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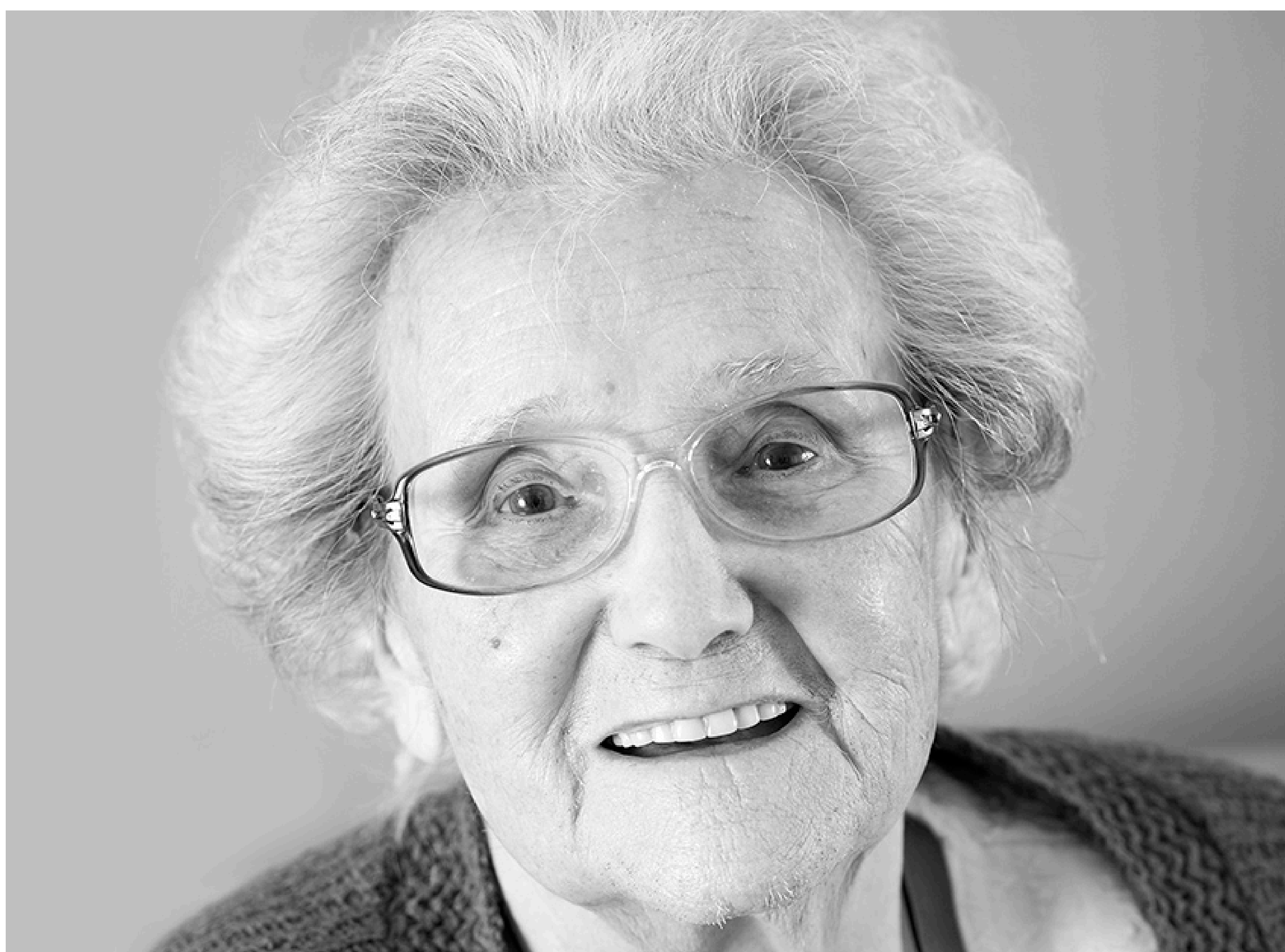

NHS Continuing Healthcare Funded Care Report Guidance for Clinical Commissioning Groups 2018/19

Version: 1.7

NHS Continuing Healthcare

Funded Care Report Guidance 2018/19

Version number: 1.7

Released: 15th March 2018

Updated: 27th November 2018

Prepared by: NHS England, Operational Information for Commissioning

Classification: OFFICIAL

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1 General Instructions

1.1 Validation Errors and Incomplete Reports

All cells highlighted yellow must be completed otherwise a validation error will remain on your report. Once you have completed a cell it will turn white. Do not return your submission with any yellow cells or validation errors remaining. If you have no activity or a category does not apply to your CCG enter a zero and include further information in the 'comments' sections where necessary.

1.2 Sign-off of Reports

To ensure data quality and accountability please ensure a local process is in place for sign-off at Responsible Director for NHS Continuing Healthcare (NHS CHC) level. This should be the Responsible Director based at the Clinical Commissioning Group and not an external provider e.g. Commissioning Support Unit (CSU).

1.3 How Activity should be Recorded

All activity refers to number of cases. In the case of Snapshot activity this will always also translate into number of people. For cumulative activity it's possible for more than one case for the same individual to be included (e.g. if an NHS CHC eligible individual becomes no longer eligible and newly eligible again in the same year, or if responsibility for an individual already eligible at one CCG moves to another CCG within the same year).

Individuals may also be counted in both NHS CHC and NHS-funded nursing care (FNC) cumulative activity if they have been eligible for both within the same financial year . Please see Frequently Asked Questions (FAQs) for further information.

Genuine instances of more than one referral for the same individual i.e. 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) (see Table 3 – NHS CHC Referrals in Quarter on page 11), should also be counted in each case.

Activity should be included in the report according to the date a case is *agreed eligible* **not** the date the funding commences (or is backdated to). E.g. if an individual is agreed eligible for NHS CHC in quarter 2 with the funding backdated to start in the previous quarter, the activity should be reported in quarter 2 according to the date the case was agreed eligible. It is also the case that if an individual has been agreed eligible but the package costs have not yet been determined the activity should still be included according to the date the eligible decision was made.

2 NHS Continuing Healthcare (NHS CHC)

2.1 NHS Continuing Healthcare (NHS CHC) Definition

'NHS Continuing Healthcare' (NHS CHC) means 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 the National framework for NHS

Continuing Healthcare and NHS-funded nursing care. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness.

2.2 Data to Include in NHS CHC Tables 1 to 10

2.2.1 Persons eligible for NHS CHC as defined by the National Framework

For the purposes of this report "NHS CHC" refers to individuals eligible for NHS Continuing Healthcare who have a primary health need under the National framework for NHS Continuing Healthcare and NHS-funded nursing care. Only include this type of funding in NHS CHC Tables 1 – 10. Individuals who have not gone through the formal assessment outlined in the National Framework (i.e. they have not had a Decision Support Tool (DST) or Fast Track Tool completed which results in NHS CHC eligibility) are not NHS CHC and should not be included.

2.2.2 All activity relating to the CCG's NHS CHC function, whether carried out by the CCG or by another organisation on the CCG's behalf

As per the National Framework 'Clinical Commissioning Group' (CCG) is intended to include any person or body authorised by the CCG to exercise any of its functions on its behalf in relation to NHS CHC. Where a CCG delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework. The CCG cannot delegate its final decision-making function in relation to eligibility decisions, and remains legally responsible for all eligibility decisions made (in accordance with Standing Rules).

If a CCG transfers money or responsibility to any other person, body, organisation, local authority, trust, partnership, or any other type of service to exercise any NHS CHC functions on the CCG's behalf (including section 75 transfers to local authorities, block contract arrangements, trusted assessor arrangements, outside trusts etc.) then this still constitutes NHS CHC that the CCG is responsible for and should be included in reporting. This is to ensure that all NHS CHC activity is captured for reporting and publication purposes.

2.2.3 Transition cases in all activity where applicable ***apart from*** snapshot information on NHS CHC Cases Exceeding 28 days.

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).

2.3 Exclusions in NHS CHC Tables 1 to 10

2.3.1 Persons funded through other NHS funding streams which are not NHS Continuing Healthcare (CHC)

Do not include cases full or part NHS funded through other NHS funding streams which are not NHS CHC (i.e. those that have **not** gone through the formal NHS CHC assessment procedures outlined above). Those that have gone through assessment but have **not** been found eligible for NHS CHC should be included in referrals and assessment information in tables 3 and 4 but should not appear in your activity for eligible cases.

2.3.2 Persons funded under any section of the Mental Health Act

Please do not count funding under any section of the Mental Health Act 1983 as NHS CHC (as per above, this is not NHS CHC as defined by the National Framework and should therefore not be included). If an individual is funded under a Mental Health Section *and* eligible for NHS CHC under the National Framework eligibility criteria (as defined above) then please include the CCG activity related to the NHS CHC only and do not include any activity covered by the Mental Health section.

2.3.3 Interim Cases - Persons receiving interim care or temporary NHS CHC funding pending eligibility decision or persons who have ceased being eligible but are still being funded

Please exclude people who receive interim care or temporary NHS CHC funding from any activity figures for eligible NHS CHC cases. This includes those receiving interim care under discharge to assess arrangements or those receiving temporary NHS CHC funding pending the outcome of an NHS CHC eligibility decision (sometimes referred to as 'funding without prejudice'). This also includes those who have ceased being eligible but are still being funded (e.g. requests for reviews of an eligibility decision or pending transfer to social services).

2.3.4 Persons under 18 years of age

NHS CHC packages are funded for individuals aged 18 and over only therefore only individuals aged 18 years or over should be included in this return. Activity and expenditure relating to individuals aged under 18 years should be excluded from the Funded Care Return. This applies to all sections of the report.

Occasionally CCGs fund all or part of a young person's educational placement where the young person is aged 18 and over, from what is known as the Children's Continuing Care budget. This activity should also be excluded from the Funded Care Return, unless the client and their package have been approved for 100% Adult NHS CHC funding (as per the NHS Continuing Healthcare (NHS CHC) Definition on page 5).

2.4 NHS CHC Categories

2.4.1 Standard NHS CHC (non Fast Track)

NHS CHC cases as per the definition on page 5 which are not Fast Track. This includes those that have been agreed eligible via the standard NHS CHC assessment route (i.e. normally via a positive checklist, DST etc.) and those Fast Track cases that have been reviewed and changed category to Standard NHS CHC. Do not include Previously Unassessed Periods of Care (PUPoCs).

2.4.2 Fast Track

Cases that have been agreed eligible for NHS CHC via the fast track assessment route. The Fast Track tool is used where an appropriate clinician considers that a person should be fast tracked for NHS CHC because that person has a rapidly deteriorating condition and the condition may be entering a terminal phase. The person may need NHS CHC funding to enable their needs to be urgently met (e.g. to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in a care setting).

Occasionally a Fast Track NHS CHC case may be reviewed and change category to Standard NHS CHC (non Fast Track). Please reflect any changes to category in your baselines (column A Tables 1 and 2) and do not put cases through ‘no longer eligible’ on one line / ‘newly eligible’ on another as this causes double counting in Table 2. Please see FAQs for further information on how to deal with category changes.

2.5 NHS CHC Commissioned Services

2.5.1 NHS CHC Commissioned Services

Please indicate whether your CCG authorises any other person or body to exercise any of its NHS CHC functions on its behalf e.g. CSU, NHS Trust, section 75 arrangement with Local Authority, or ‘Other’. ‘Other’ may include, but is not limited to private providers, social enterprises, Partnership Support Units (PSUs) etc. If you select ‘Other’ please specify the partner organisation(s) in the field provided below.

3 Table 1 – NHS CHC Snapshot Activity

Snapshot Activity is an isolated observation of numbers eligible *as at* the last day of the quarter. It only includes those eligible on that day and does not include anyone who became no longer eligible before or on that date due to death, discharge or being no longer eligible for any other reason.

E.g. snapshot activity at the end of Q2 would be all those eligible on 30th September.

Snapshot activity for the current quarter is calculated for you in the final column of Table 1 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).

Do not include PUPoCs in Table 1 as these 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 (and / or table 9 if appropriate), whilst activity relating to the standard NHS CHC package (ongoing care) should be included in Tables 1 to 9 as appropriate. Requests for review of eligibility via the local resolution process (local appeals) which relate to PUPoCs should also be counted in table 9.

3.1 Column A: BASELINE - Closing snapshot activity end of previous quarter

Please enter the number of people eligible for NHS CHC *as at* the last day of the previous reporting quarter (Snapshot Activity as per the definition above).

If this figure is different from the closing snapshot activity reported last quarter (included to the left of this field in grey for information) due to updated / corrected information please include an explanatory note in the comments section to confirm the latest information is correct. Please see FAQs for further information on how to deal with corrections to your previous quarter's activity.

3.2 Column B: Number agreed eligible in quarter

Please enter the number of cases newly meeting the NHS CHC eligibility criteria for any length of period during the quarter.

Newly eligible activity should be based on the date a case is *agreed eligible*, not the date the funding commences.

Please include those people agreed eligible who have also subsequently ceased to be eligible during the quarter (in this case they would also be included under 'No longer eligible' column C).

If an individual is agreed eligible but deceases before funding commences they should still be included in the activity (again, in this case, they would also be included under 'No longer eligible' column C).

Only use the 'number agreed eligible' column for the purpose of counting factual instances of newly eligible cases within the reporting quarter (i.e. do not use this column for the purposes of moving an individual from one category to another as this will cause double counting). Please see FAQs for how to deal with category changes.

3.3 Column C: No longer eligible in quarter

Please enter the number of cases no longer eligible in the quarter for whatever reason e.g.:

- client no longer meets criteria
- client is deceased

This includes those that were agreed eligible but turned down funding or any individuals that were agreed eligible but did not go on to commence a package for any other reason.

'No longer eligible' should not include any individuals who are going through a review process. Only remove the activity if the individual becomes no longer eligible.

Only use the 'no longer eligible' column for the purpose of counting factual instances of no longer eligible cases within the reporting quarter (i.e. do not use this column for the purposes of making adjustments to your overall activity figures or for moving an individual from one category to another as this will cause double counting). Please see FAQs for how to deal with category changes.

4 Table 2 – NHS CHC Cumulative Activity Year to Date

Cumulative Activity is a running total of **all** NHS CHC eligible cases *for any period* within the year to date even if they also became no longer eligible within the year to date. The figure includes those that were already eligible at the beginning of the financial year in addition to any cases that became newly eligible within the year to date up to the end of the current reporting quarter.

E.g. cumulative activity up to the end of Q2 is all those cases eligible for **any** period between 1st April and 30th September inclusive.

Cumulative activity year to date for the current quarter is calculated for you in the final column of Table 2 by adding the number of cases eligible up to the end of the previous quarter (column A) to the number of cases newly eligible in the current quarter (column B).

Do not include PUPoCs in Table 2 as these are counted as separate claims in Table 10 (and / or table 9 if appropriate). 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 (and / or table 9 if appropriate), whilst activity relating to the standard NHS CHC package (ongoing care) should be included in Tables 1 to 9 as appropriate.

4.1 Column A: BASELINE - Closing cumulative activity end of previous quarter

Please enter the number of cases eligible for NHS CHC *year to date* up to the end of the **previous** quarter (Cumulative Activity as per the definition above).

i.e. **all** cases eligible at **any time** between 1st April up to and including the last day of the previous reporting quarter.

If this figure is different from the closing cumulative activity reported last quarter (included to the left of this field in grey for information) due to updated / corrected information please include an explanatory note in the comments section to confirm the latest information is correct.

Note: In the Q1 reports only, 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 count to start picking up the running total of all eligible cases year to date.

5 Table 3 – NHS CHC Referrals in Quarter

5.1 Number of referrals in quarter

A referral is the earliest notification (to the CCG or person or body acting on behalf of the CCG) that *full assessment* of NHS CHC eligibility is required (e.g. a *positive* checklist, Fast Track Tool or other notification that full assessment is required).
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 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.

Please enter the number of referrals for NHS CHC in the quarter.

Do 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), or PUPoCs. Only count the outcome of an FNC review if needs have materially changed and the case is referred for full assessment of NHS CHC eligibility by an MDT. Referrals submitted more than once due to incomplete or incorrect information should still be counted but only be counted **once** from the earliest notification. Genuine instances of more than one referral for the same individual i.e. 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 some examples of different scenarios relating to referrals and when they should and should not be counted please see FAQs.

6 Table 4 – NHS CHC Referral Outcomes in Quarter

6.1 Number assessed as eligible for NHS CHC in quarter

Populated automatically from the number of cases agreed eligible in quarter from Table 1.

6.2 Number assessed as not eligible for NHS CHC in quarter

Please enter the number of people assessed as **not** eligible for NHS CHC in the quarter.

For Standard NHS CHC these are cases that have had a new DST / MDT recommendation and a verified 'not eligible' decision on NHS CHC eligibility from the CCG. This could also include those cases that were found **not eligible** for Standard NHS CHC but were eligible for FNC or a Joint Funded individual package of care.

Please note, for fast track cases this field is greyed out and unavailable for completion, as it shouldn't ever be possible to fully process a fast track referral as not eligible. It is

only possible to discount a fast track referral before it is fully processed. 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' (see 6.4 below) rather than 'assessed not eligible'.

6.3 Total number assessed in quarter

Calculated automatically by adding column A + column B in Table 4.

6.4 Number discounted before assessment completed in quarter

Please enter the number of referrals discounted before assessment was complete.

Examples include deceased individuals (in some instances only – please see FAQs), people referred for fully funded interim care in discharge to assess arrangements, people who deteriorate and need further acute treatment, referrals made via a 'positive' checklist but further QA of the paperwork identifies that the checklist is negative, withdrawn, cases closed without carrying out an assessment for other reasons etc. This also includes 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).

6.5 Total referrals concluded in quarter

A referral is concluded when there has been a verified decision on NHS CHC eligibility or the referral has been discounted before this stage (please see 'Number discounted after referral' definition above). Calculated automatically by adding column C + column D in Table 4.

7 Table 5 – NHS CHC Conversion Rates in Quarter

7.1 Assessment Conversion Rate

The number of cases agreed eligible in the quarter as a percentage of the total number of cases assessed in the quarter. Calculated automatically by dividing column A by column C in Table 4.

7.2 Referral Conversion Rate

The number of cases agreed eligible in the quarter as a percentage of the total number of referrals concluded in the quarter. Calculated automatically by dividing column A by column E in Table 4.

8 Table 6 – NHS CHC Location of DST in Quarter

8.1 Column A: Number of DSTs carried out in quarter

Please enter the number of DSTs carried out in quarter. Only include DSTs carried out as a result of a referral (either as a result of a new referral or a referral resulting from an

FNC review if needs have materially changed). Please use the same definition of a referral that is set out on page 11.

8.2 Column B: Number of DSTs in acute hospital setting in quarter

Please enter the number of DSTs from column A that were carried out in an acute hospital setting in quarter. Please see FAQs for further information.

8.3 % of DSTs carried out in an acute hospital setting

Calculated automatically by dividing column B by column A in Table 6.

9 Table 7 – NHS CHC 28 Days Referral Time

9.1 Total referrals concluded in quarter

Calculated automatically from 'Total referrals concluded in quarter' in Table 4.

9.2 Number of concluded referrals within 28 days

Please enter the number of referrals from column A (Total referrals concluded in quarter) that were completed within 28 calendar days. 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).

Please note that the National Framework **does not** specify any scenarios in which CCGs should 'stop the clock' when counting 28 day referral time.

The 28 days clock should start from the earliest notification that full assessment is required (as per the above definition) 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.

Referrals submitted more than once due to incomplete or incorrect information should only be counted once and from the earliest notification for the purposes of counting 28 days. 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 10. Requests to review eligibility decisions via the local resolution process following initial assessment which are referred back to the MDT should not be included. (See Table 3 – NHS CHC Referrals in Quarter on page 11 and FAQs for examples / further information).

9.3 % of referrals concluded within 28 days

Calculated automatically by dividing column B by column A in Table 7.

9.4 Incomplete 28 days Snapshot

Please enter the number of incomplete referrals exceeding 28 calendar days as at quarter end. This should be the total number of cases waiting to be concluded that have exceeded 28 calendar days as at the last day of the quarter. Do not include transition cases (see 2.2.3 on page 6 for further information).

10 Table 8 – NHS CHC Cases Exceeding 28 days

10.1 Column A - Incomplete 28 days Snapshot

Calculated automatically from ‘Number of incomplete referrals exceeding 28 days as at end of quarter’ in Table 7.

10.2 Time band categories

In each of the remaining columns in Table 8 please record as appropriate the number of referrals in column A that have exceeded 28 calendar days by:

- Up to 2 weeks (1 to 14 days)
- Above 2 and up to 4 weeks (15 to 28 days)
- Above 4 and up to 12 weeks (29 to 84 days)
- Above 12 and up to 26 weeks (85 to 182 days)
- Over 26 weeks (183 days and over)

E.g. a referral that hits day 29 has exceeded 28 days by 1 day and would be recorded in the ‘up to 2 weeks’ category.

The total of the time band categories together must be the same as the total in column A.

Do not include transition cases (see 2.2.3 on page 6 for further information).

11 Table 9 – NHS CHC Local Resolution: Appeals (requests for a review of an eligibility decision)

An appeal is a request for a review of an eligibility decision, by the individual or their representative, following a full assessment undertaken using the Decision Support Tool (or by use of the Fast Track Pathway Tool). Local appeals are those that are addressed through the local resolution process by the CCG (or organisation acting on behalf of the CCG). Do not include Independent Reviews or Ombudsman appeals. Do not include complaints related to checklists, or other elements of the assessment process, which do not constitute a local appeal as outlined above.

11.1 Column A: Number of Local Appeals Completed in Quarter

Please enter the number of local appeals completed in quarter. A local appeal is complete at the point the outcome of the local resolution process is communicated to the patient or their representative (e.g. the date a decision letter is sent).

Please include any type of local appeal (i.e. local appeals related to current cases, reviews or PUPoCs). Do not include Independent Reviews, Ombudsman appeals, or complaints.

11.2 Column B: Number of Local Appeals resulting in eligibility

Please enter the number of local appeals from column A that resulted in full or partial eligibility.

11.3 Column C: % of Local Appeals resulting in eligibility

Calculated automatically by dividing column B by column A in Table 9.

11.4 Incomplete Local Appeals Snapshot

Please enter the number of incomplete local appeals as at quarter end. This includes any local appeals received but not yet actioned or any which are in progress but have not reached the point at which a decision letter (or other communication of appeal outcome) has been sent.

12 Table 10 – Previously Unassessed Periods of Care

Claims for Previously Un-assessed Periods of Care (PUPoCS – formerly "retrospectives") refer to a specific request to consider eligibility for a past period of care, where there is evidence that the individual should have been assessed for eligibility for NHS CHC funding

PUPoCs may relate to either deceased or ongoing eligible cases. For example, an individual may be deceased and their family may make a claim to consider eligibility for a past period of care in isolation or an individual may be agreed eligible for Standard NHS CHC via the normal assessment route *and* also have a claim for a past period of care considered. In this case any data relating to the PUPoC should be recorded in Table 10 whilst any data relating to the standard NHS CHC package (ongoing care) should be included in in Tables 1 to 9 as appropriate.

In March 2012 a 'closedown' exercise was initiated following an announcement from the Department of Health setting deadlines for patients and their families to apply for consideration of previously unassessed periods of care between 1 April 2004 and 31 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). It is also still possible for CCGs to receive requests for 'non-closedown' PUPoCs relating to periods of care after 31 March 2012.

For the purposes of this report all PUPoCs that meet the definition at the beginning of this section should be counted irrespective of whether they are closedown or non-closedown type, provided they were agreed eligible in the current financial year. Please see FAQs for further information.

PUPoCs should be recorded according to the date an eligible decision was made e.g. if a PUPoC relates to a period of care between Aug 2013 and Sep 2014 and is agreed eligible in quarter 1 2018/19 it should be included in your quarter 1 report.

A standard NHS CHC referral which is processed late with the costs reimbursed to the time of the referral does **not** come under the PUPoC definition. (For further information on the difference between a PUPoC and a reimbursement please see FAQs).

Only include activity for PUPoCs once they are agreed eligible. Do not include any cases which are waiting for a decision.

12.1 PUPoCs agreed eligible YTD

Please enter the number of PUPoC Claims **agreed eligible** year to date up to the end of the current reporting quarter.

13 NHS-Funded Nursing Care

13.1 NHS-funded Nursing Care Definition

NHS-funded Nursing Care (FNC) is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse. Since 2007 FNC has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS CHC before a decision is reached about the need for FNC.

13.2 Exclusions in FNC

Please do not count funding under any section of the Mental Health Act 1983 as FNC. If an individual is funded under a Mental Health Section *and* eligible for FNC under the National Framework eligibility criteria (as defined above) then please include the CCG activity related to the FNC only and do not include any activity covered by the Mental Health section.

Do not include cases where consideration for FNC funding is in process but not yet approved (i.e. awaiting eligibility outcome).

14 Table 11 – FNC Activity

14.1 FNC Cumulative Activity Year to Date

Please enter the number of cases eligible for FNC *year to date*, i.e. **all** cases eligible for **any time** between 1st Apr up to and including the last day of the quarter.

14.2 FNC Snapshot Activity

Please enter the number of people eligible for FNC *as at* the last day of the quarter.

15 Further Reading

National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care.