Annex D: Independent Review Panel Procedures

The purpose and scope of independent review panels

1. Standing Rules[1] require NHS England to maintain independent review panels (IRPs).

2. An IRP's key tasks are, at the request of NHS England, to conduct a review of the following:

   a) the primary health need decision by a CCG; or

   b) the procedure followed by a CCG in reaching a decision as to that person's eligibility for NHS continuing healthcare

   and to make a recommendation to NHS England in the light of its findings on the above matters.

3. An IRP should not proceed if it is discovered that the individual has not previously received a comprehensive assessment of needs and a determination of their eligibility for NHS Continuing Healthcare, including use of the Decision Support Tool or the Fast Track Pathway Tool, as appropriate. Where an IRP request is received in such circumstances, NHS England should refer the case to the relevant CCG and ask for an assessment of needs and a determination of the individual's eligibility for NHS continuing healthcare to be carried out, if it appears that there may be a need for such care.

4. The IRP procedure does not apply where individuals, their families or any carer wish to challenge:

   - the content of the eligibility criteria;
   - the type and location of any offer of NHS-funded continuing care services;
   - the content of any alternative care package that they have been offered;
   - their treatment or any other aspect of the services they are receiving or have received (this would properly be dealt with through the complaints procedure).

5. The IRP should apply the key principles for dispute resolution processes, as set out in paragraphs 196-207 of the National Framework.

6. Individuals (and their carer and/or representative, where appropriate) should be given clear information about the IRP procedure, the situations it does and does not cover, and how it operates locally. Advocates should be provided where this will support the individual through the review process. NHS England and CCGs

should ensure that there are agreed protocols as to how the provision of advocates will operate and the circumstances in which they are to be made available.

7. It is particularly important that, before an IRP is convened, all appropriate steps have been taken by the relevant CCG to resolve the case informally, in discussion with the NHS England where necessary. NHS England should have a named contact, who is the first port of call for queries from partner organisations for the relevant locality.

8. If the case cannot be resolved by local resolution (or local resolution will cause undue delay), the individual (or their representative) may ask the NHS England to arrange an IRP to review the case with regard to the matters listed in paragraph 2 above. Before doing so, NHS England should ensure that none of the circumstances listed at paragraphs 3 and 4 of this annex apply. If any of them are applicable, NHS England should contact the individual and advise them of the appropriate routes for dealing with these matters. If the case nevertheless has some issues that fall within an IRP's responsibilities, the IRP should proceed, but should only deal with the relevant matters.

9. NHS England should designate individuals to maintain the review procedure and to give advice to IRPs and to the parties involved on the content of the requirements of the National Framework and the associated tools, as well as on any procedural issues.

10. Clear and timely communication is very important. NHS England should develop and publish timescales for the hearing of IRP cases.

11. NHS England does have the right to decide in any individual case not to convene an IRP. It is expected that such a decision will be confined to those cases where the individual falls well outside the eligibility criteria, or where the case is very clearly not appropriate for the IRP to consider. Before taking such a decision, NHS England should seek the advice of the chair of the IRP, who may require independent clinical advice. In all cases where a decision not to convene an IRP is made, NHS England should give the individual, their family or carer a written explanation of the basis of its decision, together with a reminder of their rights under the NHS complaints procedure.

12. No individual should be left without appropriate support while they await the outcome of the review. The eligibility decision that has been made is effective while the independent review is awaited. This does not preclude review of eligibility in the meantime by the CCG, using the process set out in paragraphs 194-195 of the National Framework, if the individual's needs change or if the time for the next scheduled review of the individual has arrived. Please see Appendix E for guidance on responsibilities when a decision on NHS Continuing Healthcare eligibility is awaited or is disputed.

Establishment and operation of the panels

13. IRP chairs should be selected by the NHS England, following an open recruitment process. Those chosen should have a clear understanding of the IRP's purpose and be able to communicate this to the individual, their family and any carers concerned. On the basis of the evidence received and the advice given at the IRP, the chair should be able to determine, in consultation with other IRP members, whether eligibility criteria have been correctly applied. The chair should have the capacity to make balanced decisions in sometimes difficult circumstances, while taking a sympathetic view of the concerns of individuals, their family and any carers.

14. Selection of the right people as chairs – people who are capable of gaining the confidence of all parties – will be a crucial factor in the success of the IRP. Current NHS staff, board members of NHS organisations, LA staff and LA elected members should not be considered but people who have formerly held such a position are eligible. NHS England is advised to involve lay people in the selection process.

15. The appointment of representatives from CCGs and LAs will be on the basis of the nomination of those organisations. They should take account of professional and other skills that are relevant to the work of the IRP. The chair and members of an IRP should receive reasonable expenses.

16. The members of the IRP should meet to consider individual cases. A designated NHS England representative should be responsible for ensuring that the relevant information has been received from the CCG before the IRP. The IRP should also have access to the views of key parties involved in the case, including the individual, his or her family and any carer, health and social services staff, and any other relevant bodies or individuals. It will be open to key parties to put their views in writing or to attend. If parties attend, they should be given the opportunity to hear the submissions of other parties and to ask them questions.

17. An individual may have a representative present to speak on his or her behalf if they so choose, or if they are unable to, or have difficulty in presenting their own views. This role may be undertaken by a relative or carer or advocate acting on the individual's behalf. The IRP should be satisfied that any person acting on behalf of the individual accurately represents their views, and that the representative's interests or wishes do not conflict with those of the individual. The IRP should respect confidentiality at all times.

18. The IRP will require access to independent clinical advice, which should take account of the range of medical, nursing and therapy needs involved in each case. Such arrangements should avoid any obvious conflicts of interest between the individual clinician(s) giving the advice and the organisation(s) from which the individual has been receiving care. The chair of the relevant IRP should consider in advance of the hearing whether, bearing in mind the nature of the case, the evidence supplied and the role of the clinical adviser set out in paragraph 19 below, there is a need for the panel to access independent clinical advice, and

whether this should be in the form of attendance at the hearing or of the clinician supplying written advice.

19. It is the role of the clinical adviser to advise the IRP on the original clinical judgements and on how those judgements relate to the National Framework. It is not the adviser's role to provide a second opinion on the clinical diagnosis, management or prognosis of the individual.

20. An IRP may ask all parties to withdraw while it deliberates and agrees its recommendations. Where appropriate, an IRP may ask an NHS England representative and/or the clinical adviser to be present to give advice. NHS England may also be represented in order to keep a record of deliberations.

21. In reaching a view on whether the CCG followed the correct process and whether it correctly applied the eligibility criteria, the range of recommendations made by the IRP for consideration by the CCG could include:
    a) that the case should be reconsidered by NHS England or the CCG, addressing identified deficiencies in the process used or in the application of the eligibility criteria; or
    b) that, on the evidence submitted, when compared to the eligibility criteria, the individual should or should not be considered to have a primary health need.

22. A full record should be made of the IRP hearing, including details of those present and their role, the issues and evidence considered, the conclusions and recommendations reached by the IRP, and the reasons for them. A copy of this should be sent by NHS England to all parties.

23. The recommendations of an IRP should be accepted by NHS England in all but exceptional circumstances.

24. If NHS England decides, in exceptional circumstances, not to accept an IRP recommendation in an individual case, it should explain this in writing to the individual, the CCG and the chair of the IRP, including its reasons for not accepting it.

25. In all cases, the NHS England should communicate the outcome of the review, with its reasons, to the individual and the CCG.

26. A CCG should accept the recommendations of the IRP, as forwarded by the NHS England, in all but exceptional circumstances. If a CCG decides, in exceptional circumstances, not to accept an IRP recommendation in an individual case, it should explain this in writing to the individual and NHS England, including its reasons. If NHS England or CCG does not accept the recommendations, and if the individual is dissatisfied with this, the matter should be pursued through the NHS complaints procedure.

27. NHS England or the CCG, as appropriate, should ensure that the individual is informed in writing of their right to use the NHS complaints procedure in such circumstances.

Annex E: Guidance on responsibilities when a decision on NHS Continuing Healthcare eligibility is awaited or is disputed

1. This guidance sets out the approach to be taken by CCGs and local authorities (LAs) in three situations:

   a) where there is a need for health or care and support to be provided to an individual during the period in which a decision on eligibility for NHS Continuing Healthcare is awaited, in a case that does not involve hospital discharge (refer to paragraphs 109-115 of the National Framework).

   b) where a CCG has unjustifiably taken longer than 28 calendar days to reach a decision on eligibility for NHS Continuing Healthcare; or

   c) where, as a result of an individual disputing an NHS Continuing Healthcare eligibility decision, the CCG has revised its decision.

a) Where care needs to be provided whilst a decision on NHS continuing healthcare is awaited, in a case that does not involve hospital discharge

2. A person only becomes eligible for NHS continuing healthcare once a decision on eligibility has been made by a CCG, informed by a completed Decision Support Tool or Fast Track Pathway Tool. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment.

3. If, at the time of referral for an NHS Continuing Healthcare assessment, the individual is already receiving ongoing care and support funded by a CCG, or a local authority, or both, those arrangements should continue until the CCG makes its decision on eligibility for NHS Continuing Healthcare, subject to any urgent adjustments needed to meet the changed needs of the individual. In considering such adjustments, local authorities and CCGs should have regard to the limitations of their statutory powers.

4. Some health needs fall within the powers of both CCGs and local authorities to meet. However where:

   i) a local authority is providing services during the period in which an NHC Continuing Healthcare eligibility decision is awaited; and
   ii) it is identified that the individual has some health needs that are **not** within the power of a local authority to meet (regardless of the eventual outcome of the NHS Continuing Healthcare eligibility decision); and
   iii) those health needs have to be met before the decision on eligibility is made;

the CCG should consider its responsibilities under the NHS Act to provide such health services to such extent as it considers necessary to meet all reasonable requirements. NHS England or the CCG should therefore consider whether the individual's health needs are such that it would be appropriate to make services available to help meet them in advance of the NHS Continuing Healthcare eligibility decision.

5. Where an individual is not already in receipt of ongoing care and support from the local authority or CCG (or both), they may have urgent health or care and support needs which need to be met during the period in which the NHS Continuing Healthcare eligibility decision is awaited, for example because previous private arrangements are no longer sustainable or there were not previously any care needs requiring support. Where there are urgent healthcare needs to be met, these should be assessed by the relevant healthcare professional.

6. Where the individual appears to be in need of care and support, the local authority should assess the individual's eligibility for these under section 9 of the Care Act 2014.

7. If, in carrying out a needs assessment (under the Care Act 2014), it appears to the local authority that the individual may be eligible for NHS Continuing Healthcare the local authority must refer the individual to the CCG. The CCG must then take steps to ensure that an assessment of eligibility for NHS Continuing Healthcare is carried out. The local authority and CCG should jointly agree actions to be taken in the light of their statutory responsibilities until the outcome of the NHS Continuing Healthcare eligibility decision making process is known. No individual should be left without appropriate support because statutory bodies are unable to agree on respective responsibilities.

b) <u>Where the CCG has unjustifiably taken longer than 28 calendar days to reach a decision on eligibility for NHS continuing healthcare</u>

8. Decision-making on eligibility for NHS Continuing Healthcare should, in most cases, take no longer than 28 calendar days from the CCG (or organisation acting on behalf of the CCG) being notified of the need for assessment of eligibility for NHS Continuing Healthcare e.g. an appropriately completed positive Checklist, or other notification that an assessment of eligibility is required.

9. When
   i) the CCG makes a decision that a person is eligible for NHS continuing healthcare; and
   ii) it has taken more than 28 calendar days to reach this decision; and
   iii) a local authority or the individual has funded services whilst awaiting the decision;

   the CCG should, having regard to the approaches set out in paragraphs 11 to 13 below, refund directly to the individual or the local authority, the costs of the services from day 29 of the period that starts on the date of receipt of a completed Checklist (or where no Checklist is used, other notification of potential

payment in respect of the period of unreasonable delay.

14. Such payments would need to be made in accordance with the guidance for ex-gratia payments set out in Managing Public Money[1]. This sets out that, where public services organisations have caused injustice or hardship, they should provide remedies that, as far as reasonably possible, restore the wronged party to the position that they would have been in had matters been carried out correctly. This guidance sets out other issues to be considered and CCGs should take these into account in reaching their decision.

c) Where, as a result of an individual disputing an NHS continuing healthcare eligibility decision, a CCG has revised its decision

15. When a CCG has made a decision on NHS Continuing Healthcare eligibility, then that decision remains in effect until the CCG revises the decision. This National Framework sets out that IRPs make recommendations but that these recommendations should be accepted by NHS England and the CCG in all but exceptional circumstances. Where a CCG accepts an IRP recommendation on NHS Continuing Healthcare eligibility, it is in effect revising its previous decision in the light of that recommendation.

16. Where:
    i) a local authority has provided care and support to an individual in circumstances where a CCG has decided that the individual is not eligible for NHS continuing healthcare, and

    ii) the individual disputes the decision that they are not eligible for NHS Continuing Healthcare and the CCG's decision is later revised (including where the revised decision is as a result of an IRP recommendation),

    the CCG should refund the local authority the costs of the care package. This should be based on the gross care package costs that the local authority has incurred from the date of the decision that the individual was not eligible for NHS Continuing Healthcare (or earlier, if that decision was unreasonably delayed – see the previous section) until the date that the revised decision comes into effect. The CCG can use its powers under section 256 of the NHS Act to make such payments. Where the local authority has collected an assessed charge from the individual, the refund from the CCG should include interest on that amount so that this can be reimbursed to the individual (see paragraph 17 below)

17. Where a CCG makes such a refund, the local authority should refund any financial contributions made to it by the individual (with interest) in the light of the fact that it has been refunded on this basis.

18. Where:
    i) no local authority has provided care and support to an individual in

[1] Managing Public Money