continuing Healthcare

When does a CCG’s funding responsibility cease for a Continuing Healthcare (CHC) Care Package?

Background

This paper should be read in conjunction with “When does a CCG’s funding responsibility start for an NHS Continuing Healthcare (CHC) care package?” The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care is clear about when funding responsibility for a CHC care package starts - it is less clear when it ends.

CCGs and local authorities are reminded that the National Framework states:

‘It is a core principle that neither a CCG nor a local authority should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement. Therefore, if there is a change in eligibility, it is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding, in order to ensure continuity of care. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If agreement between the local authority and the NHS cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding and care management responsibilities should remain in place until the dispute has been resolved....’ (National Framework paragraph 190)

Reasons for an individual CCG to cease CHC funding

List of occurrences which can result in CHC funding responsibility coming to an end include:

- An individual in receipt of CHC funding dies.
- It has been determined, using processes set out in the National Framework, that the individual is no longer eligible for CHC.
- An individual is admitted to hospital for a prolonged period of assessment and treatment.
- An individual moves to a private address out of the CCG area.
- Funding responsibility has transferred between CCGs in line with current Responsible Commissioner guidance ‘*Who Pays? Determining responsibility for payments to providers.’*

Difference between eligibility ending and financial responsibility ending

Eligibility to fund a CHC care package ends on the day of the agreed decision to cease for the examples given above. The ending of financial responsibility is dependent on local arrangements and any clauses within contractual agreements.

The following are the recommended arrangements for the circumstances listed above:

An individual dies
If an individual in receipt of CHC funding dies whilst resident in a Nursing Home, payment should continue for three days after death as defined in the Consumer Law guidance to Care Homes from the Competition and Marketing Authority.
If an individual in receipt of CHC Domiciliary Care via an agency dies, payment should end the day after death.

For individuals in receipt of CHC Domiciliary Care via a Personal Health Budget (PHB), final payment arrangements need to be compliant with the terms and conditions of the contract between the PHB holder and the care agency. PHB holders need to be supported during the setting up of these contracts to ensure the notice period is fair and equitable. If the PHB holder employs Personal Assistants, then the CCG needs to ensure they are supported to adhere to employment and contractual law.

Individual is assessed as no longer eligible for CHC funding - For this decision to have been made, the National Framework is clear that the Local Authority should have been involved in the decision regarding eligibility and therefore the transfer of financial responsibility to the local authority should be as per local arrangement. It is recommended that this transfer should be as quickly as possible, no longer than 28 days and preferably within 14 days or less after the decision.

Admitted to hospital - Should an individual who is in receipt of CHC be admitted to hospital for assessment and treatment, the financial responsibility should be dealt with in line with the provider's contract.

If the individual is resident in a nursing home, it could be expected that under contract a locally agreed retainer fee would be paid to the home for up to 6 weeks; in some operational practices this fee is 70% of the normal charge for the individual. For hospital stays beyond 6 weeks there needs to be further local negotiation, or if the likelihood is that the care will no longer be required then then notice should be given to the provider. Throughout this whole period the individual and their family/representative should be advised and involved in any adjustments.

If the individual is receiving domiciliary care, a locally agreed small retainer may be contractually agreed for up to 6 weeks if it is not possible for the agency to redeploy the member of staff. If the member of staff is redeployed, then no retainer fee should be paid. As above, the individual family/representative should be advised and involved in any adjustments.

If an individual in receipt of a PHB is admitted to hospital, with some formal written agreement with the hospital, their Personal Assistant could provide support to them during the hospital admission as their presence could reduce the distress someone experiences and maintain continuity of care. Alternatively, there would need to be consideration of the Personal Assistant's employment rights so that they are not disadvantaged and can be retained to continue to deliver care and support when the individual returns home.

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An individual voluntarily moves out of the CCG area
As CHC has a single National Framework, if an individual is voluntarily moving into a private address in a different CCG and becomes registered with a GP in that new area their eligibility is unchanged. The individual and their case file should be transferred to the new CCG who should take financial responsibility from the day the individual registers with the new GP. Where an individual in receipt of CHC is placed in a care home setting in another CCG area the placing CCG retains funding responsibility.

The National Framework is clear when it says: *"It is expected that the most recently completed Decision Support Tool (DST) will normally be available at the review and should be used as a point of reference to identify any potential change in needs. Where there is clear evidence of a change in needs to such an extent that it may impact on the individual's eligibility for NHS Continuing Healthcare, then the CCG should arrange a full reassessment of eligibility for NHS Continuing Healthcare." (National Framework Paragraph 184)*

The receiving CCG should not carry out an eligibility review unless there is clear evidence of a change of need. A change in CCG or in accommodation is not clear evidence of change in need.

The National Framework states: "*There should be no gap in the provision of care. People should not find themselves in a situation where neither the NHS nor the relevant local authority (subject to the person's means and the person having needs that fall within the eligibility criteria for care and support) will fund care, either separately or together" (National Framework Paragraph 57)*

References

- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2018) https://www.gov.uk/government/publications/national-framework-for-nhscontinuing-healthcare-and-nhs-funded-nursing-care
- *Who Pays? Determining responsibility for payments to providers* https://www.england.nhs.uk/who-pays/