POLICY ON NHS CONTINUING HEALTHCARE REDRESS PAYMENTS
DOCUMENT CONTROL SHEET

Document Owner: Director of Operations
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Change History:

<table>
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<tr>
<th>Version</th>
<th>Date</th>
<th>Reviewer(s)</th>
<th>Revision Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2.0</td>
<td>21-07-2016</td>
<td>Mills &amp; Reeves</td>
<td>Revised policy</td>
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</table>

Implementation Plan:

| Development and Consultation | NHS England
Mills & Reeves
Director of Governance
Governing Body |
<table>
<thead>
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<tbody>
<tr>
<td>Dissemination</td>
<td>Staff can access this policy via the Intranet.</td>
</tr>
</tbody>
</table>
| Training                    | In-house training and shadowing
Intranet – accessing the policies and operating procedures
NHS England guidance
Ombudsman reports           |
| Monitoring                  | Continuing Healthcare annual audit or as required.           |
| Review                      | The CCG will review this policy regularly in the light of decisions made in respect of redress and will make any necessary changes to the policy to reflect those decisions. |
| Equality, Diversity and Privacy | 12-07-2016 - Equality Impact Assessment  
12-07-2016 - Privacy Impact Assessment |
| Associated Documents        | None identified.                                             |
| References                  | NHS England
NHS Continuing Healthcare Redress Guidance Policy for CCGs     |
1.0 Introduction

1.1 Content of this Policy

1.1.1 This policy describes the approach ENHCCG will follow in order to assess and manage a claim for Continuing Healthcare redress.

1.2 Legal responsibility for commissioning NHS Continuing Healthcare passed from Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs) on 1st April 2013. For avoidance of doubt, this policy will apply to cases which predated the establishment of East and North Hertfordshire CCG (thereafter “ENHCCG” / “the CCG”).

1.3 In March 2007, in response to the Parliamentary and Health Service Ombudsman’s report Retrospective Continuing Care Funding and Redress, the Department of Health ("DH") published best practice guidance NHS Continuing Healthcare: Continuing Care Redress (thereafter the “2007 Guidance”) to help PCTs to review the approach they took, and CCGs continue to take, to making redress where funding for NHS Continuing Healthcare (formerly known as NHS Continuing Care and hereafter referred to as “Continuing Healthcare”) had been wrongly withheld.

1.4 The 2007 Guidance was revised by NHS England’s guidance NHS Continuing Healthcare: Refreshed Redress Guidance published April 2015 (thereafter the “2015 Guidance”). The 2015 Guidance is the appropriate guidance for assessing CHC redress claims where a decision on eligibility has been made after 1 April 2015.¹

1.5 This policy is in line with the 2007 Guidance and 2015 Guidance and applies to cases where Continuing Healthcare has been wrongly withheld and it is appropriate for redress to be paid, including:

1.5.1 The review of cases dating back to 1 April 1996 ("Historic Redress Cases"); and

1.5.2 Cases where Continuing Healthcare funding has been wrongly withheld and redress has yet to be made ("Current Redress Cases").

1.6 Claims to which this policy applies must have been notified to ENHCCG or its predecessor bodies on or before the following deadlines²:

1.6.1 For claims where the majority of time is prior to April 2004, the deadline for notification was 30 November 2007;

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¹ The 2015 Guidance is a revision of the 2007 Guidance and has been developed in conjunction with the NHS National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care published November 2012 effective 1 April 2013

² See NHS Continuing Healthcare Guidance for Strategic Health Authorities and Primary Care Trusts on the time limits for individuals to request a review of an eligibility decision for NHS Continuing Healthcare Funding published March 2012
1.6.2 For claims where the majority of time falls between 1 April 2004 and 31 March 2011, the deadline was 30 September 2012;

1.6.3 For claims where the majority of time falls between 1 April 2011 and 31 March 2012, the deadline was 31 March 2013.

1.7 ENHCCG will only consider claims outside of the relevant deadlines in exceptional circumstances.

1.8 This policy should be read in conjunction with the Fraud Act 2006, The Bribery Act 2010 and the Clinical Commissioning Group Anti-Fraud and Bribery Policy, which are located on the intranet under the Policies, Strategies and Terms of Reference Section. Failure to adhere to the policies could result in disciplinary action, and where misconduct is identified could be referred to the Local Counter Fraud Specialist (LCFS).

2.0 Scope

2.1 This policy applies to all CCG staff members, including Governing Body Members and Practice Representatives, involved in the CCG’s policy-making processes, whether permanent, temporary or contracted-in (either as an individual or through a third party supplier).

3.0 Purpose

3.1 Objective of this Policy

3.1.1 This policy has been prepared to ensure that ENHCCG is compliant with the 2007 Guidance and the 2015 Guidance.

3.1.2 The 2015 Guidance states the purpose of redress as being “solely to restore the individual to the financial position they would have been in had NHS Continuing Healthcare been awarded at the appropriate time.” Redress should not lead to a profit or an advantage and so where maladministration has resulted in financial injustice the principle of redress “should generally be to return individuals to the position they would have been in but for the maladministration which occurred.”

3.1.3 ENHCCG will always consider the specific circumstances of each individual case when determining the appropriate level of redress and will always provide a transparent rationale for its decision.
4.0 Definitions

4.1 Redress where Continuing Healthcare has been assessed and determined and wrongly withheld.

4.2 National Health Service (NHS)

The publicly funded national healthcare system in the United Kingdom.

4.3 Primary Care Trust (PCT)

Local organisations who were responsible for commissioning primary and secondary health services in the community. PCTs were replaced in March 2013 by CCGs.

4.4 Clinical Commissioning Group (CCG)

NHS organisations set up by the Health & Social Care Act 2012 to organise the delivery of NHS services in England.

4.5 Continuing Healthcare (CHC)

NHS continuing healthcare is a package of on-going care that is arranged and funded solely by the NHS. It is designed to support individuals aged 18 or over who are found to have a primary health need which have arisen as a result of disability, accident or illness.

4.6 Department of Health (DH)

Government department responsible for policy on health and adult social care matters.

4.7 Local Counter Fraud Specialist (LCFS)

The LCFS is responsible for taking forward all anti-fraud work locally in accordance with national NHS Protect standards.

5.0 Roles and Responsibilities

5.1 CCG Redress Panel

ENHCCG has set up a Continuing Healthcare Redress Panel consisting of:

• Company Secretary (Chair)
• Deputy Chief Finance Officer
• Clinical representative from the CHC Team
The Continuing Healthcare Redress Panel will:

(i) Review the evidence provided by the claimant of financial loss, costs and expenses incurred or distress suffered;

(ii) Consider what settlement should be offered to the claimant in accordance with this policy;

(iii) Make a recommendation to the CCG on the settlement to be offered;

(iv) Formulate an offer or a negotiating position; and

(v) If all offers are rejected by the claimant, decide on an action plan.

(vi) Ensure responsible commissioners are identified in each case and appropriate use and monitoring of any shared risk budget for redress and restitution spend.

5.2 CCG Governing Body

The governing body is responsible for approving the policy for CHC redress.

5.3 Chief Executive – Accountable Officer

The Chief Executive is accountable for all CHC activity and its policies and operating procedures.

5.4 Chief Finance Officer

The Chief Finance Officer is responsible for ensuring that public monies are clearly used appropriately.

5.5 Director of Operations

The Director of Operations is responsible for the operational activities and monitoring of CHC.

5.6 Assistant Director, Continuing Healthcare

The Assistant Director is responsible for the day-to-day operational activities of CHC.

5.7 All Staff

All staff should be aware of the Redress Policy.
6.0 Processes

6.1 Reimbursement of Historic and Current Redress Cases

6.1.1 Where in respect of any Current Redress Cases the decision on eligibility is made on or after 1 April 2015 the CCG will calculate the value of the redress claim in line with the 2015 Guidance. If the decision on eligibility pre-dates 1 April 2015 then the value of the redress claim will be calculated in accordance with the 2007 Guidance.

6.1.2 Where in respect of any Historic Redress Case, the application of the formula in the 2007 Guidance indicates that the patient was over-reimbursed for all of their financial losses, including interest, taking into account any appropriate ex gratia payment that ought to have been made, the CCG will not attempt to recoup any overpayment, except in the case of misinformation or fraud.

6.1.3 ENHCCG will give assurances to patients and their families that if patients were financially advantaged by the method used to calculate their reimbursement prior to 2015 and received more than they would have received had the formula in the 2015 Guidance been applied, they will not be required to pay the difference.

6.2 Reimbursement of Care Costs

6.2.1 This is the cost of care incurred by the patient or their family which ought to have been met by the NHS. ENHCCG will determine the sum for any reimbursement of care costs in line with the 2015 Guidance. Care costs are paid with interest typically calculated in line with the Retail Price Index.

6.2.2 All claimants have a duty to actively take steps to keep their losses to a minimum. In view of this ENHCCG will consider whether the care home fees are reasonable and reflective of the fees payable by ENHCCG had the patient been in receipt of Continuing Healthcare funding during the period of retrospective eligibility. If the CCG considers care costs incurred are excessive relative to the patient’s needs, then the CCG may reduce the amount of any compensatory sum to reflect the reasonable cost of providing care reflective of that it would have provided at the time.

6.3 Other Financial Compensation

6.3.1 Where it is reasonable and appropriate to do so ENHCCG will consider compensation for financial losses other than care costs that have been incurred as a result of Continuing Healthcare
having been wrongly withheld. ENHCCG will only reimbursement financial losses other than care costs where the claimant is able to provide documentary evidence of losses and the CCG is sufficiently satisfied that the losses being claimed are directly linked to the failure to provide Continuing Healthcare.

6.3.2 The CCG will consider the evidence provided by the claimant to determine the context in which the losses were incurred and the CCG must be satisfied that the losses being claimed were incurred entirely due to a need to meet care costs and not wholly or partly for other reasons, e.g. to pay debts relate to care costs incurred before the patient became eligible for fully funded Continuing Healthcare.

6.4 Inconvenience and Distress

6.4.1 The CCG has no general legal liability for any inconvenience or distress.

6.5 Legal Costs

6.5.1 The Parliamentary and Health Service Ombudsman has indicated that it will rarely be appropriate for a claimant to receive a refund of legal and professional costs incurred in bringing a claim for Continuing Healthcare redress. A claimant does not require legal advice to obtain an assessment of eligibility for Continuing Healthcare or to have a decision on eligibility reviewed.

6.5.2 ENHCCG will support claimants through the process, which is designed to be collaborative and unbiased. Where an individual is dissatisfied with ENHCCG’s offer of redress then they can pursue the matter via the CCG’s complaints process. In the case of a dispute the CCG will not delay payment of any undisputed elements.

6.5.3 Independent and impartial support in respect of Continuing Healthcare redress can be obtained from Beacon; an independent third party organisation.

6.6 Interest

6.6.1 Where the decision on eligibility is made after 1 April 2015 ENHCCG will calculate interest in line with the 2015 Guidance using the Retail Price Index. The rate used will be the average rate for the year for which care costs are being reimbursed. The rates of the RPI are available online from the Office of National Statistics at: http://www.ons.gov.uk. The contact details for the
Office of National Statistics are available online at: http://www.ons.gov.uk/ons/site-information.

6.6.2 Where the decision on eligibility was made prior to 1 April 2015 the CCG will calculate interest using the historic method contained in the 2007 Guidance.

6.6.3 Following an offer of settlement, interest will continue to accrue from the date the offer is made until the date the offer is accepted or where no response to an offer is received for a period of no more than 28 days from the date the offer is made. If the settlement sum is disputed, ENHCCG will consider an interim payment to prevent the accrual of additional interest.

6.7 Ex Gratia Payments

6.7.1 Ex gratia payments are payments made in cases where there is no obligation or legal liability but where, in all the circumstances, the payer considers it is responsible for loss or damage that ought properly to be compensated or desires to address a hardship that the payee has had to suffer as a result of failure or delay on the part of the payer.

6.7.2 ENHCCG has the discretion to consider making an ex gratia payment in addition to any compensatory payment where it feels it is appropriate to do so, however, these are expected to be infrequent and will only apply in exceptional circumstances.

6.8 Settlement

6.8.1 Once ENHCCG has approved the basis of a settlement the Continuing Healthcare Team will write to the claimant to propose an agreed settlement of the claim.

6.8.2 If the CCG is unable to reach agreement with the claimant as to any settlement of their claim, the case will be referred back to the Continuing Healthcare Redress Panel to consider any representations made by the claimant as to why the settlement offered is unacceptable.

6.8.3 The Continuing Healthcare Redress Panel will recommend a further offer or negotiating position to the CCG. Cases will normally be considered at the next Redress Panel meeting but, in order to speed up the settlement of claims, cases may be discussed by the Panel members by other means, e.g. email or telephone conference and decisions or recommendations may be made in this way between Panel meetings.
6.8.4 Any further recommendation by the Redress Panel will be final and will be communicated to the claimant by the CCG. If the claimant is still dissatisfied with the settlement, he or she may make a complaint to the CCG and the CCG’s complaints procedure will be followed in the normal way.

6.9 Accepting an offer of settlement and payment of settlement monies

6.9.1 An offer of settlement can only be agreed by an individual with the appropriate authority to accept the offer. ENHCCG will only make an offer of settlement in circumstances where there is an individual with the appropriate authority to accept that offer and in circumstances where there is an individual with the appropriate authority to receive payment of the settlement.

6.9.2 Where the claimant is alive and deemed to have full capacity the claimant must approve the offer of settlement and payment must be made into a bank account in the claimant’s name or into an alternative bank account otherwise specified by the claimant in writing.

6.9.3 Where a claimant is alive but deemed to lack capacity then from that date the CCG will require a representative (an attorney under an Enduring or Lasting Power of Attorney or a court-appointed property and financial affairs deputy) be appointed to represent the claimant’s interests in a claim for redress moving forwards. The CCG will require that the offer or settlement be approved by a formally appointed representative and that all settlement monies be paid into a bank account held in trust for the claimant or into a bank account in the claimant’s name.

6.9.4 Where the claimant is deceased the claim for Continuing Healthcare redress should be brought for and on behalf of the deceased’s estate by a personal representative, that representative having obtained and provided evidence of a Grant of Probate. If a claimant dies during the claim process then their personal representatives will be permitted to continue the claim on behalf of their estate after having provided evidence of having obtained a Grant of Probate. The personal representatives of the deceased’s estate must approve the offer of settlement. The CCG will only pay settlement monies into an account held for and on behalf of “the estate of” the deceased claimant.

6.9.5 In some cases, where the full cost of care is reimbursed to the patient, this may result in the local authority seeking to recover from the claimant or a deceased patient’s estate the amount of any care costs met by the local authority which ought properly to have been met by fully funded Continuing Healthcare. In these
cases ENHCCG will advise the claimant as to the amount of any such sum and will offer to settle any payment to the local authority directly on behalf of the claimant with the balance of the agreed settlement sum paid to the claimant or their estate. If the claimant declines the offer then ENHCCG will advise the relevant local authority accordingly and it will be for the local authority to pursue any outstanding sum it may have in this respect.

6.10 Precedents

6.10.1 It is important that ENHCCG is consistent in respect of its decision making and negotiation stance for each claim considered. The CCG recognises that its decisions and any settlements made with claimants will form a precedent for other similar decisions or settlements they might make or negotiate in the future.
Dear

Re:

I am writing to you regarding your (or insert claimant’s name) claim for a retrospective payment for Continuing Healthcare Funding, following your acceptance of the decision made in the letter dated XX/XX/XXXX, that YOU/PATIENT NAME was eligible for NHS funded Continuing Healthcare for the period XX/XX/XXXX to XX/XX/XXXX (the “period of eligibility”).

Principle of redress

The principle of redress is to return the claimant to the position he/she would have been in had they been found eligible for continuing healthcare at the commencement of the period of eligibility. Compensation should not lead to material gain, and a claimant has a duty to take reasonable steps to attempt to mitigate any loss they incur. This means that any losses should be kept to a minimum and be as a direct result of the failure to provide care.

Reimbursement and other financial compensation

The Clinical Commissioning Group (CCG) will reimburse you for the reasonable cost of care incurred for which it would have been liable during the period of eligibility. The CCG will also pay interest on that sum calculated in line with the Retail Price Index in accordance with the recent guidance from NHS England. You will need to provide evidence of the losses you have incurred, usually in the form of receipts for the relevant period of care.

In the majority of cases the claim will comprise of reimbursement of care costs and interest only. If you believe that you have incurred other losses, (for example, a family member may have given up work to care for an individual rather purchase care), the CCG will consider other claims on an exceptional basis and where full documentary evidence is provided. The CCG must also be satisfied that the loss arises directly from the failure to provide NHS Continuing Healthcare and the decision to incur the loss was both reasonable and foreseeable.
Please note that the CCG is not required to pay compensation for distress or inconvenience arising out of a claim for continuing healthcare redress, nor is the CCG liable to pay any legal costs incurred as a result of pursuing a claim for continuing healthcare redress.

**How will we reimburse you?**

The CCG will pay compensation to the individual eligible for NHS Continuing Healthcare or their estate where they incurred the losses. Where a family member funded the care and incurred the losses, the CCG will refund that individual provided the requisite proof of loss is provided.

Where a patient has passed away, the CCG may insist that a grant of probate is obtained so that payment can be made to the estate, care of the Personal Representatives. This can take several months and therefore, this should be pursued as soon as possible where necessary to avoid any delay in payment.

**Further information**

Please contact me to discuss this further if you have any queries.

Yours sincerely,

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**Alison Sansom**  
**Interim Assistant Director**  
**Adult Continuing Healthcare**
### Appendix 2
Equality Impact Assessment Stage 1 Screening

#### 1. Policy

<table>
<thead>
<tr>
<th>Title:</th>
<th>☑ Proposed</th>
<th>☐ Existing</th>
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<tbody>
<tr>
<td>Date of Completion:</td>
<td>Review Date:</td>
<td></td>
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</table>

#### EIA Completion Details

- Names & Titles of staff involved in completing the EIA:
  - Mills & Reeves
  - Sharn Elton - Director of Operations
  - Alison Sansom – Interim Assistant Director
  - Sue Phillips – Interim Clinical Services Manager
  - Alison Rees – Interim Business Process Manager

#### 2. Details of the Policy. Who is likely to be affected by this policy?

- ☑ Staff
- ☑ Patients
- ☑ Public

#### 3. Impact on Groups with Protected Characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Probable impact on group?</th>
<th>High, Medium or Low</th>
<th>Please explain your answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>☑ Positive</td>
<td>☐ Adverse</td>
<td>☐ None</td>
</tr>
<tr>
<td>Being married or in a civil partnership</td>
<td>☑ Positive</td>
<td>☐ Adverse</td>
<td>☐ None</td>
</tr>
<tr>
<td>Disability (inc. learning difficulties, physical disability, sensory impairment)</td>
<td>☑ Positive</td>
<td>☐ Adverse</td>
<td>☐ None</td>
</tr>
<tr>
<td>Having just had a baby or being pregnant</td>
<td>☑ Positive</td>
<td>☐ Adverse</td>
<td>☐ None</td>
</tr>
<tr>
<td>Race, (inc. ethnicity, nationality, language)</td>
<td>☑ Positive</td>
<td>☐ Adverse</td>
<td>☐ None</td>
</tr>
<tr>
<td>Religion or belief</td>
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</tr>
<tr>
<td>Sex (inc. being a transsexual person)</td>
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<td>☐ Adverse</td>
<td>☐ None</td>
</tr>
<tr>
<td>Sexual Orientation</td>
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<td>☐ None</td>
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</table>
### Other:

<table>
<thead>
<tr>
<th>Low</th>
<th>Policy will affect or be applicable to all</th>
</tr>
</thead>
</table>

**No impact on any of the groups above.** Please explain and provide evidence

### 4. Which equality legislative Act applies to the policy?

- [x] Equality Act 2010
- [ ] Health & Safety Regulations
- [ ] Mental Health Act 1983
- [x] Mental Capacity Act 2005

### 5. How could the identified adverse effects be minimised or eradicated?

No adverse effects identified.

### 6. How is the effect of the policy on different Impact Groups going to be monitored?

Continuing Healthcare is continuously monitored as part of the National Framework
Appendix 3
Privacy Impact Assessment Stage 1 Screening

1. Policy

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<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☑ No</td>
<td>☑ Please explain your answers</td>
</tr>
</tbody>
</table>

- **Technology**
  Does the policy apply new or additional information technologies that have the potential for privacy intrusion? (Example: use of smartcards)
  - ☑ No

- **Identity**
  By adhering to the policy content does it involve the use or re-use of existing identifiers, intrusive identification or authentication? (Example: digital signatures, presentation of identity documents, biometrics etc.)
  - ☑ No

  By adhering to the policy content is there a risk of denying anonymity and de-identification or converting previously anonymous or de-identified data into identifiable formats?
  - ☑ No

- **Multiple Organisations**
  Does the policy affect multiple organisations? (Example: joint working initiatives with other government departments or private sector organisations)
  - ☑ No

- **Data**
  By adhering to the policy is there likelihood that the data handling processes are changed? (Example: this would include a more intensive processing of data than that which was originally expected)
  - ☑ No

  If Yes to any of the above have the risks been assessed, can they be evidenced, has the policy content and its implications been understood and approved by the department?