NHS England

NHS Continuing Healthcare Funded Care Report Frequently Asked Questions for Clinical Commissioning Groups 2018/19

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1 What is the difference between 'Cumulative Activity' and 'Snapshot Activity'?

1.1 Snapshot Activity

Snapshot Activity is an isolated observation of numbers eligible <u>as at</u> a specific date i.e. the last day of the quarter.

<u>Working Example of NHS Continuing Healthcare (NHS CHC) Snapshot Activity</u>
Snapshot Activity at the end of quarter 1 is the number of people eligible for NHS CHC *specifically on* the 30th June and this would not include anyone who became no longer eligible before or on this date due to death, discharge or being no longer eligible for any other reason.

This is calculated for you in the <u>final column of Table 1</u> by adding the number of cases already eligible at the beginning of the quarter (column A) to the number of cases newly eligible in the quarter (column B) and taking away any cases no longer eligible in the quarter (column C).

1.2 Cumulative Activity

Cumulative Activity is a running total of all cases NHS CHC eligible for any period within the year to date even if they also became no longer eligible within the year to date.

<u>Working Example of NHS CHC Cumulative Activity</u>
Cumulative Activity at the end of quarter 2 is the number of cases that have been eligible for NHS CHC for *any period* within the financial year to date (i.e. any time between April 1st and 30th September). This would include those that were already eligible at the beginning of the financial year and any newly eligible cases on or after April 1st (even if they also became no longer eligible within the financial year to date i.e. *on or after* April 1st).

This is calculated for you in the <u>final column of Table 2</u> by taking the cumulative total at the end of the previous quarter and adding on any cases that have become newly eligible during the current reporting quarter.

NB: The only exception to this is in the Q1 reports, where the baseline in both Tables 1 and 2 is an Activity **Snapshot** to capture the numbers eligible at the start of a new financial year. From Q2 onwards, Table 2's baseline becomes a **Cumulative** Activity to start picking up the running total of all eligible cases year to date.

2 What's the difference between a Previously Un-assessed Period of Care (PUPoC) payment and a reimbursement?

2.1 Reimbursement

A Reimbursement is a payment made to cover a specified period after a standard NHS CHC referral to when the regular funding commences (or the patient passes away).

Individuals on a waiting list for assessment may have reimbursements. The National Framework sets out that when a decision has taken more than 28 calendar days from referral, backdated NHS CHC payments may need to be made to cover the costs of services from day 29 after the referral. This backdated payment for a Standard NHS CHC case that has been processed late is a reimbursement not a PUPoC.

2.2 PUPoC Payment

A PUPoC Payment is a payment made to cover a claim for a past period for which the patient had not been referred to NHS CHC.

E.g. an individual or relatives of an individual may believe that they might have met eligibility for a past period and ask for a PUPoC assessment.

NB: A patient might be alive or deceased in both categories so this is not a distinguishing criterion. A patient could also have a reimbursement *and* a PUPoC.

Working Example
"We receive a referral in May, but a decision is not made until June and the funding is backdated to May. Would this backdated period be classed as a PUPoC payment or standard NHS CHC?"

ANSWER: It should still be counted as standard NHS CHC not a PUPoC. This is a standard application so this is a reimbursement not a PUPoC.

3 How do we record an individual who is eligible for both standard NHS Continuing Healthcare (NHS CHC) via the normal assessment route and a PUPoC?

ANSWER: PUPoCs are counted separately to standard NHS CHC in the Funded Care Report and are counted as separate claims in Table 10. In cases where an individual is eligible for standard NHS CHC via the normal assessment route *and* a PUPoC, any data relating to the PUPoC should be recorded in Table 10 whilst activity relating to the standard NHS CHC package should be included in Tables 1 to 9 as appropriate.

PUPoCs relate to number of eligible claims. For example, an individual is referred for NHS CHC via the usual assessment route. They have a checklist carried out which comes out positive followed by a DST and are then agreed eligible for NHS CHC during quarter 2. They are included as newly eligible for NHS CHC in the 'Number Agreed Eligible in Quarter' column (Table 1) in the CCG's quarter 2 report. Following their

eligibility decision, their family believe they should have met NHS CHC eligibility for a past period of care from 2016 up to the time they were referred for NHS CHC and request a PUPoC assessment. This is agreed eligible in quarter 4 and is included in the quarter 4 report under Table 10 'PUPoCs Agreed Eligible YTD.

4 In instances where an individual has more than one PUPoC agreed eligible how should this be counted?

In instances where an individual has more than one past period agreed eligible these should be included as separate claims (e.g. 2 PUPoCs agreed eligible for the same individual would be counted as 2 PUPoC claims agreed eligible YTD).

An example may be more than one PUPoC for the same individual for separate periods (e.g. one PUPoC covering January 2016 to April 2016 and another covering November 2016 to February 2017).

Another example may be where an overall period for consideration is broken down further by the CCG, either by different episodes of need or according to availability of evidence, for the CCG to consider each 'sub-period' separately. For example a claim may be submitted which covers the period January 2016 to February 2017. The period from January to April 2016 may have all the required evidence and records to ascertain eligibility whereas the remaining period from May 2016 onwards (up to February 2017) signifies a change in need and further work is needed to gather the appropriate records and evidence to ascertain eligibility. The CCG may decide to assess the period from January to April 2016 sooner so this can be funded if eligible, and consider the remaining period from May 2016 to February 2017 later once the necessary evidence is available. Each part of the claim to which a distinct eligible decision is applied should be counted separately, and if agreed eligible, included in reporting according to the reporting quarter the eligible decision is made.

5 What's the difference between a closedown and non-closedown PUPoC and which should be counted?

ANSWER: In 2012 the Department of Health introduced 'closedown' deadlines for requesting assessments of eligibility for past periods of care falling between 1st April 2004 and 31st March 2012. These deadlines have now passed and all valid cases have had an initial assessment. However it's still possible some 'closedown' PUPoCs may still become eligible via requests to review eligibility decisions (e.g. local appeals).

CCGs may also receive requests for assessments of past periods falling after 31st March 2012 ('non-closedown' PUPoCs). Both of these scenarios fall under the definition of being a PUPoC (a specific request to consider eligibility for a past period of care).

For the purposes of Funded Care Report all PUPoCs should be counted irrespective of whether they are closedown or non-closedown, provided they were agreed eligible in the current financial year.

6 Should data be based on the date people are agreed as being eligible for NHS CHC or the date when funding commences?

ANSWER: The date they are agreed as being eligible.

Activity should be included in the quarter in which an **'eligible decision'** is made **not** the date the funding commences.

E.g. patient X has a checklist and DST carried out during June. The CCG meet in early July, agree the case eligible, and backdate / reimburse the funding to the date of the initial checklist (see question 2 for further information on reimbursements).

Even though the funding is backdated to the checklist in quarter 1 the case wasn't **agreed eligible** until quarter 2. Therefore patient X is included as 'Newly Eligible' in the quarter 2 report.

In the case where an individual is agreed eligible but funding hasn't yet commenced, the activity should still be included in the quarter in which the '**eligible decision**' is made.

Individuals who are agreed eligible but turn down funding, or do not go on to commence a package for any other reason, should also still be included in the activity (in this case they would also be included under 'No longer eligible').

7 What should we do if our baselines change from what was reported the previous quarter?

Working Example
"Our Snapshot Activity as at the last day of quarter 2 was 120 on our Q2 report. However, following submission of our Q2 report we received late notification that three cases had deceased during September meaning it should have been a Snapshot Activity of 117. Should we use the figure we reported on our Q2 report as the baseline for our Q3 report or use the corrected figure?"

ANSWER: Please report the most up to date and correct figure in your baseline i.e. 117. If there is a mismatch between what your headcount was at the end of Q2 on your Q2 report compared to what is known at the time of your Q3 report (e.g. after receiving updated or corrected information), then please use the correct figures for the baseline in the Q3 report. Where there are any discrepancies from what you reported last time, please include a comment to confirm that the Q3 version is correct (e.g. "Baseline updated from Q2 figure due to…. [brief explanation why]."

Do not report the incorrect activity from last quarter as your baseline and then put erroneous instances of 'Numbers Agreed Eligible in Quarter' or 'No Longer Eligible in Quarter' to yield the correct activity at the end of the quarter (as these are not genuine instances of newly eligible or no longer eligible cases in that reporting quarter, this would make these data items incorrect and could also cause double counting in your cumulative total in Table 2).

Your CCG's Funded Care Report template includes your CCG's closing activity from the previous quarter for ease of reference to what was reported last time. These appear in grey 'For info' columns at the beginning of Tables 1 & 2. Your opening activities at the beginning of the quarter reported in the baselines of Tables 1 & 2 would normally be expected to be the same, or at least similar to, the closing activities reported last quarter. However in instances like the above, when late information means corrections are required to the activity reported last time, please report the correct figure and include an explanatory note in the comments section where there are any significant discrepancies.

8 How should cases be recorded when they are not eligible for NHS CHC but are receiving interim care (e.g. funding without prejudice or rehabilitation)?

ANSWER: Examples of interim cases include persons receiving temporary funding pending an NHS CHC eligibility decision or persons who have ceased being eligible for NHS CHC but are still being funded (e.g. requests for reviews of an eligibility decision or pending transfer to social services).

Individuals on discharge to assess pathways are also examples of cases that may receive interim funding or rehabilitation before eligibility for NHS CHC is determined at a later stage post discharge.

Please exclude people who receive interim care from any activity figures for eligible NHS CHC cases, as they do not meet the NHS CHC definition as per section 2.3.3 p7 of the report guidance until the point they are agreed NHS CHC eligible (if applicable) following assessment.

9 How should we record a case that moves category part way through the financial year e.g. a 'Fast Track' case is reviewed and becomes re-categorised under 'Standard NHS CHC (non Fast Track)'?

ANSWER: If a case is NHS CHC eligible under Fast Track and then is re-categorised further down the line to Standard NHS CHC (non Fast Track) then they are still only counted once.

Do not put them through the 'No Longer Eligible' column on the Fast Track line and then 'Newly Eligible' on the 'Standard NHS CHC (non Fast Track)' line (as they didn't technically become 'no longer eligible' for NHS CHC and this would also cause double counting in your cumulative total in Table 2).

Instead, if they were Fast Track in Q1 but then changed to Standard NHS CHC (non Fast Track) in Q2, on your Q2 report reduce your 'Fast Track' baseline by 1 and increase your 'Standard NHS CHC (non Fast Track)' baseline by 1. Then include details in the comments section e.g. "Baselines adjusted due to one case moving from Fast Track to Standard NHS CHC (non Fast Track)".

10 How should we count an individual already eligible who moves to a different CCG?

ANSWER: If an individual is eligible for NHS CHC but the responsibility for that individual moves to another CCG within the same year then both CCGs should count the case in their cumulative NHS CHC activity in Table 2 (so as to be included in the running total of all cases of that type that have been eligible within the year to date – please also see 'How activity should be recorded' at section 1.3, page 5 of the reporting guidance). The case would also appear in the NHS CHC snapshot activity of numbers eligible at the end of the quarter (Table 1) for the new CCG (provided they were still eligible by the end of the reporting quarter) but would no longer appear in the NHS CHC Snapshot of numbers eligible at the end of the quarter for the originating CCG.

If responsibility for the individual is moved to another CCG but the change is backdated / reimbursed to the start of the financial year (or before the start of the financial year) then the originating CCG should remove the activity from both their table 1 and table 2 baselines including an explanatory comment if necessary e.g. "CHC cumulative and snapshot activity baselines have reduced from previous quarter due to responsibility for 1 patient moving to another CCG with the change backdated to pre April 1st".

All adjustments should be made in the baselines of tables 1 and 2 as appropriate and not by putting the individual through the 'no longer eligible' line on one CCG report and the 'newly eligible' line on the other CCG report (as the individual didn't technically become no longer eligible or newly eligible, they just moved CCG).

11 Which NHS CHC referrals should be counted and start 28 days?

ANSWER: All cases that have been referred for full assessment of NHS CHC eligibility as per the definition of a referral in section 5.1 p11 of the report guidance should be counted and also trigger the start point for the purposes of counting 28 days (as per section 9.2 p13 of the report guidance). This includes:

- Referrals with incorrect or missing information
  Earliest notification to the CCG (or person or body acting on behalf of the CCG) that full assessment of NHS CHC eligibility is required constitutes the point at which a referral should be counted and 28 days counting starts, irrespective of whether or not there is any further processing or triage required to determine whether the Checklist is positive or negative, or whether or not there is any other information missing or any questions unanswered on the Checklist. These scenarios should still be counted as a referral - even though they may be based on incorrect / incomplete information they were still referred all the same. If an individual is referred for NHS CHC assessment via a 'positive' checklist but quality assurance (QA) of the paperwork identifies that the checklist is in fact negative, the referral should still be counted at the point of earliest notification (and before any further processing, QA or triage on the Checklist takes place), however if it transpires that the checklist is in fact negative, and the case does not need to proceed to full assessment, the referral should also be counted in 'Number discounted before assessment completed in quarter' in table 4 (as per 6.4 p12 of

the report guidance). Referrals resubmitted more than once due to incomplete or incorrect information should only be counted once and from the earliest notification.

- Referrals with missing consent
  In instances where referrals are made but a consent form is not included, or the consent question on page 6 of the Checklist is not completed, the referral should still be counted. As per the above item, even though the paperwork is incomplete the individual has still been referred for full assessment all the same. The CCG should ensure that any missing information is obtained as swiftly as possible, to allow the CHC referral to proceed to full assessment. The referral-to-assessment clock should not be paused or the clock-start delayed while this information is being obtained.

- Different referrals for the same individual relating to different needs / time periods
  Genuine instances of more than one referral for the same individual i.e. due to a change in needs rather than administrative error (see 'Referrals with incorrect or missing information' above), or due to different periods of care (e.g. pre and post fully funded interim care in a discharge to assess model), should be counted separately. Note that this scenario would apply with individuals previously referred and found not eligible, who were subsequently re-referred due to a change in needs. An individual already eligible for CHC, who has another DST carried out due to a change in needs, would not be counted as this is part of a review rather than a new referral.

  This scenario also applies with discharge to assess arrangements where **fully funded** interim care is first provided instead of carrying out a full assessment. At the point the interim care has come to an end and / or the individual has stabilised, and a DST is requested again (either by carrying out another checklist or by direct referral for the DST to take place without carrying out another checklist) this counts as a new referral as it relates to a different period of care (i.e. from the end of the interim care onwards rather than from the original / first referral onwards which was covered by interim care). See 12.1 for an example.

- Referrals resulting from FNC review
  Only count the result of an FNC review as a referral if needs have materially changed and the case is referred for full assessment for NHS CHC by an MDT.

Referrals should **NOT** include:

- Negative checklists where a need for full assessment is not indicated

- Requests to review eligibility decisions (e.g. via the local resolution process. Local resolution cases referred back to the MDT following initial assessment should also not be included)

- Reviews of existing NHS CHC cases

- PUPoCs

- Checklists from FNC reviews where there has been no material change in needs

When reviewing the need for FNC potential eligibility for NHS CHC must always be considered. This will normally be achieved by completing a Checklist and where necessary a full assessment for NHS CHC using the DST. However as per section 83 of the FNC Best Practice guidance a DST will not be required where:

- a Checklist and/or DST has previously been completed (with the result that the individual was not found eligible for NHS CHC),

  and

- it is clear that there has been no material change in need

12 In what scenarios are referrals discounted before being assessed for NHS CHC, also stopping 28 days?

ANSWER: Table 4 captures the outcomes of all referrals concluded in a given quarter. A referral is concluded when there has been a verified decision on NHS CHC eligibility or the referral has been discounted before assessment is complete. The point at which a referral is concluded also ends 28 days counting.

Depending on the outcome (eligible, not eligible, or discounted) all referrals that have concluded within a quarter should be counted in either column A, B or D as appropriate in Table 4.

Some worked examples of when referrals are discounted and included in column D are included below (this is not exhaustive and there may be other instances in which a referral is discounted before assessment is complete).

12.1 Example 1 - People referred for interim care

An individual is referred for NHS CHC assessment following a positive checklist however the individual's clinical team recommend a period of therapy and rehabilitation as they believe this could make a difference to the potential of the individual in the following few months.

The referral therefore does not proceed any further in the NHS CHC assessment process, and the individual is awarded interim funding to provide rehabilitation and therapy instead. In this scenario the referral is counted as 'discounted before assessment complete' in table 4 as the individual has not been assessed and has not received a verified decision on NHS CHC eligibility. Interim funded cases should also not be reported within NHS CHC activity for this reason (i.e. they are not technically NHS CHC cases).

Another possibility is that the individual's needs change detrimentally following their rehabilitation, or there is no improvement, and they are referred for NHS CHC assessment again. As this is a new referral relating to a different time period / change in needs this should be counted again in table 3. This would also trigger a new clock start for the purposes of 28 days counting.

12.2 Example 2 - Deceased individuals

An individual is referred for NHS CHC assessment following a positive checklist but passes away before the NHS CHC assessment process is complete.

In some scenarios the referral will not be discounted and eligibility for the period the individual was alive will still need to be considered e.g. where an individual was being self-funded or funded by the Local Authority. Following the assessment / verified decision on eligibility the case then needs to be counted in Table 4 in either column A or B as appropriate.

In other scenarios the referrals for individuals who have passed away may be discounted before assessment is complete and should be included in column D e.g. where an individual was already being fully funded by the NHS at the time of referral (e.g. interim care) they may be discounted.

12.3 Example 3 - Withdrawn by individual / their family

An individual is referred for NHS CHC assessment but the individual and their family wish to fund the care themselves and do not want to proceed with the NHS CHC assessment.

12.4 Example 4 - Withdrawn by the CCG

An individual is referred for NHS CHC assessment following a ‘positive’ checklist being sent to a CCG. However once the CCG processes the checklist it transpires that it has not been scored correctly and is a negative rather than positive checklist (i.e. NHS CHC assessment is not required and the case should not have been referred).

Therefore the referral does not proceed to a DST assessment and is counted in Table 4 column D as discounted.

The referral should still be counted in Table 3 ‘number of referrals in quarter’ (even though it wasn’t referred correctly it was referred all the same).

Referrals via the Fast Track route may also be withdrawn by the CCG if it is deemed they do not meet the criteria for a Fast Track referral and the individual may be redirected to a different funding stream or referral route instead.

12.5 Example 5 - People requiring further acute treatment

Section 18.4 of the Practice Guidance Notes in the National Framework state: “If at any point after a Checklist has been sent to the CCG the individual’s needs change such that he/she requires further treatment, the completed Checklist will no longer be relevant and a new Checklist should be undertaken once the treatment has been completed.” A working example of this scenario would be:

An individual is referred for NHS CHC assessment following a positive checklist. The referral is counted in table 3 as a new referral in quarter and this also constitutes the ‘clock start’ for the purposes of 28 days counting. However their condition deteriorates and they require further acute treatment. The referral is therefore discounted and

included in ‘discounted before assessment complete’ in table 4, as this referral does not proceed any further in the NHS CHC assessment process. The point at which the referral is discounted constitutes the ‘clock stop’ for the purposes of 28 days counting.

The individual then completes their treatment and another checklist is undertaken. This checklist also comes out positive and is referred to the CCG. This second referral is also counted as a new referral in table 3 and again constitutes the ‘clock start’ for the purposes of counting 28 days. This time the individual is taken through the full assessment process and is agreed eligible. They are therefore counted in ‘number assessed as eligible for CHC’ in table 4 and this constitutes the ‘clock stop’ for 28 days counting.

Another possibility is that the second checklist does not result in a second referral, in which case, only the original discounted referral is counted for reporting purposes.

12.6 Example 6 - Referrals made via a ‘positive’ checklist but further QA of the paperwork identifies that the checklist is in fact negative

An individual is referred for NHS CHC assessment via a ‘positive’ checklist but QA of the paperwork identifies that the checklist is in fact negative. The referral should still be counted at the point of earliest notification (and before any further processing, QA or triage on the Checklist takes place), however if it transpires that the checklist is in fact negative, and the case does not need to proceed to full assessment, the referral should also be counted in ‘Number discounted before assessment completed in quarter’.

12.7 Example 7 - Fast Track tools which are not accepted (i.e. it is deemed they do not meet the criteria for a Fast Track referral and the individual may be redirected to a different funding stream or referral route instead)

Paragraph 218 p63 of the National Framework states that a “…completed Fast Track Pathway Tool… is in itself sufficient to establish eligibility.” CCGs must therefore “accept and immediately action a Fast Track Pathway Tool where the Tool has been properly completed.” (National Framework paragraph 236 p66). For this reason it is not possible to record a fast track fully assessed as not eligible in reporting.

However, as per paragraph 237 p66 of the National Framework, exceptionally “… there may be circumstances where CCGs receive a completed Tool which appears to show that the individual’s condition is not related to the [Fast Track] criteria at all. For example, if a completed Fast Track Pathway Tool states that the person has mental health needs and challenging behaviour but makes no reference to them having a rapidly deteriorating condition which may be entering a terminal phase. In these circumstances, the CCG should urgently ask the relevant clinician to clarify the nature of the person’s needs and the reason for the use of the Fast Track Pathway Tool. Where it then becomes clear that the use of the Fast Track Pathway Tool was not appropriate, the clinician should be asked to submit a

completed Checklist (if required) for assessment of eligibility through the process outlined in this National Framework."

For this reason Fast Track tools which are not accepted constitute another example in which a referral may be discounted before assessment is complete. Fast Track tools which are not accepted (i.e. it is deemed they do not meet the criteria for a Fast Track referral and the individual may be redirected to a different funding stream or referral route instead) should be counted in 'discounted before assessment complete' rather than 'assessed not eligible'.

13 How should we count an individual who is FNC eligible and changes to being NHS CHC eligible following review?

ANSWER: If the individual is eligible for both FNC and NHS CHC in the same year count them in both the FNC and NHS CHC cumulative activities (so as to be included in the running total of all cases of that type that have been eligible within the year to date). They would also appear in NHS CHC snapshot activity of numbers eligible at the end of the quarter (provided they were still eligible by the end of the reporting quarter) but would no longer appear in the FNC Snapshot of numbers eligible at the end of the quarter.

If the individual changes from being FNC to NHS CHC eligible and the funding is backdated / reimbursed to the start of the financial year (or before the start of the financial year) then the activity should be moved to the NHS CHC sections Tables 1 – 10 as appropriate and removed from FNC Table 11 with an explanatory comment if necessary e.g. "FNC cumulative activity YTD has reduced from previous quarter due to 6 patients being reassessed as NHS CHC backdated to pre April 1st".

14 Which DSTs should be counted in table 6 'Location of DST in quarter'?

ANSWER: All DSTs carried out within the reporting quarter as a result of a referral (either as a result of a new referral or as a result of an FNC review if needs have materially changed) should be counted. Please use the same definition of a referral that is set out on page 11 of the report guidance. Please also see 'Which NHS CHC referrals should be counted and start 28 days?' on page 10 of the FAQs for examples of which referrals should be counted.

If more than one DST is carried out for the same individual (e.g. if a first DST was not completed correctly/the time between the DST completion and panel was too long and it was deemed that the DST needed to be redone) then both DSTs should be counted.

15 What is an ‘acute hospital setting’ for the purposes of completing table 6 ‘Location of DST in quarter’?

ANSWER: Acute care in a hospital is where a patient receives active short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In this way it is different from chronic care or longer term care.

‘Acute hospital setting’ does not include those people in step down beds or community beds. Once someone moves into a step down bed this is classed as interim arrangements as outlined in the National Framework and a checklist should only be completed once the individual has met their potential.

Where step down beds have been purchased from acute providers for the purposes of rehabilitation or reablement it is expected that this would not constitute an ‘acute hospital setting’.

16 When does the clock start and stop for the purposes of counting 28 days referral time?

ANSWER: 28 days referral time starts from the earliest notification (to the CCG or organisation acting on behalf of the CCG) that full assessment of NHS CHC eligibility is required (e.g. a positive checklist or other notification that full assessment is required).

Referral time ends at the date the CCG makes a verified decision on eligibility (or the referral is discounted – see ‘Number discounted before assessment completed in quarter’ definition on page 12 of the report guidance).

Please note that the earliest notification that full assessment is required (as per the above definition) constitutes the point at which the referral should be counted (also starting the count of 28 days) irrespective of (a) whether or not the consent form is included; (b) whether or not the consent question on page 6 of the Checklist is completed; (c) whether or not there is any other information missing or any questions unanswered on the Checklist; and (d) whether or not there is any further processing or triage required to determine whether the Checklist is positive or negative.

The clock is not paused or stopped if the referral is not completed correctly. Please note that the National Framework does not specify any scenarios in which CCGs should ‘stop the clock’ when counting 28 day referral time. 28 days is counted in calendar days and not working days.

Genuine instances of more than one referral for full assessment for the same individual e.g. due to a change in needs rather than administrative error, or due to different periods of care (e.g. pre and post fully funded interim care in a discharge to assess model) should be counted separately. For the purposes of this report 28 days referral time relates to the initial assessment following a referral as per the referral definition on page 11 of the report guidance. Requests to review eligibility decisions via the local resolution process following initial assessment which are referred back to the MDT should not be included.

Please see questions 11 and 12 for further information on which referrals should be counted for the purposes of 28 days counting and examples of scenarios where referrals are discounted before being assessed for NHS CHC, also stopping 28 days.

17 Can someone self-refer by completing a Checklist themselves, and would this trigger the start of counting 28 days?

ANSWER: No. Section 25.1 of the National Framework states that individuals cannot self-refer: “If the individual is known to a health or social care practitioner, they could ask that practitioner to complete a Checklist. Alternatively, they should contact their CCG NHS Continuing Healthcare team to ask for someone to visit to complete the Checklist, or if they already have a care home or support provider, they could ask them to contact the CCG on their behalf. Where the need for a Checklist is brought to the attention of the CCG through these routes it should respond in a timely manner, having regard to the nature of the needs identified. In most circumstances it would be appropriate to complete a Checklist within 14 calendar days of such a request.”

The request to complete a checklist does not meet the definition for a referral for full assessment (please see section 5.1 page 11 of the report guidance for a definition of referral). If the outcome of the checklist indicates that the individual requires full assessment and they are referred for this, then the referral should be counted and 28 days start at the point the CCG (or person or body acting on behalf of the CCG) is notified / aware that full assessment is required.

18 At what point does the 28 day clock start following positive screen (checklist) when the screening is undertaken by a non CCG employee (third party) who is not acting on the CCG’s behalf?

ANSWER: Where CHC screening (checklist) is undertaken by a third party who is not acting on the CCG’s behalf, and the screen is positive, the clock start commences at the point the CCG, or person or body acting on behalf of the CCG, is notified that a full assessment is required. Notification can include by phone or email and may happen prior to documentation being sent. Once the CCG, or acting person or body, has been notified of the need for full assessment, the referral should be counted and 28 days counting start, before any QA of screening (checklist) completion. If any subsequent QA of the referral indicates that full assessment is not required (e.g. the referral was based on a false positive checklist), and the referral is not taken forward for full assessment, then it should be counted in Table 4 column D ‘Number discounted before assessment completed in quarter’. Referrals which are resubmitted more than once due to incomplete or incorrect information should only be counted once and from the earliest notification (please see question 11).

19 At what point does the 28 day clock start following positive screen (checklist) when the screening is undertaken by a CCG employee or a non CCG employee acting on behalf of the CCG (e.g. trusted assessor)?

ANSWER: Where CHC screening (checklist) is undertaken by a CCG employee, or a non CCG employee acting on behalf of the CCG (e.g. trusted assessor), the CCG notification (clock start) commences at the point this individual is aware that full assessment is needed (i.e. at the point of the checklist being positive). This will be prior to any QA of screening (checklist) completion. If any subsequent QA of the referral indicates that full assessment is not required (e.g. the referral was based on a false positive checklist), and the referral is not taken forward for full assessment, then it should be counted in Table 4 column D 'Number discounted before assessment completed in quarter'. Referrals which are resubmitted more than once due to incomplete or incorrect information should only be counted once and from the earliest notification (please see question 11).

20 What are transition cases and how should we report them?

ANSWER: Transition cases refer to children and young people (under 18 years of age) that may transition to adult NHS CHC services and are referred for NHS CHC assessment before their 18th birthday. The latest National Framework includes clarity that the 28 calendar day timescale does not apply to children and young people in transition to adult services. For this reason there is a 20% tolerance in the CCG quality premium on 'percentage of referrals complete in 28 days' (CCGs must ensure in more than 80% of cases the NHS CHC eligibility decision is made within 28 days) to account for this and other valid and unavoidable reasons for the process taking longer.

Snapshot information on 'incomplete referrals exceeding 28 days' in tables 7 and 8 has no such tolerance or other remedial action to address the inclusion of transitional cases however, and omitting transition cases in these sections is more straightforward.

Transition cases should therefore be included in **all activity** throughout the report where applicable ***apart from*** snapshot information on 'incomplete referrals exceeding 28 days' (final column only of table 7 and all sections of table 8).