Maximising the statutory funding pot

NHS Continuing Healthcare and PHBs

SUE PETERS HCMS.

National Framework for Continuing Healthcare 2007, revised 2009, 2012 and 2016

2 stage process - Screening Checklist and Decision Support Tool – 11 Care Domains

1. Behaviour
2. Cognition
3. Psychological Needs
4. Communication
5. Mobility
6. Nutrition
7. Continence
8. Skin
9. Breathing
10. Drug Therapies & Medication
11. Altered States of Consciousness

Continuing Healthcare Screening

- Upon discharge from acute services
- Upon completion of rehab
- From the community if presentation/condition subsequently worsens

- 11 care domains scored A,B or C,
- Screening tool must be completed by a member of health/social care staff

A full assessment of NHS CHC is required if there are:

- 2 or more domains selected in Column A
- 5 or more in Column B, or 1 in A and 4 in B
- 1 domain in Column A for one of the 4 domains that carry a priority level in the DST
- NB. The CCG has a timescale of 4 weeks from receipt of completed checklist to arrange the MDT.

Threshold is deliberately low.

Name of Patient: Date of Completion:

Please circle statement A, B or C in each domain	C	B	A	Evidence in records to support this level
Behaviour	No evidence of 'challenging' behaviour. **OR** Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self or others or a barrier to intervention. The person is compliant with all aspects of their care.	'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self or others. The person is nearly always compliant with care.	'Challenging' behaviour that poses a predictable risk to self or others. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	

Decision Support Tool

- Multi disciplinary meeting: 11 care domains

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NB 12th domain to record any additional needs- very important for spinal claimants- AD.

DST

- Any care domain scored as priority – automatically eligible to receive CHC funding
- 2 or more identified incidences of severe needs across all domains – CHC eligibility would be expected
- 1 score of severe or combination of high/moderate needs- clinical judgement, needs to be a primary healthcare need otherwise not CHC.

Behaviour

Description	Level of Need
No evidence of “challenging” behaviour.	No Needs
Some incidents of “challenging” behaviour. A risk assessment indicates that the behaviour does not pose a risk to self or others or a barrier to intervention. The person is compliant with all aspects of their care.	Low
“Challenging” behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self or others. The person is nearly always compliant with care.	Moderate
“Challenging” behaviour that poses a predictable risk to self or others. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	High
“Challenging” behaviour of severity and/or frequency that poses a significant risk to self and/or others. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.	Severe
“Challenging” behaviour of severity and/or frequency that presents an immediate and serious risk to self and/or others. The risks are so serious that they require access to an urgent and skilled response at all times for safe care.	**Priority**

Continence

Description	Level of Need
Continent of urine and faeces.	No Needs
Continence care is routine on a day-to-day basis; Incontinence of urine managed through for example medication, regular toileting, use of penile sheaths etc. **AND** Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence.	Low
Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence and/or the management of constipation.	Moderate
Continence care is problematic and requires timely and skilled intervention.	High

Communication

Description	Level of Need
Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.	No Needs
Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or may need additional support either visually, through touch or with hearing.	Low
Communication about needs is difficult to understand or interpret, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Moderate
Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to do so have been taken.	High

Right to receive a personal health budget came into effect 01/10/15 for persons eligible to receive continuing healthcare/childrens continuing care.

Also now for mental health services and wheelchairs

7 key steps to a PHB

- CHC eligibility
- Discuss and explain PHB (usually requires referral to PHB lead within the CCG and another meeting)
- Identify health needs service requisition
- Indicative budget setting
- Support planning
- Final budget approval
- Start PHB
- REVIEW AT 3 MONTHS, THEREAFTER ANNUALLY

- Key stage of the process is determining the budget – varies between CCGs with 3 mechanisms used-:
  - The Manchester Tool
  - The Oxfordshire Tool
  - LA Resource Allocation Scheme (RAS).

PHB options

- Health Direct Payment
- 3rd party budget/payment
- Notional budgets

NHS Continuing Healthcare Practice Guidance 2010, Para 11.5

Personal Health Budgets – First Steps 2010

Guidance on Right to Receive a PHB

Case Study 1 – Top-up in residential care

- Gunter v N W Staffordshire PCT- top-ups permitted for non-healthcare services
- ABI client, severe behavioural problems, placed by East Sussex in residential unit (St Joseph's) – cost of £2235.13 per week
- Preferred placement TRU- cost of £2940 per week- top-up of base placement cost not permitted, BUT……
- Negotiated with TRU that vocational and leisure costs amounted to £650 per week and could be 'taken out' of the costing to the PCT- this sum could then be subject to top-up.
- Cost differential now £54.87 per week, evidenced the need for specialist behaviour management- Panel approved placement

Case Study 2 – Top-Up with PHB Direct Payment

- Ventilator dependent young man discharged to live at home with parents
- Care package through agency not working
- Recruit own care team – agree complex care rate of £15.80 per hour (includes insurance and NI so carers paid £13 per hour)
- Only 15 hours per week of nurse input
- Family want full-time nurse team-leader – not acknowledged as a need by CCG therefore able to top-up

CASE STUDY 3 – Top-Up in Domiciliary Care Package – 3rd Party Budget

- ABI Client – at home with care team already in place, eligible to receive CHC funding, did not want to lose existing care team
- Needs assessment – personal health budget…could not be health direct payment because existing staff paid in excess of the direct payment rate….so, 3rd party budget
- Care Plan – 1 carer 24/7 waking night, 2nd carer 4 hours per day plus 10 hours per week respite care for wife
- 2 carers all daytime hours in place already – additional hours not an identified need therefore can be subject to top-up…….thus 74 hours per week top-up

NB: Couldn't be health direct payment because hourly rate less than staff already paid.

ISSUES FOR CASE MANAGERS TO THINK ABOUT….

- ESTABLISH CLINICAL NEEDS

  Except in the most complex of cases there will almost inevitably be a differential between needs assessed within the context of statutory funding and those assessed within the context of a PI claim.

- HOURLY RATES….'CAN'T BE TOPPED UP'

  NHS finance policy – a service user cannot 'top-up' a PHB to purchase an item of higher specification or to gain greater benefit.

  Para 13 of Health Direct Payment Regulations:

  'A health body must ensure that the amount of the direct payment paid to or in respect of a patient is sufficient to provide for the FULL COST of each of the services specified in the care plan.

- EMPLOYING FAMILY MEMBERS

  NHS Direct Payments Regulations –'a direct payment can only be used to pay an individual living in the same household, a close family member or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the need for that service. CCGs will need to make these judgements on a case by case basis.'
- INFLEXIBILITY

  be prepared to work with CCGs – a partnership
- BE CREATIVE

CASE STUDY 4 – HOURLY RATES

- HEALTH DIRECT PAYMENT
- SPINAL INJURY, TETRAPLEGIC, LIVES ALONE
- ASSESSED NEED IS 1 LIVE-IN CARER PLUS WAKING CARER 24/7
- LARGE POC – IDICATIVE BUDGET £3318.30 PER WEEK

BUT……

- HOURLY RATE DETERMINED TO BE LONDON LIVING WAGE - £11 PER HOUR AND LIVE-IN CARER RATE OF £650 PER WEEK.
- CM WANTED TO PAY £14 PER HOUR and £850

CASE STUDY 5 – CARE PACKAGE ALREADY IN PLACE

- DISCHARGED FROM ROYAL BUCKS AND CARE PACKAGE SET UP BEFORE CHC ELIGIBILITY CONFIRMED AND CARE PACKAGE AGREED
- 2:1 24/7 WAKING CARE
- PULSE CARE AGENCY
- WEEKLY CARE COSTS EXCEED £6,500 PER WEEK
- CCG WANT TO LOOK AT OTHER AGENCIES FOR COMPARISON
- CLAIMANT AND CM WANT TO KEEP REGIME IN PLACE