All Age Continuing Care (AACC)

Operational Policy

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| Stakeholders engaged in development of Policy (internal and external)  | * CHC Team leads, Mid & South Essex.
* CYPCC Team, All Essex.
* NHS England Regional CHC Lead.
* CHC leads, North East Essex CCG, West Essex CCG.
* Care Sector Quality Lead, Mid & South Essex.
* Local Authority colleagues with touchpoints with NHS AACC:
	+ Essex County Council.
	+ Southend Borough Council.
	+ Thurrock Council.
 |
| Impact Assessments Undertaken *(Delete if non-applicable)* | * Equality and Health Inequalities Impact Assessment.
 |

# Version History

| Version | Date | Author (Name and Title) | Summary of amendments made |
| --- | --- | --- | --- |
| 0.1 | 3/12/2021 | Matt Gillam / Maria Whelan | Review of former CCGs’ policy |
| 0.2 | 17/2/2022 | Alyson Taylor | Move to ICS Policy template.Include high level indicator statements from NHSE CHC Maturity Matrix. Incorporate previously separate policies: Equity and Choice, Safe and Supportive Observations, Cessation of Funding, Appeals, Redress, Disputes, CYPCC Operational Policy.  |
| 0.3 | 25/2/2022 | Viv Barker | Clarification of ICB governance and job titles; query on delegated sourcing to hospital discharge teams.  |
| 0.4 | 2/3/2022 | Carolyn Lowe | Addition of further clarifications of points of difference between CHC and CYPCC.  |
| 0.5 | 11/3/2022 | CYPCC Team  | Addition of further clarifications of points of difference between CHC and CYPCC. |
| 0.6 | 8/4/2022 | Alyson Taylor& Kevin Howard& Alfred Bandakpara-Taylor | Clarification of points from previous feedback. Clarity on redress v retrospective claims for newly eligible cases. Clarification of invoicing requirements, funding suspension/cessation parameters.Collaboration and addition of Zero Tolerance section.  |
| 0.7 | 19/4/2022 | Alyson Taylor  | Tracked changes accepted, reformatted to add further subheadings to contents page for ease of location of specific elements. Spelling / grammar check. Final draft created for approval.  |
| 0.8 | 26/4/2022 | Alyson Taylor | Clarification of ICB position on CQC registration requirements for delivery of commissioned care packages.  |
| 0.9a | 23/5/2022 | Carolyn Lowe | Clarification @ 6.5.5 and 6.26.12 re LAC. |
| 0.9b | 28/6/2022 | Alyson Taylor, Sam Galvin | Final update of linked policies and statutory references; formatting for ICB requirements.  |
| 1.0 | 06/07/2022 | Charlotte Tannett | Final review of version 1.0. |
| 1.1 | 28/06/2024 | Helen Chasney | Review date amended to 31 August 2024 by Quality Committee (28 June 2024). |
| 1.2 | 25/10/2024 | Helen Chasney | Review date amended to March 2025 by Quality Committee (25 October 2024). |

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## Introduction

The Mid and South Essex Integrated Care Board (MSE ICB) has a statutory responsibility to deliver NHS Continuing Healthcare (CHC) and Children and Young People’s Continuing Care (CYPCC) for the population of approximately 1.4 million people registered with a General Practitioner (GP) within the ICB’s boundaries.

The Children and Young People’s Continuing Care service also includes hosting of CYPCC services on behalf of other NHS commissioning organisations in Essex, outside of the Mid and South Essex ICB boundaries.

This Policy brings together CHC and CYPCC in a single, All Age Continuing Care Policy.

## Purpose / Policy Statement

This policy sets out the principles and processes for implementation of the National Framework for Continuing Healthcare and NHS Funded Nursing Care (July 2022) and the National Framework for Children and Young People’s Continuing Care (2016), hereinafter referred to as the National Framework(s).

It is expected that readers of this policy will already be familiar with the content of the relevant National Frameworks. This policy avoids inclusion of the in-depth explanatory text from those National Frameworks wherever possible, to keep this policy to a reasonable length.

## Scope

3.1 This Operational Policy applies to Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary / bank / agency / work experience staff, students and volunteers) for the AACC operational teams, whether in the Business Unit or at Place. This policy interacts with some Provider and Local Authority (LA) activity in contributing to assessments for AACC, and although it is not binding upon other organisations and contractors, it may set out best practice that will facilitate effective joint working.

## Definitions

| **Term** | **Acronym** | **Definition** |
| --- | --- | --- |
| All-Age Continuing Care | AACC | A combined approach to the delivery of NHS CHC and CYPCC, a development by NHS England’s CHC Strategic Improvement Programme, promoting integration of those services. |
| Accessible Information Standard | AIS | The Accessible Information Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of individuals, service users, carers and parents with a disability, impairment or sensory loss.  |
| Best Interests | BI | A statutory principle set out in Section 4 of the Mental Capacity Act. It states that 'Any act done, or a decision made, under this Act or on behalf of a person who lacks capacity must be done, or made, in his best interests'. |
| Care Quality Commission | CQC | The independent regulator of all health and social care services in England.  |
| Checklist |  | A screening tool designed to indicate whether or not full assessment of eligibility for NHS funding is required. |
| CHC Competency Framework |  | A suite of staff training modules relating to implementation of the National Framework for Continuing Healthcare and NHS Funded Nursing Care |
| Children and Young People’s Continuing Care  | CYPCC | Continuing Care is a general term that describes a tailor-made package of care which is required over an extended period of time for children and young people with complex health needs which arise because of disability, accident or illness (including life limiting or life-threatening conditions). Continuing Care may be provided for children and young people whose health needs cannot be met by existing universal, targeted or specialist health services. The aim of the care package is to support the child/young person’s parent (s) and/ or carers to manage their child/young person’s care at home and/or in other settings. It may require the provision of services from the NHS, social care, education, or other organisations to enable the child/young person’s parent (s) and/ or carers to be appropriately supported in their community. |
| Continuing Healthcare  | CHC | A package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a ‘primary health need’ as set out in this National Framework. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident or illness. Eligibility for NHS CHC is not determined by the setting in which the package of support can be offered or by the type of service delivery. |
| Court of Protection Deputy |  | An authorisation by the Court of Protection to make decisions on behalf of a named individual if they ‘lack mental capacity’ to make a decision for themselves at the time it needs to be made.  |
| Decision Support Tool | DST | A document designed for recording the MDT assessment for CHC/CYPCC funding eligibility.  |
| Deprivation of Liberty Safeguards | DoLS | An amendment to the Mental Capacity Act 2005 which ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. |
| Domiciliary Care |  | Care, including clinical care, delivered in the individual’s own home. |
| Do Not Attempt Resuscitation form | DNAR | A document agreed between the individual (or approved representative) and their responsible medical clinician, instructing that in the event of a cardiac arrest, the individual’s wishes to not be resuscitated will be respected. |
| Education Health and Care Plan | EHCP | A plan agreed between child, family and the three agencies to meet all of a child’s identified health, social care and educational needs.  |
| Funded Nursing Care  | FNC | Funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse. |
| Fast Track | FT | An AACC funding stream that can be implemented without full assessment for a person who is rapidly deteriorating and may be in the terminal stage of their life / life-limiting condition.  |
| Gillick competence |  | Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent. |
| Health Needs Assessment | HNA | An assessment to determine eligibility for funding for children and young people (also referred to as the DST), aimed at promoting a child's physical and mental health and to inform the child's Individual Health Plan. |
| Independent Mental Capacity Advocate | IMCA | A legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. |
| Independent Review Panel  | IRP | An expert panel with an independent Chair, to enable individuals and/or their representatives to look at the primary heath need decision by a Clinical Commissioning Group (CCG), or the procedure followed by a CCG in reaching a decision about their eligibility for NHS Continuing Healthcare; and to make a recommendation to NHS England in the light of its findings. |
| Integrated Care Board | ICB | An organisation with responsibility for NHS functions and budgets; the lead organisation for the Integrated Care System (ICS),  |
| Integrated Care System | ICS | A partnership that brings together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. |
| Integrated Discharge Team | IDT | An integrated multi-disciplinary team of social care professionals, nurses, and discharge trackers who triage individuals who have ongoing care needs, planning and facilitating discharge from hospital.  |
| Integrated Residential and Nursing Framework | IRN | A contractual arrangement between the Local Authority and NHS with nursing and residential homes to operate as preferred providers (with priority over non-framework providers) within a pre-agreed pricing framework when care placements for individuals are being commissioned.  |
| Joint Funding | JF | CHC: Where the NHS contributes funding to a primarily social care-funded package of care for an individual who is not eligible for CHC but has a clearly evidenced health need that the NHS is responsible for funding. CYPCC: This may include joint or Tri part funding with Education/social care |
| Lasting Power of Attorney | LPA | A legal document that lets the ‘donor’ appoint one or more people (known as ‘attorneys’) to help them make decisions or to make decisions on their behalf if they lack mental capacity. |
| Liberty Protection Safeguards | LPS | The replacement for DoLS, announced in a Mental Capacity (Amendment) Bill which passed into law in May 2019. Key features will include starting at 16 years of age, and deprivations of liberty having to be authorised in advance by the ‘responsible body’. |
| Local Appeal Panel | LAP | A formal panel approach to review of an individual / family disputed eligibility decision.  |
| Local Health and Care Records | LHCR | Individuals’ electronic health records, which include information from multi care settings e.g. GP practices and hospitals. |
| Local Resolution Meeting | LRM | A meeting with the individual / family aimed at transparently reviewing and explaining the process taken to come to the eligibility decision.  |
| Multi-Disciplinary Team  | MDT | For AACC, an MDT is defined as at least two care professionals from different disciplines. These should be practitioners who know the individual and are knowledgeable about their specific care needs.  |
| Mental Capacity Act | MCA | A legal framework to support decision-making as to the ability of an individual to make decisions. The Act has five main principles: presumption of capacity; support to make a decision; ability to make unwise decisions; best interests; least restrictive. |
| Needs Portrayal Document  | NPD | A document similar to the DST, but used to collate information spanning several years, to assist the CCG in deciding whether the individual had healthcare needs or social care needs. |
| Nursing Needs Assessment | NNA | An assessment of health and care needs, focussed on identifying needs that require the direct supervision of a Registered Nurse.  |
| Parliamentary and Health Services Ombudsman | PHSO | A formal body which makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations.  |
| Personal Budget | PB | A budget given to the individual to purchase care independently to meet their assessed needs and personal preferences. This may be for a joint / tripart funded package of care |
| Personal Health Budget | PHB | Funding provided for an AACC package to be delivered in a highly personalised approach, commissioned either by the ICB, via a third party, or directly by the AACC-eligible individual / their legal representative via a direct payment.  |
| Previously Unassessed Period of Care  | PUPoC | A time period during which the individual had not been assessed for CHC funding – by Checklist, Nursing Needs Assessment or DST.  |
| Primary Care Network | PCN | A group of GP Practices grouped together to enhance delivery of primary care services to a local population.  |
| Primary Health Need | PHN | A concept developed by the Secretary of State for Health to assist in deciding when an individual’s primary need is for healthcare (which it is appropriate for the NHS to provide under the 2006 Act) rather than social care (which the Local Authority may provide under the Care Act 2014).  |
| Quality Innovation Productivity and Prevention | QIPP | A scheme aimed at improving quality, encouraging innovation, delivering preventative activities to reduce demand on health services and to improve use of resources.  |
| Resource Allocation Panel  | RAP | A multi-agency panel led by local authorities, comprising health, social care and education representation to make decisions on allocation of funding.  |
| Shared Business Services | SBS | A provider of corporate services to the NHS, including invoice management.  |
| SPINE |  | The system supporting the IT infrastructure for health and social care in England, allowing information to be shared securely between over 20,000 organisations.  |

## Roles and Responsibilities

### Integrated Care Board (ICB)

* + 1. The ICB Board has statutory responsibility for delivery of CHC and CYPCC. The ICB Board will ratify and adopt this AACC Operational Policy and appoint a named Executive Lead for CHC and CYPCC, to be accountable for AACC strategy and service delivery.

### Quality Committee

* + 1. The Quality Committee is responsible for receiving reports, assurance and escalations relating to AACC service quality and delivery, escalating appropriate issues to the Board.

### System Oversight and Assurance Committee (SOAC)

* + 1. The System Oversight and Assurance Committee are responsible for receiving exception reports relating to AACC service performance against national and local targets and financial management including Quality, Innovation, Productivity and Prevention (QIPP) savings plans and financial benefits realisation.

### Chief Executive

* + 1. The Chief Executive is ultimately accountable for the delivery of the AACC service statutory responsibilities.

### Chief Nurse

* + 1. The Chief Nurse is responsible for the delivery of AACC services.

### Policy Authors

* + 1. The Head of AACC is responsible for ensuring that review of this policy occurs at least two-yearly, and for ongoing review of this policy in light of any national or local developments, Acts of Parliament or other mandates which may materially impact on the operation of the AACC service and to make recommendation to the Quality Committee on any required amendments to this policy.

### Arden and GEM Commissioning Support Unit (AGEMCSU)

* + 1. AGEMCSU is responsible for providing appropriate support to the AACC service with regard to Information Technology and Information Governance requirements to enable the service to function effectively and within all legal requirements.

### Governance Lead

* + 1. The Governance Lead is responsible for ensuring that all appropriate governance requirements are met in the development, approval and implementation of this Policy.

### Line Managers

* + 1. Line Managers within the AACC service are responsible for accountable for ensuring that the service is appropriately resourced, trained and supported to implement this policy.

### All Staff

* + 1. All staff are responsible for following the processes laid out in this policy when working with and within the AACC services.

## Policy Detail

## Enablers (6.1-6.9)

### Strategy and Leadership

* + 1. The ICB will appoint a dedicated accountable lead for AACC, sponsored by the Accountable Officer and Chief Finance Officer to steer the direction of operations and provide leadership.
		2. The ICB will develop and implement an over-arching AACC strategy, to drive clear accountability and evidence of high performance across the end-to-end service, including LA and Provider partners.
		3. The AACC service will have significant integration and frequent interaction with external stakeholders and other commissioned services, within and outside of the Integrated Care System (ICS) and LAs, with active partnerships to bridge the gap between social and health care.
		4. The AACC Operational Policy has been developed to meet operational and legal safeguards and take into account precedence from other geographies. It will align with and complement the wider ICB vision.
		5. The AACC budget is determined with significant operational and senior leadership input; it is adjusted to account for prior trends in expenditure and forecasts budgetary pressures arising in the upcoming financial year. Budgetary and savings analysis is tracked throughout the year and is used to inform short and medium-term decision making. Expenditure analysis is also conducted on the cost of the service as a whole and review is given to expenditure trends by care group and seasonality. The outcome of analysis is used to inform short and long-term decision making and support transformative cases for change.
		6. The AACC service will have a comprehensive list of QIPP schemes in place, all of which achieve or exceed the QIPP target expected. All QIPP schemes are closely monitored and opportunities to expand or extend schemes are maximised.
		7. The ICB will ensure that clear lines of accountability are present in AACC services, well-defined and well documented for all processes and that there is proportionate governance architecture in place to support the delivery of a fair and sustainable, high quality service.
		8. The ICB will operate an organisational climate that is positive, resilient and progressive and is not susceptible to operational pressures. The AACC team will be supported in their decision making and understand the wider positioning of the AACC service within the ICB and be clear as to the objectives of their role and that of the AACC service as a whole.

### Individuals and Families

* + 1. The AACC service will work proactively to involve the individual and/or their family/representatives in referral and assessment processes and to formally acknowledge, record and consider their views, through attendance at meetings (face to face, video/teleconference) or through submission of written statements for consideration during the Multidisciplinary Team (MDT) /single agency assessment.
		2. To manage expectations and to provide further understanding of the decision-making processes, national and local information leaflets on AACC assessment and decision-making processes and available advocacy services will be provided to the individual/family/representative following receipt of referral to the services, with the initial appointment invitation letter.
		3. This Policy, leaflets and relevant guidance referred to in this policy will be made publicly accessible via the AACC service’s webpages.
		4. The AACC service will utilise templated letters communicating the outcome of referrals and decisions relating to assessment / eligibility for funding, sent to the individual and/or their representative (where applicable) with relevant supporting documentation enclosed within 48 hours of receipt of referral and decision.
		5. The AACC service will have due regard to the ICB’s statutory duty to follow the Accessible Information Standard in its operations and to support implementation of the Standard in its commissioned services. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of individuals, service users, carers and parents with a disability, impairment or sensory loss.
		6. In accordance with Parliamentary and Health Services Ombudsman (PHSO) recommendations, other adjustments required to meet individual communication support needs will also be facilitated as far as practicable, relating to any protected characteristic under the Equality Act 2010.
		7. A named coordinator will be assigned to each individual and the individual/family/representatives will be formally advised of the coordinator’s contact details.
		8. Individual and family feedback will be collected and utilised to improve the service, through proactive information gathering via surveys and recording of compliments; the outcome of investigations into complaints; cases reviewed by the PHSO; the outcome of resolution meetings and appeals; and will be used alongside feedback from NHS England’s Independent Review Panels (IRP).
		9. The AACC service will ensure that elements of the service are developed through co-production with individuals and families and partner organisations.

### Zero Tolerance

* + 1. The AACC service will follow the ICB’s strategy and policy on Zero Tolerance of abuse.
		2. The service will develop processes as per the NHS and Social Partnership Forum’s [Violence prevention and reduction standard](http://www.england.nhs.uk/wp-content/uploads/2020/12/B0319-Violence-Prevention-Reduction-Standards.pdf) (2020), which provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence, as supported by the Secretary of State for Health’s Correspondence: [Violence against NHS staff: letter to the workforce](https://www.gov.uk/government/publications/violence-against-nhs-staff-letter-to-the-workforce/violence-against-nhs-staff-letter-to-the-workforce) (18 February 2020). We will take a robust approach to zero tolerance of violence, aggression and discrimination toward staff and will adopt the guidance issued by the British Medical Association (BMA): [How to manage discrimination from individuals and their guardians/relatives](https://www.bma.org.uk/media/5144/bma-guidance-on-how-to-deal-with-discrimination-from-patients-march-2022.pdf) (BMA, 2022) in responding to incidents relating to discrimination, harassment, racism, hate crime, etc.
		3. The AACC service will support its commissioned providers in responding to incidents of this nature, ensuring the protection of staff and without causing detriment to the care and support to the individual requiring care.

### People and Skills

* + 1. AACC documentation should be completed by trained staff who are familiar with the principles of the National Framework and are trained in the use of the published tools. The AACC service will take the necessary steps to train particular groups of staff and to ensure that trained staff are supporting assessments, through provision of access to a suite of mandatory e-learning ([www.e-lfh.org.uk/programmes/continuing-healthcare/](http://www.e-lfh.org.uk/programmes/continuing-healthcare/)) and supporting the development and delivery of joint training programmes with Local Authority and other partners/providers regarding all process and policies (local and national) regarding eligibility for CYPCC, CHC and FNC and the delivery of Personal Health Budgets (PHB).
		2. The AACC service will actively identify staff groups that are completing Checklists or completing AACC assessments and ensure that an effective, rolling training programme is in place to ensure that these identified groups complete training that reflects the contemporaneous National Frameworks and is delivered with a joint equitable approach with the LAs. Training on the National Frameworks will be undertaken and include appropriate hospital, community and adult social care staff involved in the implementation and application of the National Frameworks. Training will be provided in the use of the National Tools, the identification of a “primary health need”, the application process and the timescales for completion of assessments.
		3. Training will be delivered collaboratively wherever possible, led by the ICB AACC team as part of a planned programme throughout any given year. Training uptake will be monitored and utilised to proactively inform where targeted additional training can be offered appropriately, including when there are changes made to the National Frameworks.
		4. The AACC service will ensure that staff are supported through effective training and supervision and have protected time for learning & development. Staff will be supported to take opportunities forward in developing senior leadership, patient management and administrative skills and in developing resilience, supported by the workforce plan and senior management. Training uptake will be monitored and utilised to proactively inform where further support may be required.
		5. All staff that contribute to the AACC pathway will have completed all face to face and/or e-Learning relevant to their role. The service will have a system in place through registration of relevant practitioners to submit Checklists and take part in the multidisciplinary teams undertaking assessments, to ensure the appropriate professionals are always involved and that all staff (internal and external) involved in AACC process are trained, assessed and competency reviewed in line with the National CHC Competency Framework. All staff that contribute to the AACC pathway will have either been assessed as competent for their role or have development plans in place and understand their role within the AACC service.
		6. The AACC service operates a clearly defined prioritisation matrix for assessment and timely reviews of eligibility and commissioned care, to help the team balance the workload; this ensures that effective resource allocation is carried out.
		7. The AACC service model ensures that the right resources are in place within the service to meet the operational requirements across the end-to-end process. Ongoing workforce capacity planning is in place and any gaps are understood and addressed.

### Governance

* + 1. The AACC service has a fully implemented governance schedule that monitors decision-making processes to enable a consistent and fair application of eligibility according to the Frameworks. The AACC service will ensure that there is a robust process in place to determine equity of decision making and appropriateness of the application of the Primary Health Needs test (CHC) and scoring of domains (CYPCC), via regular audit of decision-making and standardisation reviews / internal peer support for practitioners. External peer review is provided via NHS England’s IRPs and ‘deep dives’ into performance data.
		2. Clear lines of management and reporting are in place to support the effective discharge of AACC duties. Roles and responsibilities of practitioners, teams and organisations delivering any elements of AACC on behalf of the ICB have been clearly defined and are supported by comprehensive Key Performance Indicators (KPIs), specifications and contracts to ensure the ICB can effectively meet the mandate of the National Frameworks.
		3. There is strong oversight of external parties with active enforcement of contracts to ensure the effective delivery of any outsourced AACC services, with a focus on value for money. Clear oversight of provider performance will be maintained, requiring regular reporting from providers against their contractual obligations and monitoring KPIs, with a plan in place to address provider quality if concerns are identified.
		4. Joint LA governance processes are in place and are actively utilised to manage the transfer of responsibilities between ICB and LA, proactively meeting the 28-day target.
		5. Where a child or young person has a special educational need or disability (SEND), then the ICBs and LAs should endeavour to coordinate the assessment and agreement of the package of continuing care, as part of the process to develop the child’s Education, Health and Care plan in accordance with the Children and Families Act 2014. It is important to note that where a child is ‘looked after’ by the local authority they have responsibility to safeguard and promote the welfare of the child as set out in section 22(3) of the Childrens’ Act 1989.
		6. The AACC service will ensure clarity and agreement with all stakeholders on ways of working, organisational obligations and performance management processes. This includes agreement with any organisations commissioned to deliver AACC on the ICB’s behalf and extends to other providers and delivery partners in the AACC landscape - e.g. LAs, Education, acute trusts and care homes/residential schools.
		7. There is clear line of sight at all times of how many individuals are at each stage in the AACC pathway in order to effectively reallocate resources, as required, and maintain clear understanding of risks.

### Technology and Systems

* + 1. The AACC service will work with software providers to develop fully interoperable caseload management software for use across the end-to-end AACC process, which facilitates a single source of the truth, enables data fluidity (i.e. all data flows), is integrated with wider NHS systems, including but not limited to Shared Business Services, SPINE, Local Health and Care Records (LHCR), which fully meet the NHS digital, data and technology standards framework. This will remove any requirement for use of additional applications for individual management, reporting, scheduling, finance, etc.
		2. Notification of both upcoming and overdue assessments and reviews is available live within the system. Clerical procedures and scheduling are supported by the use of the caseload management database and / or other customisable software. Individuals requiring assessment or review are flagged by the integrated technology platform through the production of reports that can be run at any time and demonstrate progress in pathway against a countdown clock.
		3. The AACC service will operate comprehensive digitisation of clinical administrative procedures. Assessment forms will always be completed electronically at the time of assessment and there is facility to capture information typed into data fields for direct upload and reviews.
		4. Equipment and technology to support remote working over a secure connection, enabling access to individual level data has been made widely available to the AACC team and is the default expectation.
		5. Workflow(s) are fully structured and/or addressed using software, with assessments carried out electronically and automatically directed to the relevant team member.
		6. Invoice processing and validation is supported by a high level of automation with governance workflows built in.
		7. Referrals are submitted via a digital platform with quality control and mistake-proofing at source.
		8. The AACC service will work to develop a secure “Individual portal” to facilitate communications with individuals and families, which when implemented will be the default method in use. Use of telephone, paper and post will be by exception at request of the individual/representative only.

### Data and Information

* + 1. There is a central repository of information that integrates all data across the end-to-end AACC process, is actively maintained and audited for data quality and is accessible remotely with a user-friendly drill-down interface.
		2. The AACC service will implement a regularly refreshed data strategy, which spans the core processes and regularly informs the development of the service as a whole. There is clear governance and high practitioner engagement across the ICB & providers.
		3. A data dictionary will be defined, shared and maintained across the AACC team. External sources of data to AACC are included into the data sets to enhance insights, e.g. local population health data.
		4. Information and insights are visualised and monitored electronically through interactive dashboards; these are available to all AACC teams across the pathway and can be customised to suit the needs of specific teams and replace manual reporting where possible.
		5. Individual-level data updates from providers to the ICB are rarely subject to delay. AACC contractual and individual data is updated without time lags so that financial information is accurate.
		6. Regular data quality checks are in place as a matter of routine.
		7. Strategic predictive demand analytics and financial forecasting is employed and utilised to inform operating decisions.
		8. AACC insights are shared between Place-based Alliances via the central Business Unit repository to share best practices and lessons learnt.

### Invoicing and Payment

* + 1. Invoices from domiciliary care providers must be accompanied by evidence in the form of timesheets confirming staff attendance, which will be validated by the ICB against the funding agreement / contract prior to payment being approved.
		2. Invoices should include the individual unique individual identifier number to facilitate payment process. Invoices will be rejected at source where GDPR is deemed to have been breached.
		3. Providers are expected to have due regard to the ICB’s policy regarding Initiation, Suspension and Cessation of Funding (6.24) when an individual in receipt of funding is admitted to hospital, dies, or is not in receipt of the commissioned package of care for any other reason. For example: an individual in a residential placement going to stay with relatives for a period of time without care provision moving with them. The reduction or suspension of fees paid to the provider will be negotiated accordingly and revised funding agreements issued for that time period.
		4. Robust financial arrangements between the ICB, Local Authorities and providers will be facilitated through ‘Care Package Agreements’ and quarterly financial monitoring.
		5. The ICB will ensure that invoices that meet the required standards are processed and paid in a timely manner in scheduled payment runs.

### Market Management

* + 1. Proactive and long-term support and management of the provider market, including strategic commissioning and procurement will be in place via a clearly articulated strategic commissioning plan, which is understood by commissioners, clinicians, suppliers and individuals.
		2. Clear contracting routes will be in place for all providers, with up-to-date care specifications. With the support of the ICB’s Contracting Team, the AACC service will ensure that ‘spot purchasing’ outside of pre-agreed contracting routes is used for exceptional cases only which will be reviewed in accordance with AACC policy.
		3. Comprehensive understanding and benchmarking of prices paid in the market will inform provider discussions and agree a fair price of care, by care group, with collaborative commissioning across neighbouring ICS and LAs, where appropriate. Pricing and quality will be benchmarked and prices for care and accommodation negotiated with providers, using a common pricing strategy agreed with LA partners.
		4. The AACC service will understand the long and short-term demand for AACC and put plans in place to address any gaps. Local market capacity, pricing and drivers affecting this are understood and forecasting is undertaken for long term AACC demand to inform capacity planning and engagement with the market to address gaps across cohorts. Plans are implemented to mitigate risks, including contingency plans to mitigate risk of market failure and home closure, which have been proactively tested, with learning applied. All relevant practitioners understand and follow these plans.
		5. A market engagement plan will be implemented to engage the market to proactively communicate and receive feedback in a structured way and to ensure consistent messaging across the ICS, including LAs.
		6. The AACC service will develop a comprehensive understanding and active combined use of data for all ICB and LA Commissioned Services, to ensure that AACC-commissioned services are a blended mix of Population-Based (at scale) and individualised commissioned models that are sustainable and meet the needs of the individual and the local population. There is a clear and active engagement plan to share and receive feedback on integrated commissioning intentions from stakeholders

## Process (6.10 - 6.28)

### Consent, Mental Capacity, Safeguarding, and Deprivation of Liberty Safeguards (DoLS)

* + 1. Assessment of AACC individuals should take account of safeguarding policy and legislation. The Children Act 2004 places a duty on all agencies to safeguard and promote the welfare of children and young people; it is noted that those children and adults who are being considered for continuing care may be especially vulnerable. The AACC service will operate with due regard to its duties to safeguard individuals and in accordance with the overarching child and adult safeguarding policies of the Southend, Essex and Thurrock (SET) Local Authorities: SET Safeguarding and Child Protection Procedures (revised 2019) and SET Safeguarding Adult Guidelines (revised 2019).
		2. All AACC activity relating to individuals must have valid consent, or if an adult (age 16 and over) lacks capacity, be formally assessed to be in their best interests. The AACC service follows the Southend, Essex and Thurrock Safeguarding Adults Boards Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Policy and Guidance.
		3. The consent of the child or young person, or their parents where necessary, must be sought. Children under the age of 16 can consent to their own treatment if they are believed to understand the risk and consequences that may arise from their decision. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them. Consideration must be given to a child/young person’s capacity to consent in accordance with Gillick competence to ensure that a child/ young person’s opinion and choice is not undermined. It should be made explicit to the individual what this consent covers, including the sharing of personal information between different professionals and organisations involved in their care.
		4. Where there are concerns that an individual may have significant ongoing needs and that the level of appropriate support could be affected by their decision not to give consent, the ICB should discuss with the LA the implications, as in any other case where consent for treatment is withheld. If the young person is 16 or over, the Mental Capacity Act may apply.
		5. If an individual does not consent to consideration of eligibility for NHS AACC, the potential effects on the ability of the NHS and LA to provide appropriate services should be carefully explained to them. Where there are concerns that an individual may have significant on-going needs and the level of appropriate support could be affected by their decision not to consent, the appropriate way forward should be considered jointly at a senior management level in the ICB and LA.
		6. Consent, where there is no indication of a concern over mental capacity, can be given verbally or in writing. Written consent is preferred, as it enables the practitioner taking that consent to specify in writing exactly the parameters of the consent given and to have this agreed with the competent person’s signature or other mark. Where taken verbally, the practitioner should carefully document all information shared with the person to enable them to give valid informed consent in a dated/timed, signed entry in the individual record.
		7. Where there is evidence that a person being referred for assessment lacks capacity to consent to the assessment, MCA assessment must be undertaken, in accordance with the MCA (2005) and local Safeguarding Board policy and procedure. This includes the appointment of an Independent Mental Capacity Advocate (IMCA) if the person is un-befriended.
		8. Best Interests (BI) decisions should include the views of the individual and their family / close friends. Where the person is assessed to lack capacity but has a legal representative (Lasting Power of Attorney for Health and Welfare or Court of Protection deputyship), the representative is able to make decisions on the person’s behalf. The AACC service will ensure that LPA has been registered with the Office of the Public Guardian.
		9. Consent for the AACC eligibility assessment process will generally cover the entire process from referral, through screening and full assessment, and include reviews, although consent for review will always be reaffirmed at the time of those reviews taking place. The consent will also cover the sharing of personal information with relevant other professionals and organisations, in order to undertake the assessment and reviews.
		10. Further consent must be gained if the commissioning of a care package will require the individual to move from their usual accommodation. While consent to be assessed is a minor requirement, ‘Change of Accommodation’ is a major life decision.
		11. Where an individual is assessed to not have mental capacity to consent to AACC processes, consideration must also be given to whether any decisions will deprive that individual of their liberty, requiring a formal application for authorisation of Deprivation of Liberty Safeguards (DoLS).
		12. The AACC service will work closely with colleagues from Safeguarding and LAs in relation to developments and implementation plans for the introduction of the Liberty Protection Safeguards (LPS). Policy will be updated accordingly as plans progress for this implementation.

### Initial screening

* + 1. Anyone can refer an individual (including the individual themselves) for initial screening to ascertain if a full eligibility assessment for AACC is required. A request will be accepted from non-professionals via email, letter or in exceptional cases, a referral can be initiated by telephone. Health & Social Care Professionals including care providers must make referrals through the electronic referral portal. In all cases, valid consent is required (Section 6.10).
		2. Where a child or young person is eligible for continuing care and the young person is aged 14 years or over adult CHC are requested to become formally involved in the young person’s continuing care so that eligibility of CHC funding can be determined immediately following the individual’s 17th birthday. This negates the need for a formal referral to adult CHC.
		3. Where the referral comes from an individual, family, representative or any professional who has not completed a AACC screening tool (Checklist), the AACC service aims to complete the Checklist screening within 14 days of receipt of that referral.
		4. The process for decisions about eligibility for AACC will be transparent for individuals and their families and for partner agencies. All AACC practitioners will confidently and proactively communicate the consistent message to individuals, families and relevant professionals (e.g. District nurses, social care, discharge teams), that screening via the AACC Checklist is not an indication of eligibility; that the threshold to progress to full assessment is appropriately set to ensure that all possibly eligible individuals are identified for full assessment.
		5. When an individual is referred for screening, the AACC service will first take steps to ensure that the individual is at their clinical optimum and in a stable condition for their needs to be assessed. Welfare checks will be undertaken by the AACC service to ensure ongoing individual safety. Where necessary to maintain safety, funding can be awarded without prejudice to provide a package of care until assessment is completed.
		6. Training (Section 6.4) will ensure that there will be limited inappropriate or poor-quality Checklist referrals received, as all referral agencies will know when and when not to carry out a checklist and referrals are only accepted via a digital platform with quality control mistake-proofing at source, following registration of the referrer requiring proof of training.
		7. The AACC service will be confident that they are in receipt of the majority of Checklists conducted, including those that do not trigger for a full assessment. The team have processes in place to encourage practitioners to submit all completed Checklists and, where appropriate, the AACC team keeps a record of when Checklists have not been undertaken and why.
		8. Receipt of Checklists will be recorded in the case management system, with formal recording of the outcome of those screening assessments and appropriate adjustment of the record to reflect the contemporaneous pathway stage and decisions reached. Regular quality audits are performed, with data and information routinely used to identify practitioners and/or organisations requiring targeted support to improve the quality of screening.
		9. Receipt of a referral / Checklist will be triaged and acknowledged to the referrer within 5 working days. Referrals will be rejected if incomplete or if the ICB is not the responsible commissioner.
		10. The outcome of referral screening will be made in writing to the individual, with next steps outlined in the letter, including, in the case of a negative Checklist, information relating to the NHS Complaints process, which is the next step if the individual / representative wishes to dispute the outcome (Section 6.21).
		11. Requests for reviews of positive Checklists will be denied. The subsequent full eligibility assessment will override the Checklist and re-applying the Checklist is not considered good use of resources. However, comments and concerns will be documented on the individual’s record and the AACC service will take into account any concerns relating to process or evidence that was available but was not considered, to take forward as learning.

### Full Assessment

* + 1. Assessments are scheduled by the CHC team administrators at the optimum point in an individual’s rehabilitation and in an appropriate care setting. Assessments can only be rescheduled by the administrative team. The team will request and collate any individual records required to support the MDT and will invite attendance and/or a written submission from the individual / family / representative for the DST meeting.
		2. For CYPCC, assessments are scheduled by the Clinical Managers, who will also collate any individual records required to complete the assessment.
		3. The default methodology for meetings involving individuals and families remains ‘virtual’, following the extensive Covid-19 pandemic: online via videoconference. Should the default methodology not be considered appropriate due to individual or family needs, teleconference or face to face assessment may be offered, the latter of which is by exception only and where clinical judgement indicates face to face meetings are essential to complete an accurate assessment.
		4. The time taken from receipt of a positive Checklist to eligibility decision will very rarely extend beyond 28 days for adult cases and (as guidance) 42 days for CYPCC cases. Where there is a delay, referrers and individuals will be kept advised of the situation and anticipated revised timelines, and welfare checks will be undertaken by the AACC service to ensure ongoing individual safety. Where necessary to maintain safety, funding can be awarded without prejudice to provide a package of care until assessment is completed.
		5. Assessments for CYPCC will be undertaken via a holistic and objective Health Needs Assessment DST completed by the CYPCC Clinical Manager, after meeting with the child/young person and family and ensuring transparency of process by explaining how a decision on eligibility is made. Where possible, joint visits with social care and education representatives are undertaken in the assessment planning stage, to minimise duplication and promote joint working.

There are four key areas of evidence that should be considered in the CYPCC assessment:

* the preferences of the child or young person and their family;
* a holistic assessment of the needs of the child or young person and their family;
* reports and risk assessments from a multidisciplinary team or evidence collated during the Education, Health and Care plan assessment; and;
* the Decision Support Tool for children and young people.
	+ 1. The CYP Clinical Manager will also obtain and collate all pertinent assessments and information relating to the child/young person’s needs. The continuing care assessment draws on earlier assessments that the child/young person may have already undergone, however focuses on the needs of the child / young person in the preceding 3 months.
		2. For CYPCC, he outcome of the assessment is a recommendation from the clinical manager as to whether or not the child or young person has continuing care needs and is eligible for CYPCC funding.
		3. If eligibility is recommended, Social Care, Education professionals (as appropriate) may also be asked to provide a professional assessment report and the child/young person and family will be given the opportunity to review the DST and contribute further to the report prior to the subsequent panel stage.
		4. Assessments for CHC will be undertaken by an appropriately trained, constituted MDT in accordance with the National Framework and the NHS Commissioning Board and CCG (Responsibilities and Standing Rules) Regulations 2012 (Part 6, Regulation 21, Paragraph 13). All members of MDT must be deemed competent in line with the CHC Competency Framework and at least one member of the MDT must know the individual. The practitioners will have a strong understanding of their respective roles within the MDT and of the wider system pressures.
		5. Where the individual has a specific condition or diagnosis that requires a specialist understanding of their presentation and needs, the AACC service will ensure that a relevant subject clinical specialist is also part of the MDT.
		6. DSTs will be completed digitally and uploaded to the case management system. Supporting evidence will be scanned and uploaded electronically.
		7. The MDT will consider all evidence collated for the assessment, including written submissions from the individual / family / representative if unable to attend in person. The assessment draws on earlier assessments that the individual may have already undergone, where relevant, however focuses on the needs present in the preceding 3 months. All domains of the DST will be discussed in full against the documentary and verbal evidence and the discussion recorded in the DST documentation.
		8. The MDT will allocate scoring levels in each domain of the DST. Where there is disagreement from any party during the MDT process, this will be clearly recorded in the documentation. Where the MDT are unable to agree the scoring for a domain against the domain descriptors, the higher score will be selected and narrative recorded to reflect that decision.
		9. Following the MDT discussion against the DST domains, the MDT will consider and record their deliberations relating to the PHN test in closed session without the individual / family / representative present.
		10. It is expected that the MDT will make recommendation to the ICB with regard to the eligibility decision in each case. The MDT is able to recommend full eligibility for CHC or no eligibility, the latter of which can be accompanied by a further recommendation for Funded Nursing Care (with or without an added continence payment) or Joint Funding (Section 6.27) by health and social care.
		11. Where the MDT is unable to unanimously agree the outcome of the PHN test, this will be clearly recorded in the DST document and the MDT Coordinator (AACC team practitioner) will make recommendation to the ICB regarding eligibility, for panel consideration (Section 6.13). No DST will be accepted by the ICB in the absence of a recommendation.
		12. Receipt of DST assessments will be recorded in the case management system, with formal recording of the outcome of those assessments and appropriate adjustment of the record to reflect the contemporaneous pathway stage and decisions reached.
		13. Regular quality audits are performed, with data and information routinely used to identify practitioners and/or organisations requiring targeted support to improve the quality of MDT assessments.

### Verification

* + 1. The vast majority of verifications of MDT adult eligibility recommendations will be undertaken via peer review or manager review within the AACC service.
		2. CYPCC cases will be peer reviewed internally as required, to confirm eligibility or escalated to the service lead if there are any concerns relating to the eligibility decision. DSTs should rarely be returned for additional supporting evidence, as all relevant documentation will have been requested in advance. The DST is then presented at the respective Joint Agency Verification Panel for ratification and approval.
		3. It is expected that only a limited number of adult DSTs will require a panel review for verification. Each Place-based AACC team will have arrangements with the Local Authority to convene a Joint Agency Verification Panel comprising a senior social worker and senior nurse at least weekly, to verify MDT recommendations by exception.
		4. Verification should always be achieved within two working days of the DST, where panel review is not required. However, in cases requiring Joint Agency Verification Panel, there will be a maximum of 5 working days between DST and a joint verification panel decision.
		5. Where an individual dies while awaiting a decision on NHS CHC eligibility and has been in receipt of care that could have been funded through the NHS, the process will be concluded to a final eligibility decision. Where no services have been received, the process concludes on notification of death and will not proceed to final decision.
		6. MDT recommendations will be accepted by the ICB unless there is a clear breach of process or lack /mismatch of evidence to support the recommendation made by the MDT.
		7. MDT recommendations requiring joint panel review include cases where the MDT has not agreed on the recommendation, where a recommendation for Joint Funding has been made following a ‘not eligible’ recommendation and those cases where there are elements of complexity that the MDT have agreed will require a joint panel to verify the recommendation. These cases will be ‘flagged’ by the MDT Coordinator on submission to the ICB, to ensure that they are included on the next scheduled joint verification panel meeting.
		8. Outcome letters advising the individual of the ICB or Multi-Agency CYPCC panel’s decision as to eligibility will be issued within 5 working days of verification of the MDT recommendation. Outcome letters contain the information relating to the decision and relevant dates of eligibility, information on how and by when to appeal against a decision and will be accompanied by a copy of the fully completed DST document.
		9. Regular quality audits are performed, with data and information routinely used to identify practitioners requiring targeted support to improve the quality of MDT assessments. There is an arrangement for reciprocal quality review of a sample of DSTs across the AACC Place-based teams to ensure consistency of the application of the PHN test, via Standardisation Meetings and sample audit.

### Funded Nursing Care (FNC)

* + 1. NHS FNC is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse.
		2. FNC can be awarded following full consideration for CHC, either via a negative Checklist and subsequent Nursing Needs Assessment, or via a full MDT eligibility assessment.
		3. For individuals who are NHS-funded via the Mental Health Act 1983, Section 117 aftercare arrangements, referrals will be redirected to the Individual Placements Team in the first instance, as the majority of need is more likely to focus on the individual’s mental health support needs. A Nursing Needs Assessment is sufficient to evidence general nursing needs outside the remit of the ongoing mental health funding, for both adults and children/young people.
		4. FNC can only be paid where the individual is resident in a care home with nursing, or for the physical health nursing element of a care package funded under Section 117 of the Mental Health Act (1983 & 2007) for a resident in a care home.
		5. FNC eligibility must in the main be assessed within two weeks of a care home notifying the AACC service of the individual’s admission / need for assessment. These referrals must be made via the electronic referral portal, to enable the countdown clock to be activated.
		6. The ICB has an integrated strategy and infrastructure which supports and manages individuals in Care Homes with Nursing. This operates via the Primary Care Networks (PCNs)and prevents deterioration and avoidable hospital admissions in line with the principles of 'Ageing Well', as outlined in the NHS Long Term Plan. There is evidence of improved outcomes through this strategy and the strategy is regularly reviewed.

### Fast Track (FT)

* + 1. The ICB recognises that applications for ‘Fast Track’ funding may be reflective of a failure in the early recognition of people approaching end of life and/or the commissioning of appropriate community services to support those needs. Such applications should be by exception and not the standard approach to requesting funding of care for people at end of life. The ICB will commission sufficient provider capacity in the community to proactively identify and support most people who are in their last year of life, to ensure that the required care and support is put in place and contingency / deterioration plans are in place, thus reducing the need for FT funding applications, except in exceptional circumstances.
		2. FT applications will only be made for any age individuals who are rapidly deteriorating and may be entering the terminal stage of their life-limiting condition. The referral will be accepted from an appropriate registered healthcare professional (Doctor or Registered Nurse), via the electronic referral portal and must be accompanied by sufficient evidence to support immediate decision-making. It is expected that minimum evidence will include a prescription for anticipatory medications and (for adults only) a correctly completed ‘Do not attempt resuscitation’ (DNAR) document.
		3. The AACC service will source and commission a package of care to meet the individual’s identified needs without delay, prioritising such cases over standard brokerage/commissioning activity.
		4. Clinicians making referral via a FT application must explain to the individual / their representative that their needs will be subject to periodic review and that the funding stream may change following such a review. FT funding cannot be removed without a formal review process taking place.
		5. Receipt of a FT application will be recorded in the case management system, with formal recording of the outcome of the application and appropriate adjustment of the record to reflect the contemporaneous pathway stage and decisions reached. Regular quality audits are performed, with data and information routinely used to identify practitioners and/or organisations requiring targeted support to improve the quality of FT referrals.

### Personal Health Budgets

* + 1. PHBs are the default mechanism for delivering AACC domiciliary care packages and can also be considered with the individual and family for any other care setting.
		2. There is a well-established local PHB offer for AACC that is supported by the local health and social care system, with an over-arching ICB PHB Policy (Personal Health Budgets: Ethos, Practice and Guidance Policy) and comprehensive information available for people and families on the ICB website and in paper form on request. Please refer to that policy for further detail on the PHB process.
		3. There are clear, well documented and comprehensive PHB processes in place, with detailed guidance and support available to aid practitioners with all parts of the process, including routine and complex decision making and providing timely, person-centred advice; this includes access to expert points of contact within the ICB and in third party PHB providers.
		4. All front-line AACC staff will have the skills, confidence and resilience to manage complex cases and decisions and to deliver PHBs in a timely and sustainable way. All staff members have access to training and senior support and where necessary have a clear competency and development plan in place which is reviewed regularly. Progressive integrated training will be in place for continuing learning and development of PHB practitioners, with active tracking of staff progression against the skills matrix (Novice to Expert). The AACC service will require the same level of training and competency in external practitioners, where services are outsourced. The AACC service can provide mentoring and support to other ICBs and LA colleagues.
		5. The AACC service will ensure consistency, equity and transparency in how PHBs are offered to all those eligible for AACC funded home care packages. A calculator tool will be used to calculate the indicative (‘notional’) budget for all delivery methods of PHB, based on the care and support plan and advised to the individual. The individual is given a designated point of contact throughout the PHB setup process.
		6. Guidance and Policy on PHBs is regularly reviewed and updated and regular quality assurance/independent reviews are in place.
		7. The AACC service will engage collectively with individual forums or networks in relation to PHBs.
		8. The AACC service will have a focus on proactive management of clinical and financial risks in PHBs, with strong governance in place. Financial audits and clinical reviews are carried out in line with assessed risk. There is timely clawback of underspent budgets and payments that are not in line with agreed personalised care and support plans.

### Brokerage and commissioning

* + 1. The AACC service will operate a clear policy to support practitioners when determining an individual’s care package and placement. The policy allows for exceptionality and provides clear and concise practice guidance. Exceptional decisions outside of the standard brokerage and commissioning arrangements are clearly recorded for the audit trail on the electronic case management system.
		2. Provision of a care package to meet the specified outcomes for the individual and support them to achieve their potential should occur as soon as possible after the eligibility decision is verified. Individuals and families should be kept appraised of progress, anticipated timelines and any delays should be promptly notified.
		3. Clinicians in the AACC service will determine, in partnership with the individual and family, the best option for placement or domiciliary care provision, dependent on level of needs and associated risk. Sensitive conversations may be required to ensure that choices made reflect the assessed clinical needs and risks as well as the equity (considering the entire cohort of NHS-funded individuals) and sustainability of the requested care package.
		4. Individuals and family members are made aware of all available options for placements or home care providers. Where possible, individuals / families will be encouraged to visit care homes and to meet with representatives of proposed domiciliary care providers ahead of making a decision.
		5. CYPCC case funding arrangements will be agreed via a Multiagency panel (held at least monthly) comprising representatives from Health, Social care and Education. Assessed recommendations and respective costed care package options are presented and considered to determine an appropriate multi-agency package of support.
		6. The fundamental principle for agreeing a CYPCC care package is the full participation of the parent/carer and the individual at all times. This includes involvement in recruitment and appropriate training to ensure the package can be safely and sustainably implemented. However, where engagement is of concern, this will not prevent appropriate risk assessments etc from being undertaken to identify a safe and sustainable offer and/or to ensure safety in cases where a package of care is declined.
		7. Individuals and families are made aware of their rights to have care (and accommodation in a care home) fully funded by the NHS if eligible for CHC. ‘Lifestyle choice’ charges levied by care homes for additional services that are outside of an individual’s assessed care and accommodation needs will not be funded by the ICB. However, where it is not possible to separately identify the cost of specific additional services provided by a care home that are over and above what is required to meet the individual’s care and accommodation needs, the ICB will pay the full fee.
		8. Care homes are expected to gain consent to share information with the AACC service, relating to additional charges applied to any individual who is fully funded under CHC (not FNC). While such arrangements are private between the home and the individual, transparency is required in order for the service to ensure that the ICB is fulfilling its legal duty to fund for all assessed care needs.
		9. A list of negotiated prices for standard care home placements will be issued to brokerage staff (and acute hospital Integrated Discharge Teams who are commissioning care packages for Discharge to Assess), with a clear priority order for seeking placements. All placement costings provided by care homes must have a complete and transparent breakdown of all costs.
		10. Providers who are contracted with the ICB and LA on the Integrated Residential and Nursing (IRN) Framework (Essex County Council and partner organisations) will be prioritised. While priority is based on placement cost, packages will not necessarily be commissioned in order of least expensive first, as the provider must have capacity, be registered for and able to meet the needs of the individual.
		11. For ‘out of area’ placements in care homes, the AACC service will contact the ICB in the locality of the proposed placement, to check for the locally agreed costing for the placement, against which the cost will be negotiated, and any quality assurance concerns that may be known. Where there are known quality / safeguarding issues, the decision to commission a placement in that home will be escalated to senior management for decision.
		12. For specialist placements, close liaison with other ICBs and LAs is necessary, to ensure that pricing remains consistent, regardless of the commissioning organisation.
		13. Where an individual already in receipt of a care package or Personal Budget funded by social care or jointly with the NHS becomes fully eligible for CHC, the AACC service will seek to take over the package in situ. This maintains service continuity for the individual. However, this is on the proviso that the package remains appropriate to safely meet the individual’s assessed needs and that the provider is registered with the CQC.
		14. A calculator tool will be used to calculate the costs of delivery of domiciliary care packages, where the ICB is the commissioner. The prices in the calculator tool will be based on the agreed (and annually uplifted) domiciliary care rates for the providers on the ICB’s domiciliary provider framework and will be used to negotiate prices where an ‘off-framework’ provider is used.
		15. A Financial Authorisation Process (FAP) will be implemented:
* For all cases where care provision is proposed to be delivered by any provider not on a pre-approved care home or domiciliary care Framework or pre-negotiated pricing list, or where a provider on those lists requests a different price for the care package than those pre-agreed costings
* Where enhanced care support is also to be commissioned in excess of a standard package of care
* To agree notional budgets for PHBs
* To provide a comparative costing between the cost of providing a person’s care at home or in a care placement, to facilitate equity and choice decisions
	+ 1. Financial authorisation by a senior manager will be required in all cases as above, following agreement by the Clinical Lead Nurse (or designated deputy) of the clinical suitability of the proposed care location.
		2. Where an individual found eligible for AACC is in receipt of a legal medical negligence or accident claim settlement, which may cover a proportion or all of their ongoing needs as a result of this mechanism of injury, it is appropriate for the ICB to request information relating to that judgement and the terms of the settlement, though not the amount of the compensation. This is to ensure that the NHS does not double-fund any individual.
		3. The AACC service has a dedicated brokerage team in place, with the appropriate skill mix and is staffed at an appropriate scale for the volume of care packages requiring brokering. The brokerage team is able to negotiate and influence suppliers to achieve best value, brokering placements in a timely way that matches the level of need and provides value for money. The team is resourced to be able to balance urgent requests and to manage and mitigate out of area placements.
		4. Ongoing online and other formats for training on resilience, negotiation and market management is provided for brokerage staff and refreshed on a regular basis.
		5. A clearly defined operating model is in place, with the brokerage team actively supporting and inputting into market management, shaping, sustainability and strategic commissioning. The model includes a future state vision and roadmap to full integration with LA partners, using the latest available market intelligence and joint working with LAs and other partners, in benchmarking, negotiating and contracting for best value in commissioning care provision.
		6. Governance is in place and is actively used to ensure brokerage of all placements is in line with market management strategy and represents value for money. The multidisciplinary AACC team actively supports its brokerage team to identify viable placement options to meet complex care needs.
		7. Where more than one provider is commissioned to provide elements of a single care package, clear governance arrangements must be put in place, identifying one provider as the ‘lead provider’.
		8. Comprehensive provider information is actively maintained and readily accessible. It is available in real time and is shared with the Local Authority, via the joint health and social care nursing & residential home and domiciliary care provider monitoring hubs. Provider information is actively used to inform all placement and commissioning decisions which is shared with the Providers to aid Market development.
		9. All commissioned providers are required to have CQC registration. This requirement extends to any sub-contracting arrangements that providers may make with other agencies to fulfil care packages. For example, engaging staff via an agency that is not registered with the CQC to work in a care home or on a domiciliary care package is not supported by the ICB.
		10. New providers that have registered with but have not yet been inspected by the Care Quality Commission (CQC) may be commissioned to provide care, with appropriate assurance in place from local intelligence such as assurance of no substantiated safeguarding referrals received by the LA for that provider, and/or quality assurance visits by the ICB or LA quality teams.
		11. Providers with a CQC rating of ‘Inadequate’ overall will not be used by the service until re-inspected and the rating increased. Where a provider is rated ‘Inadequate’ in one or more of the 5 CQC inspection domains, but is not rated ‘Inadequate’ overall, the ICB may use the provider at its discretion, incorporating local intelligence for assurance in that domain and only when CQC have advised the ICB that agreed remedial plans have been completed to their satisfaction.
		12. Where a provider has an overall CQC rating of ‘Inadequate’, the AACC service will advise any individual who is in receipt of care from that provider and offer the option to change provider if they so wish.
		13. A funding agreement is issued for care provider agreement and signature following completion of negotiation and brokerage of a care package. The agreement specifies the exact service to be delivered and is accompanied by a service specification and contract. For domiciliary care packages, the number of staff, the level of need tariff and the timing of carer shifts and drop-in visits will be specified in the funding agreement.
		14. A Home Agreement will be provided for individuals and their family to define expectations of the support delivered by domiciliary care working in their home or community.
		15. For all packages and placements, an NHS Contract or Joint Health and Social Care Framework Contract (Section 75 agreement) will be in place, with clear KPIs and performance reporting that is monitored via submission of assurance information and, where necessary, contractual meetings with the Provider.

### Equity & Choice

* + 1. The ICB has a duty to meet the healthcare needs of an individual, whilst considering the best use of resources for the population it serves. Care options will be considered to meet the assessed health needs of an individual who is eligible for health funding and the ICB will always consider the most cost-effective option to meet the individual’s needs, taking into account the safety, welfare and any potential risks to the funded individual or others and care providers in the care commissioned.
		2. Equality of individuals will be upheld and any agreements will not be discriminatory.
		3. Personalisation and choice are central to decision making once the other principles above have been assured. The process of assessment and decision making should be person-centred, with the individual, their perception of their support needs and their preferred models of support at the heart of the process. The individual’s wishes and expectations of how and where the care is delivered should be documented and taken into account, along with the risks of different types of provision and access to resources.
		4. The ICB will take into consideration an individual’s views and preferences, including those relating to cultural/religious beliefs. However, there may be situations where an individual’s choice cannot be agreed or met.
		5. AACC can be provided in any setting. Where an adult is living in their own home, it means that the NHS funds all the care and support that is required to meet their assessed health and care needs. Such care may be provided either within or outside the person’s home, and includes primary healthcare and community nursing services, as appropriate to their assessment and care plan. For CYPCC health and care support may be funded by health in partnership with Social care and/or education.
		6. Where an individual has been assessed as needing a nursing home placement the ICB will work with the individual /representative to identify a choice (where possible) of suitable placements (Section 6.17).
		7. For CHC individuals living in care homes (residential or nursing), the NHS makes a contract with the care home and pays the full fees for the person’s accommodation, board and care.
		8. Where an individual wishes to complement any NHS-funded care package with any privately commissioned service to meet their personal preferences, they are at liberty to do so. However, such private arrangements are expected to be entirely separate from the NHS-funded package of care. (Section 6.17).
		9. The ICB will establish a preferred provider framework for care homes and for domiciliary care agencies, with assessed quality standards and agreed pricing parameters. All providers will have had equal opportunity to join these frameworks and those providers will be given preference when the ICB is seeking care packages. Individuals will be offered a choice of provider from the established frameworks, provided those providers can meet their assessed needs and personal preferences.
		10. The ICB may consider care provision outside of the preferred provider framework, however there may be significant cost differences in providing care in different care settings. The ICB will not commission care from any provider who does not meet the agreed quality specification for care delivery or where safeguarding concerns have been substantiated and/or embargoes are in place.
		11. When identifying appropriate care provision, the ICB will, by exercising clinical judgment, consider what is the safest option for the individual within the resources available to them. Any assessment of a care option will include the psychological and social care needs and the impact on the home and family life as well as the individual’s care needs. The outcome of this assessment will be taken into account in arriving at a decision.
		12. In instances where more than one clinically effective care option is available the ICB will consider the total cost of each package. Wherever possible the ICB will support the individual’s preferred place of care within available resources.
		13. For highly complex or specialist care packages the ICB will apply the core care package costs agreed with the preferred provider framework and the brokerage team will liaise with care providers as required regarding negotiation of costs for meeting needs in excess of a standard care package.
		14. Many individuals wish to be cared for in their own homes rather than in care homes, especially people who are in the terminal stages of illness. The individual’s choice of care setting should be taken into account, but there is no automatic right to an NHS-funded package of care at home. The option of a package of care at home will be considered after taking into account the level of risk associated with such an arrangement and the equity and sustainability of providing a care package that fully mitigates those identified risks.
		15. Individuals who are eligible for CHC have a complexity, intensity and/or unpredictability in their overall care needs which may mean it is difficult for care to be safely delivered at home. The ICB will consider if care can be delivered safely to the individual and without undue risk to the individual, carers, staff or other members of the household (including children) and property.
		16. Safety will be determined by risk assessment to include contingency planning, which will include the availability of equipment, the appropriateness of the physical environment and the availability of appropriately trained care staff and/or other staff to deliver the care at the intensity and frequency required.
		17. The following should be considered before the ICB agree to commission a package of care in the individuals own home:
* Parental responsibility for young people under 18 years of age
* The individual’s current and likely future needs
* The individual’s GP agrees to provide primary care support
* The suitability and availability of alternative care options
* The cost of the package required to meet the assessed needs and the relative costs of providing the package of choice considered against the relative benefit to the individual
* The psychological, social and physical impact on the individual
	+ 1. The ICB considers that in some circumstances an individual’s needs would most appropriately be met within a care home/residential/educational setting. The ICB will take into consideration all relevant circumstances, such as particularly high levels of care and supervision, or the need for the direct oversight of care by a Registered Nurse.
		2. In the event that the ICB considers that the safety of any member of its staff or any staff contracted to provide the care is at risk it shall take such action as it considers appropriate. Harassment or bullying, verbal or physical abuse of care workers will be neither condoned nor accepted and the ICB will take any action necessary including immediate withdrawal of services. Where, in exceptional circumstances it is necessary to withdraw services, the ICB will urgently consider how else (if at all) services can be offered.
		3. Respite care, defined as the provision of short-term, temporary relief to those who are caring for family members, who might otherwise require permanent placement in a facility outside of the home, by replacing that care with a temporarily commissioned care package. Respite can be arranged, with suitable notice to the AACC service. Respite may be arranged for the individual in a placement if this is deemed the safest option, through a temporary enhancement to the home care package, or in another suitable setting. Respite can be arranged for a maximum of 28 days per annum per case, unless agreed by exception.
		4. Holidays and overnight trips away from the usual place of care are not funded in addition to care commissioned directly by the ICB. The continuation of a care package in a temporary alternative setting may be facilitated where the care provider is willing to do so and the eligible individual funds all additional expenses associated with subsistence and accommodation for their carers. Families/friends may wish to take over provision of care to facilitate a holiday away from the usual place of care delivery and, provided this is a safe arrangement, is permissible. It should also be noted that directly commissioned AACC funding is not provided outside of the UK, although an individual with a third party or Direct Payment PHB arrangement may utilise the flexibility allowed by this funding stream to personalise their care arrangements to meet their health outcomes, which may include a holiday abroad.
		5. CYPCC, in partnership with education, may consider joint funding of support in school where complexity of need and training indicates the need for support. For example: a child who is tracheostomy ventilated.
		6. In the event that an individual who was previously funded by social services becomes eligible for NHS CHC funding, the ICB will seek to provide this care with the least disruption to the individual. This may include taking over funding of the in-situ care package. However, it is likely that this transition of funding stream from social to health funding is due to an increase of need and provision and as such, the ICB may consider that these needs cannot be met safely, or that the costs of continuing to meet these needs are excessive and inequitable in relation to other packages of care.
		7. Where an individual who is currently receiving a domiciliary care package has been assessed and it is deemed that their care needs have changed, the ICB will consider whether the current care package remains appropriate. Where the ICB deems that the current care package is not appropriate and does not approve an amended domiciliary care package, the individual will be offered an alternative care package approved by the ICB.
		8. The ICB will consider that it is a refusal of NHS-funded services where the ICB has offered the individual what it considers is an appropriate care package to meet the individual’s assessed needs and this is not accepted by the individual or their representative (including cases where the individual has requested a particular package and the ICB has taken a decision that the package will not be commissioned but has offered an alternative package of care).
		9. The ICB will work with the individual to establish a final offer. If this is declined, the ICB will formally write to the individual offering the care package. If there is no response after 14 days, a further letter will give 28 days’ notice of withdrawal of the offer of funding.
		10. An individual retains the right to decline NHS services and make their own private arrangements. However. if an individual chooses to decline support from CHC, they should be advised to not do so in the belief that they will obtain services from the Local Authority.

### Safe and supportive observations

* + 1. A number of service users, such as the vulnerable older person, those at risk of extending physical injury, people with cerebral injury, learning disabilities, children and/or those lacking the mental capacity to support safe decision making, may require enhanced levels of observations and support.
		2. Supportive observations are there to ensure the safe and sensitive monitoring of the service user’s physical and psychological well-being. This monitoring should support staff members to quickly identify changes in the service user’s condition and/or well-being to enable a rapid and appropriate response to minimise the risks or potential harm to self or others.
		3. Supportive observations should be always be set at the least restrictive level, this includes for the least amount of time, within the least restrictive environment. Regular review and early reduction in restrictive practices is the expected approach.
		4. The Standing Nursing & Midwifery Advisory Committee (SNMAC) Proactive guidance on the Safe and Supportive observation of Individuals at risk (1999) recommends four levels of observation to be adopted throughout provision of NHS care to ensure consistent practice. This methodology is adopted by the ICB.
		5. This guidance relates to individuals who are 18 and over. For CYPCC all domiciliary packages are delivered as Close Supportive Observation (Level 4) unless exceptionality is determined. Safe and supportive observations within Residential and/or residential school placements are based on bespoke need and robust individual risk assessments.
		6. General Observations (Level 1) this is the minimum acceptable level of observation for any and all service users. The location of all service users should be known to staff at all times, but not all service users need to be kept within sight. At least once every shift a nurse /senior staff member/named carer should sit down and talk with each service user to assess their health and wellbeing revising care plans as appropriate This must always be recorded in the service user’s care notes.
		7. Intermittent Supportive Observations (Level 2) sometime referred to as “Intentional Care Rounding” a system of delivering supportive care to the most vulnerable people in a residential/nursing setting. The identified vulnerable group defined as a “cohort” and assessed as requiring an increased level of observation to minimise risk and harm. The aim of this level of supportive observation is to ensure that those who need regular help and support are provided with a routine where help and care is provided. Ensuring that person centred care is delivered as part of the unit’s routine to all vulnerable people all of the time. Intentional care rounds/rounding provide assurance, prompts, and fundamental care, ensuring early response to change in condition whilst promoting independence and maintaining safety.
		8. Level 2 observations should be implemented for all who have triggered a multi factorial falls assessment/care plan and those considered to be potentially, but not immediately, at risk to themselves or others.
		9. The frequency of observations must be clearly documented in the care plan and reviewed/evaluated daily. Timed interventions must be recorded on appropriate assessment, care and activity charts.
		10. Continual Supportive Observations (Level 3) is required where individuals could, at any time, make an attempt to harm themselves or others. The individual must be kept continuously within line of sight of a designated carer.
		11. A continual supportive observation care plan (Level 3) should be developed and activated and a continual supportive observation chart which should be used to record all incidents and the required interventions undertaken by those providing the continual supportive observations.
		12. Close Supportive Observation (Level 4) refers to a carer being continuously within arm’s length of an individual who is at the highest level of risk of harming themselves or others and may need to be nursed in close proximity due to the frequency or level of risk. On rare occasions more than one carer may be necessary. Consideration should be given to privacy, dignity and gender of the person for whom close supportive observation is being provided.
		13. Staff allocation and environmental dangers need to be discussed and incorporated into the care plan. A close supportive observation care plan (Level 4) should be developed and initiated and a close supportive observation chart which should be used to record all incidents and the required interventions undertaken by those providing the close supportive observation.
		14. Within the domiciliary care setting, most support is arranged on a 1 to 1 or greater staff to individual ratio. This is not deemed to be Level 3 or 4 (as described above), for the purposes of this policy. Only where it is specified in the commissioning of a domiciliary care package that enhanced care and support is required at a level in excess of general observations / Level 1, is this aspect of policy to be implemented for home care.
		15. Some providers may utilise other frequencies and approaches to supportive observations, such as Level 2 implemented as ’15-minute observations / 4 times per hour’. This is discretionary and must be accompanied by evidence to support this approach. The AACC service will only additionally fund a provider for observations at Level 3 and 4.
		16. The decision to implement supportive observations should only be made following a holistic / risk and multidisciplinary assessment of the service user’s physical and psychological state and mental health together with social and environmental factors at that moment in time based on contextualised needs.
		17. The decision to initiate supportive observation should be established through assessed need with required level and rationale for the level of care and frequency of review/evaluation clearly documented in the service user’s notes.
		18. Service users / relatives (as appropriate) are to be informed of the rationale for supportive observation, the level and procedures. A clear and open dialogue must take place regarding the reason for increasing the level of observation. The service user must be offered the opportunity to discuss their views and/or concerns and to involve a carer/relative/advocate in these discussions should they wish. The service user’s thoughts, feelings and wishes with regard to self–harm, risk of falls or harm to others must be approached using direct and respectful questions. This dialogue must be followed up in writing to both service user and carer/relative and recorded in the service users notes.
		19. Whilst the decision to implement supportive observation must be made by the multidisciplinary team, in situations where prompt action is required, the nurse in charge or unit manager can implement a heightened level of observation, ideally in discussion with another registered nurse or on call manager.
		20. If at any point following a decision to implement Level 3 or 4 supportive observation, this level of supportive observation cannot be provided, this must be appropriately reported through incident reporting and mitigated as soon as practicable.
		21. The Nurse/Unit Manager in-charge must contact the AACC service as soon as possible (within 24 hours or next working day if out of hours) informing them of the decision to provide supportive observation and providing copies all documentation to enable the service to formally validate the decision and determine the method and length of the commissioning of this level of observations.
		22. Where observations are implemented due to mental health/behavioural issues, Psychiatric Liaison Services should also be contacted as soon as possible, requesting support/assessment.
		23. Use of assistive technology where appropriate is encouraged and should be implemented where possible as least restrictive option. This includes apnoea, epilepsy and other movement sensor alarms that could allow for a lesser degree of direct observation but still enable monitoring and facility to provide direct support as required. Audio and /or video monitoring may be authorised with explicit multidisciplinary decision and risk assessment and clear parameters to ensure privacy and dignity is maintained. Video monitoring as an alternative to 1 to 1 observation is not authorised for use in under 18s.
		24. Assessment of the need for overnight supportive observation and the level required must be clearly documented.
		25. Review of requirement to continue supportive observations (day or night) and what level must be undertaken on a daily basis and documented in the service user’s notes. The AACC service, in collaboration with the multidisciplinary team and any specialist service involved in supporting the behaviours and risks leading to the requirement for supportive observations, should undertake review at planned intervals. Review should consider the need to curtail, reduce, maintain or increase the supportive observation plans. All appropriate documentation to be revised and recorded within the service user’s notes.
		26. The nurse/care manager in charge will allocate staff who have been deemed competent to carry out the required level of supportive observation. Identified staff are required to be familiar with the service user’s care plan, environment needs and any potential and actual risk. All staff must provide and receive a thorough handover at change of shift, including the current risk factors and level of risk either to the person, others or environment. The length of time any one member of staff may provide supportive observation to a service user also needs to be specified within the risk assessment/care plan.
		27. The member of staff allocated to carry out supportive observations should spend time building a therapeutic relationship with the service user. Observations should be supportive and therapeutic in nature and call for empathy, engagement, taking notes of the service user’s needs, and a readiness to act and recognise the need for escalation/de-escalation as necessary.
		28. The nurse/care manager in charge should ensure the whereabouts and well-being of staff carrying out level 3 and 4 (continual or close supportive observation) is known to him or her during each shift. Individual members of staff should take personal responsibility for informing the Nurse/Manager in charge of any change in their whereabouts, assistive technology may be required
		29. Supportive observation must be maintained during visits from, relatives, carers and friends. Different levels of observations can be implemented during visits if thorough risk assessments and discussions have occurred and are documented in the service user’s notes. This documentation must include when the levels of supportive observation is increased, reduced, time periods and rationale.
		30. Staff must, as far as possible, ensure the privacy, dignity, cultural, religious belief and gender specific needs of the service user are maintained during supportive observation. However, at times when the level of risk supersedes these issues, this must be clearly explained to the service user and documented.
		31. All AACC providers must have policy that reinforces positive behaviour and least restrictive approach in the management of violence and aggression and this must be adhered to at all times where there is a clear threat to harm self or others.
		32. Implementation of Level 3 or 4 supportive observations for an adult over 18 years will require consideration of DoLS (Section 6.10).
		33. Details of the individuals responsible for agreement to change level of supportive observation will be agreed and included in the supportive observation care plan, including out of hours process.
		34. Review of the level of observations for any service user must be reviewed on an ongoing basis, at a minimum daily, and preferably at the end of each shift by the individual in charge.
		35. The ICB will provide authorisation for supportive observation only where there is a clearly documented clinical rationale supported by appropriate risk assessments. Assessments and requests should be individual, time and environment specific. Contracts will be issued, specific to the assessed level of supportive observation requirement and separate to the core service contract cost.
		36. The ICB will provide funding to cover the additional observation and support hours identified within the risk assessment up to a maximum of 20 hours per day in nursing and residential care settings. The expectation is that each service user has 4 hours of direct (one to one) care already provided and commissioned within the contract for core services.
		37. The ICB will not provide payment for any care for which there is no agreed, evidenced clinical rationale and/or where the provider has no written authorisation/contract specifically relating to the supportive observations.
		38. To facilitate payment of invoices, copies of supportive observation charts, care plans and any other additional validation information must be provided to the AACC service on request, including staff timesheets and daily staff rotas.
		39. Requests from family members/representatives to initiate or continue supportive observation where there is no clinical rationale will not be authorised and invoices will not be paid. Families, however, are at liberty to make private contractual arrangements with the care provider for interventions and care outside of the assessed clinical need as indicated within the service users care plan. It must not, however, include or overlap any core services/costs funded under contract by the ICB.

### Review and Case Management

* + 1. A named Case Manager will be assigned to each AACC eligible case and their contact details shared with the individual / representative. Case manager details will be recorded on the individual record on the case management system. The best means by which to contact case managers will be agreed with the individual/family; however, in order to triage and appropriately respond to case management needs, individuals who are able to will be asked to communicate with their assigned case manager predominantly by email unless there is an immediate safety risk. Individuals will be advised that the generic AACC team inbox address should be cc’d to all incoming communications, to ensure timely redirection and response to case management issues that may arise in the absence of the named case manager.
		2. The service lead is responsible for allocating and rotating case management responsibilities where required, ensuring that individuals / representatives are kept informed of changes.
		3. Reviews are undertaken at 3 months following a new decision on eligibility and at 12 monthly intervals thereafter, with facility for additional reviews to take place at any stage where it is evident to that a review is required, or on request from individuals and families.
		4. Where an individual is funded under ‘Fast track’ arrangements, the review may identify that they are no longer rapidly deteriorating. In cases where the individual is improving, it is appropriate to recommend a full eligibility assessment to take place. However, if there is reasonable clinical judgement that the individual may again rapidly deteriorate in the near future, the assessor is able to recommend extension of the FT funding for a further 12 weeks, when a further review will take place.
		5. Proactive case management of AACC eligible individuals will enable review to be undertaken efficiently via regular reviews of care provision in meeting assessed needs and safety of the commissioned care plans, in accordance with the National Frameworks.
		6. Reviews are prioritised using risk stratification, with Safeguarding always taking priority. Ongoing case management will enable continual review of risk factors and re-prioritisation according to triage.
		7. AACC individual files, previous DSTs, supporting evidence, current contract and provision cost is available within the ICBs case management system. This information is accessible by all relevant practitioners and is proactively used within reviews and referred to if reassessment is required.
		8. Re-assessment of eligibility following review is triggered by material changes in care needs being identified against the established care plan, indicating that a full assessment is required. Non-material changes, which may require adjustment of the commissioned care plan, but not a return to full eligibility assessment, are facilitated through case management.
		9. Care provision is adjusted in line with the outcome of the care review, with due consideration given to whether the change may impact on the equity, safety and sustainability of the package of care.
		10. Reassessment of eligibility without a change in need should not be a routine practice. However, it may be agreed by exception between health and social care partners that there are concerns about the current eligibility status and a full assessment may be required to confirm eligibility status. Clear and agreed processes are in place to jointly undertake reassessment of eligibility.
		11. The individual and family will be fully informed and engaged in the process of reviews of care provision and are informed of the outcome of the review and supported to understand reasons for and implications of any need for reassessment. Communication must be clear and transparent. The AACC service aim is to have no formal complaints relating to reviews.
		12. Review outcomes will be clearly documented, with supporting evidence, in the case management system. Clear documentation will be recorded relating to any change in need and subsequent changes to the care plan.
		13. There is an agreed process in place for the transfer of responsibility between the ICB and LAs, where individuals are stepped up / down from social care into healthcare and vice versa. The process is comprehensive, widely understood and accepted practice, followed appropriately and reviewed at regular intervals.
		14. AACC practitioners are well supported and never feel influenced by internal or external stakeholders when reviewing eligibility and care plans. This is particularly important when stepping down packages of care where appropriate.

### Requests for reviews of eligibility decisions

* + 1. Appeals against a negative screening Checklist for the AACC service can only be made via a formal complaint to the ICB, with regard to the process undertaken to reach the decision. If the ICB’s response to the complaint is felt to not have resolved the issue, the complainant is able to approach the Parliamentary and Health Services Ombudsman (PHSO) with their complaint. Signposting to the PHSO is always included in complaint responses.
		2. Appeals against a negative screening Checklist may trigger contact from a Clinical Manager and relevant key partners, aimed at resolving concerns via informal clarification conversations regarding the decision-making process.
		3. Where a child/young person and their family have a dispute over an Education, Health and Care Plan, the AACC service may be required to provide appropriate representation. This should be in line with the respective SEND mediation Pathway.
		4. Requests for reviews of eligibility decisions from full assessment processes will be invited via the outcome letter following a full assessment for AACC funding eligibility. Individuals / families are given 6 months from the date of the outcome letter to notify the AACC service of their intention to appeal the decision.
		5. Reasons to appeal may include:
* The appellant does not agree that the correct recommendation on CHC funding eligibility was made following the Decision Support Tool meeting.
* The appellant does not consider the process followed, to be in accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in place at the time of DST.
* The appellant suspects that crucial evidence/information was incorrect, missing or not considered at the time of the Decision Support Tool meeting.
* The appellant does not agree with the verification process followed and feel the original eligibility decision was overturned without discussion with the MDT.
	+ 1. The AACC service will acknowledge the request for a review of the decision regarding a full eligibility assessment decision, within 5 working days, providing clear and timely communication and explanation of the process to the individual requesting the review.
		2. The AACC service aims to undertake all requested reviews of eligibility decisions within a maximum of 3 months from the date of receipt of the request. The ICB will prioritise those individuals currently in receipt of care.
		3. A key principle of local resolution is that the ICB does not change its decision and that the individual / representative has had a clear explanation of the rationale for the ICB’s decision. It is the expectation that the vast majority of requests for review of eligibility decisions are resolved locally and not taken forward to IRP or the PHSO.
		4. The purpose of the Local Resolution Meeting is:
* To discuss the appeal and the content of the decision support tool.
* To discuss how the decision on CHC funding eligibility was met.
* For the Chair of the LRM to provide clarification on anything not understood regarding the process.
* For the appellant to provide additional evidence to be considered at the next stage.
	+ 1. For CHC, all individuals requesting a review will initially be offered an informal local resolution meeting (LRM) within 28 days of making their request. The invitation letter will advise of the process of the LRM. This meeting will follow the guidance of the Local Resolution Best Practice Guidance: NHS Continuing Healthcare (NHSE & NHS Improvement, March 2021) and consider:
* Levels of need in disputed care domains
* Application of the Primary Health Needs Test (CHC only)
* Any concerns relating to the process
	+ 1. In some CHC cases, such as those with a legal representative making the appeal, an informal LRM may not be beneficial to resolving issues and the decision of the ICB may be to offer a formal Local Appeal Panel (LAP) as first option.
		2. Prior to the LRM, all attendees will be provided with the original DST and an electronic file containing all evidence used to make the original eligibility decision. The evidence file will meet the requirements for an NHS England IRP (CHC). This will enable a swift pathway to any further review panels that may be required / desired.
		3. The LRM will be held with a CHC or CYPCC Clinical Manager (as appropriate) who was not involved in the original decision and an AACC administrator, with the aim for the individual to:
* Receive clarification of anything that they have not understood;
* Have an explanation of how the MDT/Clinical Manager arrived at the recommendation of ‘not eligible' using as a reference the evidence used to complete the DST and the 4-part PHN test (CHC only);
* Describe additional information that has not been obtained by the MDT/Clinical Manager that the individual believe needs to be considered; and
* Describe additional information that was available to the MDT/Clinical Manager that the individual believes was not given due consideration.
	+ 1. At the conclusion of the LRM, the Clinical Manager conducting the meeting will summarise the findings of the meeting and determine if the appellant is satisfied with the explanations given.
		2. Minutes will be taken for the informal LRM. Minutes will not be verbatim, but a summary of the conversations. Meetings may be recorded for the purposes of producing accurate minutes. Recordings and transcripts are taken for accuracy only and will be deleted following the agreement by all parties that the minutes reflect the content of the meeting.
		3. In cases where the appellant has identified evidence that had not been considered in the full assessment process, or where the correct assessment process has not been followed, by the original MDT/Clinical Manager, the Chair may recommend that the full assessment process is repeated, with a new MDT (or Clinical Manager in CYPCC cases)
		4. If the LRM does not find issue with process or evidence and the appellant is satisfied with the explanations given, the Clinical Manager will confirm the ICB’s decision and advise the appellant that the LRM outcome will be advised to them in writing.
		5. If the LRM for CHC does not find issue with process or evidence and the appellant is not satisfied with the explanations given, the Clinical Manager will confirm the ICB’s decision and advise the appellant that the next steps will be to set a date for a formal Local Resolution Meeting (known as a Local Appeal Panel – LAP).
		6. If the LRM for CYPCC does not find issue with process or evidence and the appellant is not satisfied with the explanations given, the Clinical Manager will confirm the ICB’s decision and advise the appellant that the next steps will be to make a formal complaint to the ICB. If still dissatisfied following a complaint investigation and response, the complainant is able to ask the PHSO to investigate and make a decision on whether or not the NHS carried out its decision-making process in line with established guidelines (the National Framework).
		7. The written summary of the discussion from the LRM will be sent within 5 working days and be accompanied by the minutes of the LRM. The letter will confirm the ICB’s decision and, where appropriate, invite the appellant to agree a date for the LAP.
		8. Invitation to the CHC LAP will contain detail of the Panel membership in terms of roles, not individuals’ names, as identities of representatives may change prior to the meeting date. The LAP members will not have been involved in the assessment/decision-making process of that particular case to ensure impartiality. The Panel comprises a Chair, who will be a senior clinical ICB manager (not necessarily from the AACC service), a clinical representative from the AACC service, a subject specialist (if relevant to the case), a Social Worker and an administrator. The appellant is invited to provide a written statement pertaining to their concerns.
		9. The LAP will be conducted in the same manner as an IRP:
* Introductions
* CHC case presenter invited to give a verbal summary portrait of the individual and relevant history to frame the case
* Appellant / representative invited to give a verbal summary portrait of the individual and relevant history to frame the case.
* All present will then collectively review each domain of the DST against the evidence and the level descriptors, allowing discussion and the opportunity for each attendee to provide their views, which will be recorded for the minutes. All agreements and disagreements will be documented for the meeting record.
* Following review of the DST, the appellant / family / representative will leave, after being advised of the next steps.
* The panel will undertake a new PHN test (CHC only) and agree a recommendation.
	+ 1. The decision of the LAP will be re-confirmed by letter to the individual / family / representative within 5 working days, along with the minutes of the meeting, which will be produced as for an LRM. The outcome letter will include information of how to make further appeal to a formal IRP.
		2. If agreement is not reached at the LAP, the outcome letter (which will be accompanied by a copy of the minutes of the LAP) will advise how to request a further review via NHS England’s IRP and subsequently to the PHSO if desired.

### Retrospective assessments (CHC only)

* + 1. Claims for retrospective assessment of eligibility for NHS CHC funding can no longer be made for any period of care prior to 31 March 2012.
		2. Any individual or their representative who believes that they should have been NHS CHC funded for a period of care that occurred from 1 April 2012 onwards can request a retrospective assessment of a Previously Unassessed Period of Care (PUPoC).
		3. Retrospective claims can only be made for a time period where there was no consideration of eligibility for CHC funding undertaken. Consideration of potential eligibility includes negative screening Checklists and Nursing Needs Assessments. The retrospective claim route cannot be used to challenge previous eligibility decisions.
		4. A request for a retrospective assessment will be acknowledged within 5 working days in writing and accompanied by information relating to the process that will be undertaken. This includes inviting a written submission from the individual / family.
		5. The AACC team will then seek appropriate consent to undertake a desktop assessment; a process of requesting, obtaining and collating all relevant care documentation evidence for the period(s) in question and presentation of this evidence in a Needs Portrayal Document (NPD), written by a Registered Nurse.
		6. NPD is not required where a request for a retrospective claim covers a period of up to three months prior to a DST decision. In such cases, the DST and evidence used to make the DST decision will be used to determine eligibility in that period.
		7. When prepared, the NPD will be considered by a senior AACC manager who has not previously been involved in the individual’s case. If there is sufficient evidence of eligibility, this will be awarded for the relevant period. If it is considered that there is no evidence to support eligibility, this will be verified via the weekly Joint Verification Panels (Section 6.11.2) with a senior social care professional and clinician.
		8. The ICB’s decision will be recorded in the case management system and communicated by letter, accompanied by the NPD. Information on how to appeal the decision will be included in the correspondence.

### Redress (CHC only)

* + 1. Where an individual is found eligible for a period of NHS CHC funding, whether retrospectively or contemporaneously, and has been in receipt of care during that time period, they are entitled to financial restitution.
		2. The ICB will invite applications for redress when a person has been found eligible for a period of NHS funding, and will resolve the claim and pay the redress with minimal delay. The aim is to pay the redress with 28 days of all required evidence to enable a decision on payment to be made, being received by the ICB.
		3. The ICB will consider applications for redress relating to care and support costs incurred in any setting, accommodation costs incurred in care homes and will give due consideration to other costs incurred on a case-by-case basis.
		4. Claimants will be advised of the process to be followed and the anticipated timescales for resolution and updated at any point a delay occurs in the redress pathway.
		5. Redress is about placing individuals in the position they would have been in had NHS Continuing Healthcare been awarded at the appropriate time and not about the NHS or the public profiting from public funds.
		6. The Retail Price Index will be used as the appropriate interest rate to apply to redress calculations of compound interest. The index is calculated monthly, with an average for each calendar year. The ICB will apply the average rate for the year for which care costs are being reimbursed.
		7. Individuals do not need to seek legal advice in order to request an assessment of eligibility for NHS Continuing Healthcare or a review of a decision on eligibility and therefore it is rarely appropriate to receive any refund of legal and professional costs.
		8. If an individual is dissatisfied with the ICB’s redress offer, they can pursue the matter via the ICB’s complaints process. However, the ICB should not delay payment in respect of undisputed elements.

### Initiation, Suspension and Cessation of funding

* + 1. CHC and FNC funding (and the health element of Joint Funding) for adult cases will commence on the 29th day from receipt of a positive Checklist, or the date of the DST, whichever is sooner.
		2. For CYPP, funding will commence upon panel agreement of the recommended package of care, with the aim of commencement at day 43.
		3. FT funding commences on the date of verification of the referral, on implementation of a home care package or on admission to a care home.
		4. Funding will be suspended in full or in part when an individual is not in receipt of the entirety or elements of their commissioned care package. The provider is responsible for informing the AACC service of any elements of a care package that are either temporarily suspended or no longer being delivered, within two working days of the change occurring. The suspension of the relevant proportion of the funding will be agreed between the provider and the AACC service.
		5. CHC, FT, FNC and the health element of Joint Funding (Section 6.27) payments will cease when an individual in receipt of that funding has been reviewed and is no longer assessed to have a Primary Health Need, Nursing Needs (in a nursing home placement), or the specific health need that is jointly funded with the LA, as applicable.
		6. Where no longer eligible for funding, the ICB will give notice of cessation of the funding to the individual, the care provider and to the LA of no less than 28 days from the date of the decision being notified in writing, to allow a safe transfer of responsibility.
		7. Where a CYPCC care package is to be removed, a planned withdrawal of care will be implemented, contingent on meeting clinical needs that may still be present. There is no set timeframe for cessation of funding; this will be negotiated to ensure a safe transfer of responsibility.
		8. In the event of the death of a funded individual, the ICB will fund a care home placement for a further two days after the date an individual dies, to allow time to clear belongings and prepare the accommodation for a further admission.
		9. Domiciliary care packages will cease 24 hours following the death of an individual in receipt of a home care package.
		10. FNC payments will cease on the date of death.
		11. FNC payments will cease when the individual has been admitted to hospital for 5 days and will resume on the date of discharge back to the care home.
		12. CHC-funded care home placements (including FTs) will cease at 28 days following admission to hospital, unless agreement is reached that the individual will return to the same placement on discharge, in which case a negotiated reduction of the full care package cost will apply until hospital discharge, when the full cost will be reinstated.
		13. There is no right to continued NHS funding while an appeal against a not eligible decision is pending. Redress may apply if the decision is later overturned (Section 6.23).
		14. Individuals and families should be signposted to local services that could provide support and advised of those core NHS services for which they are still eligible.

### Disputes with Local Authority

* + 1. The ICB has agreed a Disputes Policy with the relevant Local Authorities for AACC. This is a jointly agreed policy requiring governance approval from the health and social care bodies and will be published on the AACC service web pages.

### Transition from child to adult services

* + 1. Transition is recognised to be crucial stage for young people who have complex ongoing health needs and/or life-limiting conditions. Child and adult service provision is often very different and it can be a stressful time for families navigating the pathway.
		2. A key aim of transition is to ensure that a consistent package of support is provided during the years before and after the transition to adulthood. The nature of the package may change because the young person’s needs or circumstances change. However, it should not change simply because of the move from child to adult services or because of a change in the organisation with commissioning or funding responsibilities. Where change is necessary, it should be carried out in a planned manner, in full consultation with the young person and family. No services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place.
		3. Individual literature regarding transition will be developed and accessible to all, to promote autonomy in decision-making.
		4. All staff will be fully aware of the AACC transition pathway and work together to achieve a high-quality and safe transfer of responsibilities.
		5. In acknowledgement that the CYPCC threshold is set very high CHC will accept the CYPCC DST as the referral document in place of a checklist.
		6. The AACC service will ensure that it learns from the experience of families, staff and providers using a co-design, co-production approach to service development. Feedback/monitoring will be designed with the focus on improving individuals’ experience of transition.
		7. The AACC service will support the provider market to prepare for meeting the needs of young people with complex needs.
		8. The AACC service will adopt Key Performance Indicators (KPIs) for CYPCC transition:
* Evidence in the case management record of notification to CHC at 14 years of age for whom it is likely that adult NHS Continuing Healthcare will be necessary;
* Evidence of discussions around transition needs, linked to Year 9 Transition Planning and as part of the Education, Health and Care Planning (EHCP).
* Evidence of formal referral for screening for CHC at 16 years of age;
* At 16-17 years of age, there is agreement in principle at the CYPCC annual review that there is evidence of a primary health need;
* Eligibility for CHC is determined within 28 days after a young person’s 17th birthday.
	+ 1. Where a young person remains in Education beyond the age of 18 years, there should be continued partnership working to ensure the continued implementation of an individual’s EHCP with each partner contributing funding according to their statutory responsibilities.
		2. If a young person who receives CYPCC has been determined by the relevant NHS Commissioner not to be eligible for a package of CHC, the AACC service will continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care.
		3. The Children and Families Act (2014) requires a young person accessing education to have an Education, Health and Care Plan up until the age of 25 years where an individual needs more support than is available through special educational needs support. This change in practice requires partner agencies to acknowledge their continued responsibility for the extended transition period and require funding streams to continue. For example, where a young person at 18 has been assessed as eligible for CHC funding but is in receipt of education this remains a jointly funded care package thus should be noted as continuing care funded within adult services.
		4. Where a young person receives support via a placement outside the ICB’s boundaries, it is important that, at an early stage in the transition planning process, there is clear agreement between NHS Commissioners as to who the responsible commissioner presently is, and whether this could potentially change in accordance with NHS England’s ‘who Pays? Determining responsibility for NHS payments to providers’ (2020). All parties with current or future responsibilities should be actively represented in the transition planning process. A dispute or lack of clarity over commissioner responsibilities must not result in a lack of provision or risk an individual’s placement. Due consideration must be given by the ICB and LA where a child is ‘looked after‘ by the LA, to ensure appropriate placement and funding responsibilities.

### Joint Funding

* + 1. Where a joint or tripart care package is agreed for CYPCC a care package funding agreement is signed by all parties following award of the commissioned care package and a lead commissioner is identified.
		2. Joint Funding for an adult is not CHC funding. However, the AACC service is the appropriate team to facilitate such arrangements for adults. Where an individual has been assessed as not eligible for CHC, but has identified health need(s) that in the opinion of the MDT are outside of the LA’s legal ability to provide under the Care Act 2014, it may be appropriate for the NHS to fund that nursing care element as part of a jointly funded package of care.
		3. Verification of the joint funding recommendation will be managed through the Joint Agency Verification Panel (Section 6.13). The panel will firstly verify the MDT recommendation. If the ‘not eligible’ recommendation cannot be verified, the MDT will be asked to reconvene to further review their PHN test and recommendation. If the ‘not eligible’ recommendation is verified, but the panel are not able to identify or agree to the health need being outside of the remit of the Care Act 2014, then the case is verified as not eligible to CHC and 28 days’ notice will be issued to transfer the case to the LA for ongoing management.
		4. Where the MDT recommendation for Joint/tripart Funding is verified by the panel, the Care and Support Plan will be used by the panel to identify the exact care provision required to meet that need. The panel will then request to the AACC team to seek costings for those elements of care provision to be NHS-funded and to set up a funding flow to the LA to cover this cost.
		5. Commissioning responsibility will be determined according to the most appropriate lead organisation. For CHC , the overall package of care will generally be commissioned by the LA as the lead commissioner, with an agreed recharge to the ICB for the agreed nursing element. In some exceptional circumstances, it may be more appropriate for the ICB to commission the health-funded element of care separately.
		6. Joint/tripart Funded cases should be reviewed in the same way as for all NHS-funded care packages – at 3 months from initial decision and annually thereafter. The review should be undertaken jointly with the LA. The same principles of care plan review apply as for all reviews. Where it is not possible for the LA to review the case with the AACC team, the care review will progress only for the NHS-funded element and the LA advised of the outcome.

### Discharge to Assess (CHC only)

* + 1. Discharge to Assess is not a specific AACC responsibility under the National Frameworks, until the individual is optimised and ready for assessment to establish funding eligibility.
		2. The ICB will delegate authority to the acute hospitals’ Integrated Discharge Team (IDT) to broker nursing home placements for D2A in some defined circumstances, at agreed costs and recognising that there is no automatic personal choice element to selecting a temporary placement under D2A. The IDT will notify the AACC service of discharge arrangements made, in order that the AACC service can issue funding agreements and contracts to the relevant care home and monitor the placement until the individual is ready to be considered for future funding streams.
		3. The AACC team may assist with the brokerage and commissioning of care home placements, where the pre-hospital discharge assessment indicates that there is a high probability of a need for CHC assessment, once the individual’s condition is clinically optimised. The team rely on the Integrated Discharge Team in the acute hospital to advise of potential referrals and readiness for discharge of individuals in this cohort.
		4. The AACC team will, in cases where they have commissioned the recovery placement (including for those individuals whose placements are arranged by the IDTs), monitor the individual’s rehabilitation until they are at a stable state in their presentation, indicating that their ongoing needs are able to be assessed. At this point the AACC service will initiate an internal referral for CHC assessment.
		5. Discharge to Assess commissioning and case management will be clearly and comprehensively recorded on the case management database and cases tracked until the individual is clinically optimised. At this stage, the case moves onto the 28-day referral to decision timeframe for CHC consideration.
		6. It is expected that, in most cases, the individual will be optimised for assessment within 4 weeks of hospital discharge. However, some individuals may take several weeks to become ready for assessment. In these cases, D2A funding will continue until assessment is feasible.

## Monitoring Compliance

* + 1. The ICB has a statutory duty to ensure compliance with the National Frameworks and to remain within annual financial allocations.
		2. The Finance and Investment Committee is responsible for assuring the ICB of compliance with financial management and performance against national and locally set Key Performance Indicators (KPIs), through receipt of regular reports and escalations where required from the AACC services.
		3. The Quality Committee is responsible for assuring the ICB of compliance with aspects of this Policy relating to quality of the AACC service and its application in practice of the National Frameworks, through receipt of regular reports and escalations where required from the AACC services.

## Staff Training

* 1. Please refer to Section 6.4: People and Skills.

## Arrangements for Review

* 1. This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.
	2. If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

## Associated Policies, Guidance and Documents

* MSEICB020 Lone Worker Policy
* MSEICB069 Personal Health Budgets: Ethos, Practice and Guidance Policy
* MSEICB063 Safeguarding Adults and Children (including Children in Care/Looked After Children) Policy
* MSEICB066 Safeguarding Children & Adults at risk of Domestic Abuse Policy
* MSEICB073 Mental Capacity Act 2005 and Deprivation of Liberty Policy
* MSEICB078 Defining Boundaries between NHS and Private Healthcare

## References

Care Act 2014

Care Standards Act (2000) Domiciliary Care National Minimum Standards Regulations

Children Act 2004

Children and Families Act 2014

Continuing Healthcare Maturity Framework (Version 1.1, March 2021)

DCB1605 Accessible Information: Implementation Guidance v1.1 (NHSE, August 2017)

DCB1605 Accessible Information: Specification v1.1 (NHSE, August 2017)

Equality Act 2010

Health and Care Act 2022

Hospital Discharge and Community Support: Policy and Operating Model (Oct 2021)

[How to manage discrimination from individuals and their guardians / relatives](https://www.bma.org.uk/media/5144/bma-guidance-on-how-to-deal-with-discrimination-from-patients-march-2022.pdf) (British Medical Association, 2022)

Local Resolution Best Practice Guidance: NHS Continuing Healthcare (NHSE & NHS Improvement, March 2021)

Mental Health Act (1983; 2007)

National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (July 2022)

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

NHS Continuing Healthcare Refreshed Redress Guidance (NHSE, 2015)

NHS Long-Term Plan v1.2 (August 2019)

Proactive guidance on the Safe and Supportive observation of Individuals at risk (Standing Nursing & Midwifery Advisory Committee [SNMAC], 1999)

Southend, Essex and Thurrock Safeguarding Adults Boards - SET Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Guidance V2 (March 2018)

Southend, Essex and Thurrock (SET) Safeguarding and Child Protection Procedures (revised 2019)

Southend, Essex and Thurrock (SET) Safeguarding Adult Guidelines (revised 2019)

[Violence prevention and reduction standard](http://www.england.nhs.uk/wp-content/uploads/2020/12/B0319-Violence-Prevention-Reduction-Standards.pdf) (NHS and Social Partnership Forum, 2020)

[Violence against NHS staff: letter to the workforce](https://www.gov.uk/government/publications/violence-against-nhs-staff-letter-to-the-workforce/violence-against-nhs-staff-letter-to-the-workforce) (Secretary of State for Health, 18 February 2020).

Who Pays? Determining which NHS commissioner is responsible for making payment to a provider (NHS England, August 2020)

## Equality Impact Assessment

* 1. The EIA has identified no equality issues with this policy.
	2. The EIA has been included as Appendix A.

## Appendix A - Equality Impact Assessment

#### Assessor’s Name: Alyson Taylor

#### Assessor’s Job Title: Head of CHC & CYPCC

#### Date: 17/02/2022

**Version:** 1.0

#### Outcomes

Briefly describe the aim of the policy and state the intended outcomes for staff

*The AACC Operational Policy aims to provide staff with the knowledge and skills to implement the National Frameworks in a way that is in accordance with all relevant legislation and ensures equity of access to services and the most independent outcomes for all who may need them.*

**Evidence**

What data/information have you used to assess how this policy might impact on protected groups?

* *Learning from previous complaints and PHSO investigations*
* *CHC assessments collect equality monitoring data*

Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?

*CHC Leads, senior managers, Governance Team, wider consultation with partner organisations including other health services and adult social care.*

#### Analysis of impact on equality

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

* **Positive outcome** – the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups
* **Negative outcome** – protected group(s) could be disadvantaged or discriminated against
* **Neutral outcome** – there is no effect currently on protected groups

Please tick to show if outcome is likely to be positive, negative or neutral. Please fill all boxes, any that aren’t applicable enter N/A.

Consider direct and indirect discrimination, harassment and victimisation.

| ProtectedGroup | Positiveoutcome | Negativeoutcome | Neutraloutcome | Reason(s) for outcome |
| --- | --- | --- | --- | --- |
| Age | x |  |  | *The development of the AACC service approach ensures a ‘cradle to grave’ service offer.*  |
| Disability(Physical and Mental/Learning) | x |  |  | *The AACC policy seeks to ensure that people with disabilities are treated equitably and that their specific needs are assessed and services identified and/or commissioned (where service gaps are identified) to meet those needs in the least restrictive and most independent way possible.*  |
| Religion or belief |  |  | x | *The AACC service policy is to ensure that no group or individual’s needs are prioritised (or devalued) over others for reasons relating to religion or belief, unless required to ensure equity of access and outcomes.* |
| Sex (Gender) |  |  | x | *The AACC service policy is to ensure that no group or individual’s needs are prioritised (or devalued) over others for reasons relating to gender, unless required to ensure equity of access and outcomes.* |
| Sexual Orientation |  |  | x | *The AACC service policy is to ensure that no group or individual’s needs are prioritised (or devalued) over others for reasons relating to sexual orientation, unless required to ensure equity of access and outcomes.* |
| Transgender/Gender Reassignment |  |  | x | *The AACC service policy is to ensure that no group or individual’s needs are prioritised (or devalued) over others for reasons relating to transgender or gender reassignment, unless required to ensure equity of access and outcomes.* |
| Race and ethnicity |  |  | x | *The AACC service policy is to ensure that no group or individual’s needs are prioritised (or devalued) over others for reasons relating to race or ethnicity, unless required to ensure equity of access and outcomes.* |
| Pregnancy and maternity (including breastfeeding mothers) |  |  | x | *The AACC service policy is to ensure that no group or individual’s needs are prioritised (or devalued) over others for reasons relating to pregnancy or breastfeeding, unless required to ensure equity of access and outcomes.* |
| Marriage or Civil Partnership |  |  | x | *The AACC service policy is to ensure that no group or individual’s needs are prioritised (or devalued) over others for reasons relating to marital status, unless required to ensure equity of access and outcomes.* |

#### Monitoring Outcomes

Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.

What methods will you use to monitor outcomes on protected groups?

*The AACC service is intending to utilise the outputs from continuous ‘internal’ individual surveys alongside lessons learned from external feedback (e.g. Healthwatch, individual forums), compliments, concerns, formal complaints, incidents and other ad-hoc intelligence sources to monitor outcomes on protected groups.*

#### Review

How often will you review this policy / service?
(Minimum every three years)

*This AACC policy will be reviewed at least every two years, or where any change to legislation and guidance impacts on the implementation of the policy.*