Continuing NHS Healthcare For Adults Practice Guidance to support the National Framework for Implementation in Wales

Last updated 22 September 2010

Frequently Asked Questions
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1. Introduction

Continuing NHS healthcare for adults (CHC) is a package of care arranged and funded solely by the NHS where it has been assessed that the individual’s primary need is a health need. It is just one part of a continuum of services that NHS and local authority bodies need to have in place to support people with health and social care needs. CHC is one aspect of care which people may need as the result of disability, accident or illness to address both physical and mental health needs.

This Practice Guidance (known hereafter as ‘Guidance’) based on Frequently Asked Questions (FAQ’s) has been developed in partnership with the Welsh Assembly Government, Local Health Boards and local authorities to support health and social care practitioners with responsibility for continuing NHS healthcare in the implementation of the Continuing NHS Healthcare: National Framework for Implementation in Wales May 2010 (issued as document EH/ML/018/10 and Welsh Assembly Government Circular 015/2010).

The Guidance provides a practical explanation of how the National Framework should operate on a day to basis. It is not a substitute for the Framework.

As implementation is embedded throughout organisations other operational and practice issues may need to be clarified or considered. This Practice Guidance is therefore a resource that will be added to and amended from time to time.

The most up to date version of this guidance may be located at:


2.1. When was the National Framework implemented?

NHS organisations are expected to follow the Framework from 16th August 2010

2.2. Does the new Framework still focus on the 4 separate criteria?

No. The sole criterion for eligibility for continuing NHS healthcare is whether there is a primary health need (this is discussed as section 4 of this Guidance). This replaces the separate criteria in the following guidance and circulars:

- WHC (2004) 54 and NAFWC 41/2004 (Guidance)
- NAFWC 41a/2004 (CHC Framework)
2.3 What is the purpose of the Framework?

The purpose of the Framework is to provide a consistent foundation for assessing, commissioning and providing continuing NHS healthcare for adults. This is to make sure that there is a consistent, equitable and appropriate application of the process for determining eligibility for CHC.

2.4 Why does the Framework focus on joint working and joint packages of care?

The fact that someone has health needs which are beyond the powers of a local authority to provide for, does not, of itself, mean that the individual is eligible for CHC. An individual may require and be entitled to services from both the NHS and local authority. Both the NHS and local authority therefore have responsibilities to ensure that assessment of eligibility for and provision of the care takes place in a timely and consistent fashion.

Joint working between the NHS and local authorities needs to focus on earlier intervention to ensure that preventative measures are in place to maintain independence and that people receive help and support which seeks to prevent their progression into more intensive care.

A joint package of care could include NHS Funded Nursing Care (NHSFNC) and other NHS services that are beyond the powers of a local authority to meet. The joint package could also involve both the LHB and the local authority contributing to the cost of a care package, or the LHB commissioning and/or providing part of the package. Joint packages of care may be provided in a nursing or residential care home, in supported accommodation or in the person’s own home.

2.5 Does this Framework apply to children?

No. This Framework applies to adults. The assessment of and provision of care for children and young people will be addressed in detail in a separate document.

2.6 How can we ensure consistency in the application of the national Framework on eligibility for continuing NHS healthcare?

This may be achieved, for example, through LHBs:

- Ensuring that the National Decision Support Tool is not altered in any way
- Monitoring patterns of eligibility decision making
• Using monitoring data to identify and address variations between areas and patient groups
• Peer review of eligibility decisions
• Management audits of practice
• Developing consistent protocols around the completion of the Decision Support Tool (DST)
• Working with staff to disseminate learning from the above processes and to identify and address development issues
• Providing effective equality, diversity and human rights training and development, with a particular emphasis on understanding the cultures of the people they are more likely to encounter in their local population area
• Providing effective Mental Capacity Act Training

2.7 How should organisations promote awareness of continuing NHS healthcare?

This may be achieved, for example, through:

• ensuring that the public information leaflet is available in appropriate formats and languages at key locations
• providing information on LHB and LA websites
• providing awareness-raising sessions for staff
• using existing networks to promote a better understanding of continuing NHS healthcare
• working with the independent and voluntary sectors to promote awareness

2.8 How can implementing and maintaining good practice be achieved?

This may be achieved, for example, through:

• clinical supervision arrangements with staff, both individually and as a team
• ensuring that training is jointly developed and delivered with LA partners and tailored to identify and promote good practice
• use of regional meetings to identify and promote good practice and consistency
• use of pathway/process analysis to identify areas for development.
2.9 How could LHBs and LAs ensure that quality standards are met and sustained?

This could, for example, include:

- agreement of quality standards across key agencies
- use of auditing tools to check process and quality at different stages
- learning from complaints/compliments.

2.10 Should organisations provide joint training and development opportunities for practitioners?

Yes. Paragraph 10.2 of the Framework requires the NHS and its partners to ensure that relevant guidance and procedures are in place to implement the Framework and that all relevant staff in health and social care are aware of them through appropriate multi agency training.

The Unified Assessment Care Management process includes a strategy for joint staff development. Within this context, it is important that training for key personnel involved in assessing for and managing the provision of CHC includes (not an exhaustive list):

- philosophy and purpose of assessment
- policies in relation to long term care
- the CHC Framework
- person centred assessment
- procedures and responsibilities for assessment, care planning and decision making

The LHB’s responsibility is to maintain an oversight as to whether staff across relevant agencies are appropriately trained in relation to continuing NHS healthcare, although this does not necessarily mean the LHB has to carry out or fund all the training itself.

The LHB’s actions could, for example, include:

- providing core training courses on a rolling programme, jointly developed and delivered with other NHS organisations and the LA
- providing specialist training sessions for coordinators/nurse assessors/case managers and others in continuing NHS healthcare roles across organisations
- ensuring training is available to relevant independent sector provider staff
- making training materials available for other organisations to use
- inclusion of continuing NHS healthcare in induction training for all relevant staff.
2.11  How should organisations identify and act upon issues arising in the provision of continuing NHS healthcare?

This could, for example, include:

- systematically reviewing complaints and disputes, including looking for patterns of unlawful discrimination or disproportionate negative impact on individuals, groups and communities
- undertaking ‘root cause analysis’ when a problem arises
- addressing the issues through contract management processes with provider organisations
- using some form of ‘joint solutions group’ with the LA
- establishing robust risk management systems
- being a ‘learning organisation’ so that the whole team discusses and identifies necessary practice changes.

3.  Legal Framework

3.1  What are the responsibilities of the NHS and Local Authorities in relation to continuing NHS healthcare?

Local Health Boards (LHBs) have the lead responsibility for continuing NHS healthcare in their locality (but there are also specific requirements for local authorities (LAs) to cooperate and working in partnership with their local LHB in a number of key areas). In addition LHBs need to have clear arrangements with other NHS organisations and independent/ voluntary sector partners to ensure effective operation of the Framework.

The NHS is responsible for assessing, arranging and funding a wide range of services to meet the health care needs, both short and long term, of the population. In addition to periods of acute health care, some people need care over an extended period of time, as the result of disability, accident or illness to address and/or physical and mental health needs. These services are normally provided free of charge.

Local authorities also provide a range of services to support their local population, including people who require extended care. These services include accommodation, education, personal and social care, leisure and other services. Local authorities must charge for residential care in accordance with the Charging for Residential Care Guidance (CRAG) and they may charge for other care services subject to any guidance or regulation by the Welsh Assembly Government.

When an individual has been assessed as having a primary health need, and is therefore eligible for CHC, the NHS has responsibility for funding the full package of
health and social care. Where the individual is living at home, this does not include the cost of accommodation, food or general household support.

NHS bodies and local authorities have responsibilities to ensure that the assessment of eligibility for, and provision of, CHC takes place in a consistent fashion and the process is actively managed to avoid unnecessary delays. If an individual is not eligible for CHC they can still access a range of health and social care services that are likely to be both part of mainstream services or individually planned to meet specific need.

3.2 What are the legal duties of the NHS and Local Authorities?

Primary legislation governing the health service does not use the terms “continuing care”, “Continuing NHS Healthcare” or “primary health need”. However, section 1 of the National Health Service (Wales) Act 2006 requires Welsh Ministers to continue the promotion in Wales of a comprehensive health service, designed to secure improvement in:

(i) the physical and mental health of the people of Wales and

(ii) the prevention, diagnosis and treatment of illness.

Furthermore, Welsh Ministers are under a duty to provide throughout Wales, to such extent as they consider necessary to meet all reasonable requirements, “such services for, or facilities for the prevention of, illness, the care of persons suffering from illness and after-care of persons who have suffered from illness as they consider are appropriate as part of the health service”. This includes accommodation for the purposes of health services provided under that Act. NHS organisations (amongst others) carry out this function on behalf of the Welsh Ministers.

What is appropriate to be provided as part of the health service therefore has to be considered in the light of the overall purpose of the health service - to improve physical or mental health and prevent, diagnose or treat illness.

Each local authority is under a duty to assess fully any person who appears to it to be in need of community care services. Community care services can include residential accommodation for persons who by reason of age, illness or disability are in need of care and attention which is not otherwise available to them as well as domiciliary and community-based services enabling people to continue to live in the community.

The local authority, having regard to the result of that assessment, must then decide whether the person’s needs call for the provision of community care services. The local authority must also notify the relevant LHB if, in carrying out the assessment, it becomes apparent that the person has needs which may fall under the National
Health Service (Wales) Act 2006, and invite them to assist in the making of the assessment (see National Health Service and Community Care Act 1990 section 47(3).

If an NHS body is assessing a person's needs (whether or not potential eligibility for continuing NHS healthcare has been identified) and the assessment indicates a potential need for community care services that may fall within a local authority's responsibilities, it should notify the authority of this and consider inviting it to participate in the assessment process.

3.3 Does the Health and Social Care Act 2001 allow local authorities to provide nursing care?

No. Section 49 of the Health and Social Care Act 2001 prohibits local authorities from providing or arranging for the provision of nursing care by a registered nurse in connection with the provision by them of community care services. “Nursing care by a registered nurse” is defined as “services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse”.

3.4 What is the role of the Local Authority in continuing NHS healthcare?

LHBs should consult the relevant social services authority before making a decision on a person’s eligibility for continuing NHS healthcare. However, once such a case has been brought to the attention of the social services authority, in addition to giving advice and assistance it should, having regard to the facts of the case, also consider whether a community care assessment is required. Where community care assessments have been carried out, the LA should use information from these assessments to assist the LHB in carrying out its responsibilities.

The roles that a LA should undertake include:

- making staff available wherever practicable to be part of multidisciplinary teams (MDTs) which will undertake joint assessments and jointly complete the DST (including where the individual is a self-funder)
- contributing to joint panels (where these exist) and participating in the quality assurance process on assessments and recommendations for CHC eligibility
- making staff available to undertake joint reviews
- having systems for responding promptly to requests for information when the LHB has received a referral for continuing NHS healthcare
- working jointly with LHBs in the planning and commissioning of care/ support for individuals deemed eligible for continuing NHS healthcare wherever
appropriate, sharing expertise and local knowledge (whilst recognising that LHBs retain formal commissioning and care planning responsibility for those eligible for continuing NHS healthcare).

LAs should also make nominations to LHBs of potential members of Independent Review Panels (IRPs) whenever requested by the LHB and, where appointed, to make their nominees available to participate as far as reasonably practicable.

3.5 There have been a number of judgements relating to what the NHS or Local Authority can provide. Where can I find a summary of each relevant case?

The Framework, at Annex 3, will provide you with the detail of The Coughlan Judgement, the Grogan Judgement and the St Helens Judgement. The implications of these judgments are summarised in paragraphs 3.10 to 3.14 of the Framework.

Additionally, the All Wales Training Handout also contains this information.

4. Primary Health Need

4.1 What is a primary health need?

The term ‘primary health need’ does not appear in primary legislation, ‘Primary health need’ is a concept developed by the Welsh Ministers to assist in deciding when the NHS is responsible for meeting an individual’s assessed health and social care needs as part of its overall duties under the NHS (Wales) Act 2006 to provide ‘services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness’ [NHS (Wales) Act 2006 3(1) (e)].

The Framework (paragraph 4.6) states that Where, following a comprehensive of all needs a persons primary need is judged to be a health need, the policy of Welsh Ministers is that responsibility for providing them with all care services they are assessed as requiring, including, where appropriate, care home accommodation, will rest with the NHS in accordance with the National Health Service (Wales) Act 2006 (sections 1, 3).

In simple terms (not a legal definition) an individual has a primary health need if, having taken account of all their needs (following completion of the DST), it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs.

A primary health need is not about the reason why someone requires care or support, nor is it based on their diagnosis; it is about their overall actual day-to-day care needs taken in their totality. Indeed it could be argued that most adults who require a
package of health and social care support do so for a health-related reason (e.g. because they have had an accident or have an illness or disability). It is the level and type of needs themselves that have to be considered when determining eligibility for continuing NHS healthcare.

Each individual case has to be considered on its own merits in accordance with the principles outlined in the Framework. The Framework cautions against drawing generalisations about eligibility for continuing NHS healthcare.

The Framework states that certain characteristics of need and their impact on the care required to manage them will determine whether a person’s primary need is a health need. There are four characteristics of need, namely ‘nature’, ‘intensity’, ‘complexity’ and ‘unpredictability’. 4.3 of the Framework states that ‘each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual’s needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered.’

Although the Framework offers definitions of these four characteristics, it may be helpful for MDTs to think about them in terms of the sorts of questions that each characteristic generates. By the MDT answering these questions they develop a good understanding of the characteristic in question.

‘Nature’ is about the characteristics of both the individual's needs and the interventions required to meet those needs.

Questions that may help to consider this include:

- How does the individual or the practitioner describe the needs (rather than the medical condition leading to them)? What adjectives do they use?
- What is the impact of the need on overall health and well-being?
- What types of interventions are required to meet the need?
- Is there particular knowledge/skill/training required to anticipate and address the need? Could anyone do it without specific training?
- Is the individual's condition deteriorating/improving?
- What would happen if these needs were not met in a timely way?

‘Intensity’ is about the quantity, severity and continuity of needs.

Questions that may help to consider this include:

- How severe is this need?
- How often is each intervention required?
- For how long is each intervention required?
- How many carers/care workers are required at any one time to meet the needs?
• Does the care relate to needs over several domains?

‘Complexity’ is about the level of skill/knowledge required to address an individual need or the range of needs and the interface between two or more needs.

Questions that may help to consider this include:

• How difficult is it to manage the need(s)?
• How problematic is it to alleviate the needs and symptoms?
• Are the needs interrelated?
• Do they impact on each other to make the needs even more difficult to address? > How much knowledge is required to address the need(s)?
• How much skill is required to address the need(s)?
• How does the individual’s response to their condition make it more difficult to provide appropriate support?

‘Unpredictability’ is about the degree to which needs fluctuate and thereby create challenges in managing them.

Questions that may help to consider this include:

• Is the individual or those who support him/her able to anticipate when the need(s) might arise?
• Does the level of need often change?
• Does the level of support often have to change at short notice?
• Is the condition unstable?
• What happens if the need isn’t addressed when it arises?
• How significant are the consequences?
• To what extent is professional knowledge/skill required to respond spontaneously and appropriately?
• What level of monitoring/review is required?

4.2 Does the ‘incidental and ancillary test’ still apply now that we have a primary health need approach?

Para 3.11 of the Framework describes the "incidental or ancillary" test in the Coughlan case. This "test" is not contained in the National Assistance Act 1948 or any other legislation, although it was developed to give an indication as to the limit of local authority powers to provide nursing care under section 21 of the 1948 Act.

At the time the Coughlan case was decided in 1999, local authorities did have powers to arrange for the provision of general nursing services in nursing homes. However, Section 49 of the Health and Social Care Act 2001 now prohibits local authorities from...
providing or arranging for the provision of nursing care by a registered nurse in connection with the provision by them of community care services (see para 3.9)

Chapter 4 of the framework describes the primary health need approach. This is the sole criterion for determining eligibility for CHC. In assessing whether a person has a primary health need, it is not necessary to consider whether a person has needs for nursing services which are beyond the powers of a local authority to provide - therefore the "incidental or ancillary" test in Coughlan is not relevant to this.

4.3 What is the difference between a healthcare need and a social care need?

Whilst there is not a legal definition of a healthcare need (in the context of continuing NHS healthcare), in general terms it can be said that such a need is one related to the treatment, control or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).

In general terms (not a legal definition) it can be said that a social care need is one that is focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and (in some circumstances) accessing a care home or other supported accommodation.

Social care needs are directly related to the type of welfare services that LAs have a duty or power to provide. These include, but are not limited to: social work services; advice; support; practical assistance in the home; assistance with equipment and home adaptations; visiting and sitting services; provision of meals; facilities for occupational, social, cultural and recreational activities outside the home; assistance to take advantage of educational facilities; and assistance in finding accommodation (e.g. a care home), etc.

Paragraph 4.7 of the Framework explains the continued responsibilities of local authorities when an individual is eligible for continuing NHS healthcare.

4.4 Can the Local Authority still provide services if the NHS has accepted that an individual has a primary health need?

In general, when it has been decided that it is appropriate to provide care services as part of the health service, local authorities cannot then lawfully provide those services to that individual. However, this does not prevent the local authority from providing other services. Local authorities do have continuing responsibilities, including, for example, a role in assessment and review, support for carers, provision of social work services and the meeting of housing and educational needs. A decision that an
individual is eligible for CHC does not exempt local authorities from meeting these other responsibilities.

4.5 If someone with a primary health need is being cared for at home, what would the NHS be responsible for?

Where people are cared for at home, the primary health need approach will apply so that if their primary need is a health need the NHS will fund all the care that is required to meet their assessed health and social care needs to the extent that this is considered appropriate and reasonable for the NHS to provide and to the extent that it is considered necessary to meet all reasonable requirements.

In these cases, the NHS would not be responsible for the cost of social work services, accommodation, food, general household support, or support for carers.

4.6 What are the responsibilities of the LHB and Local Authorities when individuals who are eligible for CHC are being cared for at home?

The Framework, at 6.23 states that where informal carers are being asked, or are offering, to support at home, the LHB and local authority must bear in mind that a carer who provides substantial care on a regular basis has the right to have their care assessed. LHB’s and local authorities must inform carer of this right in accordance with what may be provided under community care legislation, the Children Act 1989 or the Carers and Disabled Children’s Act 2000 as amended by the Carers (Equal Opportunities) Act 2004.

When considering a package of care in the community, it should never be assumed that carer is able or willing to continue to assume this role. As the MDT considers what the individual needs to be cared for in the community, consideration will also need to be paid to the support the carer requires to maintain their caring role if they have agreed to play a part in the individual care.

The LHB would remain financially responsible for all health and personal care services and associated social care services to support assessed health and social care needs and identified outcomes for the individual. This will include additional support needs for the individual whilst the carer has a break.

However, people who choose to live in their own home may have additional community care needs which it may be appropriate for the local authority to address subject to their local eligibility criteria and charging policy e.g. assistance with adaptations, support with essential parenting activities, support to access other community facilities, carer support services that may include additional general domestic support, or indeed any appropriate service that is specifically required to enable the carer to maintain his/her caring role (see Q 4.7 below).
There is a range of circumstances in which LHBs have overlapping powers with the local authority. Where this is the case, LHBs and other statutory bodies should work in partnership locally to determine how each partner organisation’s responsibilities will be exercised. LHBs should not simply assume that another organisation will meet the need. The needs appropriate for the LHB to meet will depend upon the individual circumstances of the case, having regard to the overall purpose of the health service-to improve physical or mental health and to prevent, diagnose or treat illness.

Where organisations have potentially overlapping powers/responsibilities there should be a discussion between the parties involved. If an individual is receiving CHC in their own home, their benefits are unaffected (although they will not be able to receive support from the Independent Living Fund). There is a range of everyday household costs that are expected to be covered by personal income or welfare benefits e.g. food, rent, mortgage, fuel, clothing and other normal household items. In addition, disability related benefits e.g. Disability Living Allowance and Attendance Allowance are intended to cover some disability-related costs.

As individual circumstances will differ considerably, it is not possible to give hard and fast rules on how best to divide responsibilities where overlapping powers exist. However, the following questions may help inform the decision-making process:

- Is this service part of the care plan necessary to meet the individual's health and social care needs?
- What support is necessary for the LHB to fund/provide in order for the individual to access essential services?
- What responsibilities do other organisations/agencies have to help the individual access essential services?
- What would happen if the LHB or the local authority did not fund/provide the service in question- what would the outcome be?

4.7 What are the LHB responsibilities in relation to carers when an individual is in receipt of continuing NHS healthcare?

When the LHB decided to support a package of care in the individual’s home where the involvement of a family member is an integral part of the care plan, then the LHB should consider meeting any training needs that the carer may have in undertaking this role. In particular, the LHB may need to carry out a risk assessment to make sure the carer is able to participate in the care of the individual and consider what needs to be put in place to protect the individual and the carer.

Consideration should also be given to referral for a separate carer’s assessment by the relevant LA.
Although the local authority has a statutory obligation for carers, the LHB may need to provide additional support to care for the individual whilst the carer has a break from their caring role and will need to assure carers of the availability of support when required. This is particularly relevant where the carer is providing care that is deemed a health intervention e.g. observation and management of PEG regimes. The LHB and local authority should work closely together to agree their respective responsibilities and ensure that the aim of supporting carers is paramount.

5. Assessment and Eligibility for Continuing NHS Healthcare

5.1 What are the key elements of a ‘person-centred’ approach in continuing NHS healthcare?

The Framework makes it clear that the whole process of determining eligibility and planning and delivering services for continuing NHS healthcare should be ‘person centred’. This is vital since individuals going through this process will be at a very vulnerable point in their lives. There may well be difficult and significant choices to be made, so empowering individuals at this time is essential. Where an individual lacks capacity to make informed choices, the Mental Capacity Act Code of Practice (paragraph 16.19) states:

‘healthcare and social services staff may disclose information about somebody who lacks capacity only when it is in the best interests of the of the person concerned to do so, or when there is some other, lawful reason for them to do so’

Despite professional intentions to treat individuals with dignity and respect, the perception of individuals can be that this is not always the case. It is important for practitioners to put themselves in the position of the individual by asking questions like:

- ‘How would I feel if this were happening to me?’
- ‘Have I really tried to understand what this person wants, what is important to them now and for the future?’

There are many elements to a person-centred approach but, as a minimum, it is necessary to:

- ensure that the person concerned is fully and directly involved in the assessment and the decision-making process
- take full account of the individual’s own views and wishes, ensuring that their perspective is clearly the starting point of every part of the assessment process
- address communication and language needs
- obtain consent to assessment and sharing of records (where the individual has mental capacity to give this)
- deal openly with issues of risk
- keep the individual informed.
5.2 Is eligibility based on an individual’s diagnosis?

No. The recommendation for eligibility for continuing NHS healthcare should not be based upon an individual’s specific condition or disease (e.g. stroke, cancer, Alzheimer’s disease, dementia, etc.) but on the needs that are identified. Needs that give rise to eligibility can be from any condition or disease.

Just because individuals with a particular condition or disease have previously been found to be eligible for continuing NHS healthcare does not mean that every individual with a similar condition or disease will be eligible. Each individual should be assessed in their own right and evidence provided around the range of their needs; the identification of a primary health need should not be prejudged, it requires going through the proper process in each individual case.

5.3 Should organisations keep the individual informed throughout the CHC process?

Yes. Individuals should be kept informed at all times. The care co-ordinator should ensure that this takes place by:

- Providing the individual with the name and contact number of the care co-ordinator
- Explaining to the individual the assessment process as it progresses
- Providing the individual with written information e.g. patient information leaflet, in easy to read format or in an appropriate format e.g. Braille, audio CD etc according to individual need
- Explaining timescales and key milestones
- Making the individual aware of anyone else who may be involved
- Informing the individual of any potential delays and the reasons for them
- Where the individual wishes and where family are involved in the care provision, keeping family members informed and involved in assessment and discharge planning

5.4 Should the individual concerned be fully and directly involved in the assessment and the decision-making process for continuing NHS healthcare?

Yes. Individuals being assessed for continuing NHS healthcare are frequently facing significant changes in their life. It is essential that a person-centred approach is taken throughout the assessment process. A positive experience of the assessment process that promotes genuine choice and control can empower the person, resulting in a much better outcome.
The DST specifically asks whether the individual was involved in the completion of the DST, whether they were offered the opportunity to have a representative and whether the representative attended the DST completion. It also asks for details of the individual's view of their own care/support needs, whether the MDT assessment accurately reflects these and whether they contributed to the assessment.

It also asks for the individual's views on the completion of the DST, including their view on the domain levels selected. The provision of advocacy, where appropriate, is an important means of achieving meaningful participation.

5.5 How do organisations take full account of the individual's own views and wishes, ensuring that their perspective is clearly the starting point of every part of the assessment process?

The individual's own views of their needs and their preference as to how they should be met should be documented at each stage. They should be given as much choice as possible, particularly in the care planning process. Where mental capacity issues impact on an individual's ability to express their views the approaches set out in this guidance should be used, including using family members and others who know the individual well to find out as much as possible on what the individual would want if they were able to express a view.

Where issues arise from needs and risks that may affect the care/support options available, these should be fully discussed with the individual. Care should be taken to avoid indicating any firm conclusions about care/support arrangements until needs have been fully assessed and it is clear what the funding arrangements may be.

5.6 How do organisations address communication and language needs?

It is important to establish at the outset whether the individual has any particular communication needs and if so how these can be addressed. If English or Welsh is not their first language an interpreter may be required, or if they have a learning disability the use of simplified language or pictures may be helpful.

Hearing difficulties are often exacerbated where there is background noise (so a quiet room might be needed), and many older people in particular struggle to use any hearing aid they may have. If the individual uses British Sign Language (BSL) it will be necessary to arrange for a BSL interpreter, which may have to be booked well ahead.

LHBs should consider the most likely communication needs to arise in the course of assessing for continuing NHS healthcare and make ongoing arrangements for appropriate support to be readily accessible. This could be, for example, by having arrangements with identified formal interpreters to be available at short notice.
Preferred methods of communication should be checked with the person or their relatives, friends or representatives in advance. Where a person has specific communication needs such that it takes them longer than most people to express their views, this should be planned into the time allocated to carry out their assessment.

The overall approach to carrying out the assessment is of equal importance in terms of accessibility to the technical arrangements that are put in place. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion naturally progresses, rather than working through an assessment document in a linear fashion.

It is very important that the person's own view of their needs is treated equally alongside professional views.

Practice Example (reference DoH Practice Guidance)

Clare has advanced MS and is severely physically disabled. She can’t move or communicate verbally. Her husband provides much of her personal care at home, which he is willing to continue to do. However, during a period in hospital for a chest infection concerns were raised about some bruising she had and consideration was being given to implementing safeguarding procedures. The hospital consultant was uncertain whether Clare had capacity to decide whether she should go home. However, the speech and language therapist was able to communicate with Clare using pictures and words and confirmed that she could communicate (albeit slowly) using eye and head movements. It was ascertained that there was no reason to doubt she had capacity to make informed decisions regarding her care. Clare was able to clearly indicate that the bruising had happened accidently and that it was definitely her wish to return home and for her husband to continue to provide her care.

5.7 Do all individuals being considered for continuing NHS healthcare have to be assessed through the unified assessment process?

Yes: Paragraph 5.6 of the Framework states that all assessments will be undertaken within the context of the guidance document Creating a Unified and Fair System for Assessing and Managing Care (NAFW 2002). The Framework focuses primarily on the determination of a primary health need and eligibility for CHC and its consequences and builds on, rather than replaces the above guidance.
5.8 Why is it important for social workers to engage in the assessment process prior to discharge?

In order to plan an appropriate package of care for an individual who may or may not be eligible for continuing NHS healthcare on discharge (or if their needs change in the community), social workers should work jointly with NHS staff throughout the continuing NHS healthcare eligibility process and should be involved in the MDT wherever practicable. Therefore, when the LA receives a referral for involvement in the MDT process for continuing NHS healthcare, they should respond positively and promptly.

The LA should usually be represented on the MDT completing the continuing NHS healthcare eligibility process. This means that, in most cases, the key assessment information needed for LA support is already available to prevent a delayed discharge. Therefore, where an individual is found to be ineligible for continuing NHS healthcare, the LA should be in a position to respond and action their responsibilities quickly.

LHBs and LAs could consider developing an agreed format for the continuing NHS healthcare multidisciplinary assessment that is suitable for use as a community care assessment if the person is found ineligible. Some patients will require minimal support and/or interventions on discharge, whilst others will require complex, multiagency support either on a short or longer-term basis.

The differing levels of need and risk - the level, quantity, and frequency of care - should be identified and reflected within a Unified Assessment and the care planning and management approach may include the need to consider a number of care options, which should be recorded within the service delivery plan. Examples of these care options may include (but are not confined to):

• the need to access Intermediate Care services (WHC(2002)128/NAFWC 43/2002: Intermediate Care Guidance provides further detail)

• single agency or shared packages of care in a patients' own home/community setting

• a residential or nursing care placement (including the need to ensure appropriate assessment for NHS Funded Registered Nursing Care - NHS Funded Nursing Care in Care Homes Guidance WHC(2004)024/NAFWC 25/2004 refers), and

• Continuing NHS HealthCare within a range of settings (EH/ML/018/10 WAGC 015/2010 Continuing NHS Healthcare: The National Framework for Implementation in Wales

For people who have low levels of need and are unlikely to require complex care, it may be appropriate to consider the use of support schemes developed and run by
voluntary agencies. In addition, voluntary organisations may contribute support services as part of more complex multi-agency care provision. The need for these services should be considered by LHBs when ensuring a full range of services is provided to meet need. If voluntary organisations are to provide support on discharge they must be involved in the assessment and care planning process.

LHBs and LAs should ensure that there is clarity in local discharge protocols and pathways about how continuing NHS healthcare fits into these processes, and what their respective responsibilities are.

The Hospital Discharge Planning Guidance (NAFWC 17/2005) places certain responsibilities upon both LHBs and LAs in hospital discharge situations. Where such dual responsibilities exist, LHBs and LAs should ensure that their respective responsibilities are agreed and identified in local protocols.

LHB’s should also ensure that discharge policies with providers who are not NHS bodies e.g. independent nursing homes, are clear on the respective responsibilities of the LHB and of the provider. Where appropriate, the LHB may wish to make appropriate provisions in its contract with the provider.

Where it appears to an NHS body that a person planned to be discharged from hospital may have a need for continuing NHS healthcare, a decision on eligibility should be made unless alternative NHS-funded services are provided.

5.9 If the Care Programme Approach (CPA) is used for people with mental health needs, is there a need to undertake a full unified assessment and complete the Decision Support Tool?

Yes. The guidance document ‘Creating a Unified and Fair System for Assessing and Managing Care’ (National Assembly for Wales 2002) provides the basis for determining the types and levels of assessment that will be appropriate in particular circumstances. The Framework makes clear that all assessments will be undertaken within the context of that guidance document.

The decision on what types of assessment are required may be made by any number of people involved in a person’s care. The comprehensive, multidisciplinary assessment of a person’s care needs, including all relevant specialist and non-specialist assessments, should be carried out by a multidisciplinary team who know the person best.

The Framework states that the UACM process must be followed and people with mental health problems will additionally be assessed following the Care Programme Approach guidance, (the CPA being the specialist assessment of the UACM process). The evidence concerning eligibility and the decision making process should be accurately and fully recorded and supported by the Decision Support Tool.
5.10 What is the role of the continuing NHS healthcare coordinator?

Once an individual has been referred for full assessment for continuing NHS healthcare, the LHB has the responsibility for coordinating the whole process until the eligibility decision is made. The LHB should identify an individual or individuals to carry out the coordination role. Care should be taken by LHBs to ensure an appropriate separation between the coordinator role and those responsible for making a final decision on eligibility for continuing NHS healthcare.

Whilst this is likely to be an LHB staff member, it could (by agreement) be a staff member from another organisation such as the LA e.g. a social worker in an integrated team or independent sector organisation e.g. a hospice. This could be part of a wider inter-agency agreement, or could be negotiated in specific cases due to the skills or responsibilities that the practitioner(s) have in relation to a client group or individual.

The coordination role includes:

- receiving and acting upon a referral for assessment of eligibility for continuing NHS healthcare, ensuring appropriate consent has been given
- identifying and securing the involvement of the MDT which will assess the individual’s needs and will then use this information to complete the DST. The MDT should comprise health and social care staff presently or recently involved in assessing, reviewing, treating or supporting the individual
- supporting MDT members to understand the role they will need to undertake in participating in a multidisciplinary assessment and completing the DST
- helping MDT members to identify whether they will need to undertake an updated or specialist assessment to inform completion of the multidisciplinary assessment
- supporting the person (and those who may be representing them) to play a full role in the eligibility consideration process, including ensuring that they understand the process, they have access to advocacy or other support where required, and organising the overall process in a manner that maximises their ability to participate
- ensuring that there is a clear timetable for the decision-making process
- ensuring that the assessment and DST processes are completed in accordance with the requirements in the Framework
- acting as an impartial resource to the MDT and the individual on any policy or procedure questions that arise
- ensuring that the MDT’s recommendation on eligibility is sent for approval through the relevant local decision-making processes in a timely manner
- where local arrangements place the responsibility for informing the individual of the eligibility decision within the role of the coordinator, ensuring that this
happens in a timely manner and in accordance with the requirements of the Framework.

5.11 Why does the Framework stress that the DST is not an assessment?

The purpose of the DST is to help identify eligibility for continuing NHS healthcare; it is not designed as an assessment tool in its own right. A good quality multidisciplinary assessment may well identify care/support needs requiring a response by the LHB or LA regardless of eligibility for continuing NHS healthcare.

The DST should draw on such an assessment but is itself specifically designed to collate and present the information from the assessment in a way that assists consistent decision making for continuing NHS healthcare eligibility. The DST is a national tool and must not be altered.

5.12 What are the elements of a good multidisciplinary assessment?

Assessment in this context is essentially the process of gathering relevant, accurate and up-to-date information about an individual's health and social care needs, and applying professional judgement to decide what this information signifies in relation to those needs. Both information and judgement are required. An assessment that simply gathers information will not provide the rationale for any consequent decision; an assessment that simply provides a judgement without the necessary information will not provide the evidence for any consequent decision.

Assessment documentation should be obtained from any professional involved in the individual's care and should be clear, well recorded, factually accurate, up to date, signed and dated. As a minimum a good quality multidisciplinary assessment of an individual's health and social care needs will be:

- preceded by informed consent or an appropriate 'best interests' decision as discussed in section 6
- proportionate to the situation, i.e. in sufficient depth to enable well-informed judgements to be made but not collecting extraneous information which is unnecessary to these judgements. If appropriate this may simply entail updating existing assessments
- person-centred, making sure that the individual and their representative(s) are fully involved, that their views and aspirations are reflected and that their abilities as well as their difficulties are considered
- informed by information from those directly caring for the individual (whether paid or unpaid)
• holistic, looking at the range of their needs from different professional and personal viewpoints, and considering how different needs interact
• taking into account differing professional views and reaching a commonly agreed conclusion
• considerate of the impact of the individual’s needs on others
• focused on improved outcomes for the individual
• evidence-based – providing objective evidence for any subjective judgements made
• clear about needs requiring support in order to inform the commissioning of an appropriate care package
• clear about the degree and nature of any risks to the individual (or others), the individual’s view on these, and how best to manage the risks.

Local assessment arrangements and processes differ around the country, though a number of models have formed the basis for assessment and care and support planning processes. Effective assessment processes and documentation are key to making swift decisions on eligibility for continuing NHS healthcare and for commissioning the right care package at the right time and in the right place, so that the individual can move to their preferred place of choice as quickly and safely as possible.

LHBs and LAs could consider agreeing joint models of assessment documentation and having regular training or awareness events to support them.

5.13 What are the potential sources of information?

Potential Sources of information/evidence can include: (this is not an exhaustive list)

• Health needs assessment
• Community care assessment
• Nursing assessment
• Individual’s own views of their needs and desired outcomes
• Person-centred care plan
• Carer’s views
• Physiotherapy assessment
• Behavioural assessment
• Speech and Language Therapy (SALT) assessment
• Occupational Therapy assessment
• Care home/home support records
• Current care plan
• 24-hour/48-hour diary indicating needs and interventions (may need
5.14 What is a Multidisciplinary Team in the context of continuing NHS healthcare?

‘Multidisciplinary team’ (MDT) has many meanings but in the context of NHS continuing NHS healthcare you can define a ‘multidisciplinary team’ as:

‘(i) two professionals who are from different healthcare professions, or (ii) one professional who is from a healthcare profession and one person who is responsible for assessing individuals for community care services under section 47 of the National Health Service and Community Care Act 1990’.

Whilst, as a minimum requirement, an MDT can comprise two professionals from different healthcare professions, the Framework makes it clear that the MDT should usually include both health and social care professionals, who are knowledgeable about the individual’s health and social care needs.

The individual and/or their representative should be fully involved in the process and be given every opportunity to contribute to the MDT discussion. However, once all the information has been gathered (and depending on agreed local protocols) it is acceptable for the MDT to have a discussion without the individual and/or their representative present in order to come to an agreed recommendation.

MDTs should be aware that the DST contains a section at the end of the domain tables for the individual and/or the representative to give their views on the completion of the DST that have not already been recorded elsewhere in the document, including whether they agree with the domain levels selected. It also asks for reasons for any disagreement to be recorded.

Therefore the MDT meeting should be arranged in a way that enables that individual to give his/her views on the completed domain levels before they leave the meeting. If the individual and/or their representative are not present for the part of the meeting where the MDT agrees the recommendation regarding primary health need, the outcome should be communicated to them as soon as possible.

MDT members could include:

- nurse coordinator/assessors
- social workers/care manager
- physiotherapists
- occupational therapists
- dieticians/nutritionists
- GPs/consultants/other medical practitioners
- community psychiatric nurses
- ward nurses, specialist nurses, discharge nurses and community nurses
- care home/support provider staff
This list is not exhaustive but is intended as a prompt of who may need to be invited to provide evidence regarding an individual's needs so that there is as accurate and comprehensive picture as possible.

5.15 What happens if the LHB coordinator is unable to engage relevant professionals to attend an MDT meeting?

The Framework is clear that LHBs should not make decisions on eligibility in the absence of an MDT recommendation, unless exceptional circumstances require an urgent decision to be made.

Apart from ensuring that all the relevant information is collated, it is crucial to have a genuine and meaningful multidisciplinary discussion about the correct recommendation to be made. This should normally involve a face-to-face MDT meeting (including the individual and/or their representative).

If a situation arises where a relevant professional is unable or unwilling to attend an MDT meeting every possible effort should be made to ensure their input to the process in another way, such as participating in the MDT meeting as a teleconference call.

Where this is not possible then submission of a written assessment or other documentation of views could be used but this should be the least favoured option. Where professionals use this route, the LHB should explain to them that, whilst their views will be taken into account, the eligibility recommendation will by necessity be made by MDT members physically present or participating by teleconference.

Care should be taken to ensure that alternative approaches for MDT participation still enable the individual being assessed to participate fully in the process. If, having followed the above processes, there are still difficulties with the participation of, or obtaining assessment information from, a specific professional, LHBs should consider (in liaison with the individual) whether they have sufficient wider assessment information to reach a full picture of the individual's needs, having regard to the minimum MDT membership set out above. LHBs should record the attempts to secure participation.

To ensure effective MDT decision making, LHBs should:

a) have arrangements in place for coordinators to obtain senior support to secure participation of other practitioners where necessary
b) consider agreeing protocols on MDT participation with organisations that frequently have staff who participate in MDTs.
5.16 Where should an MDT meeting take place?

An MDT meeting can take place in any setting but should be as near to the individual’s location as possible so that they are enabled to be actively involved in the process. Although the acute hospital setting is not an ideal place for MDTs to make a recommendation about eligibility, it may sometimes be the only available opportunity to have everyone involved in the process. But, wherever possible, it should still be held in a suitable room for the nature of the meeting. Alternatives to the acute hospital setting should be used for MDT meetings wherever possible. For example community hospitals, hospices, care homes or the individual’s own home may provide suitable settings.

5.17 What process should be used by MDTs to ensure consistency when completing the DST?

Whilst local conditions and therefore local processes will vary, the following elements are recommended as being core to achieving consistency:

a) The coordinator should gather as much information as possible from professionals involved prior to the MDT meeting taking place, including agreeing where any new/updated specialist assessments are required prior to the meeting.

b) The coordinator (or someone nominated by them) should explain the role of the MDT to the individual in advance of the meeting, together with details of the ways that the individual can participate. Where an individual requests copies of the documentation to be used this should be supplied.

c) Information from the process above and any additional evidence should be discussed within the MDT meeting to ensure common agreement on individual needs. Where copies of assessments are circulated to MDT members at the meeting, copies should also be made available to the individual if they are present.

d) Relevant evidence (and sources) should be recorded in the text boxes preceding each of the domain levels within the DST and this information should be used to identify the level of need within that domain, having regard to the user notes of the DST. Having completed the domains the MDT should consider what this information signifies in terms of the nature, complexity, intensity and unpredictability of the individual’s needs. It is important that MDT members approach the completion of DSTs objectively without any preconceptions that specific conditions or diagnoses do or do not indicate eligibility or fit a particular domain level without reference to the individual’s needs.

e) Depending upon local arrangements the MDT members may decide to reach the final recommendation on eligibility after the individual and their representative have left the meeting. However, the above gives clear expectations on their involvement in
the wider process. If the MDT is to reach its final recommendation privately it is best practice to give the individual/representative an opportunity before they leave the meeting to state their views on what the eligibility recommendation should be in the light of the DST discussion.

f) The MDT should then discuss, agree and record their recommendation, based on the concepts in d) above, providing a rationale which explains why the individual does or does not have a primary health need (see below for more detail on recommendations).

g) The recommendation should then be presented to the LHB, who should accept this, except in exceptional circumstances. These circumstances could for example include insufficient evidence to make a recommendation or incomplete domains.

h) If the LHB, exceptionally, does not accept the MDT recommendation it should refer the DST back to the MDT identifying the issues to be addressed. Once this has been completed the DST should be re-presented to the LHB who should accept the recommendation (except in exceptional circumstances).

i) The decision should be communicated to the individual or their representative in writing as soon as possible – see para 5.22 below.

This whole process should usually be completed within 6-8 weeks. This timescale is measured from the date the LHB receives a referral for full consideration to the date that the eligibility decision is made. However, wherever practicable, the process should be completed in a shorter time than this.

5.18 What happens if MDT members cannot agree on the levels within the domains of the DST?

The Framework advises practitioners to move to the higher level of a domain where agreement cannot be reached but there should be clear reasoned evidence to support this. If practitioners find themselves in this situation they should review the evidence provided around that specific area of need and carefully examine the wording of the relevant DST levels to cross-match the information and see if this provides further clarity to move forwards or seek further evidence, although this should not prolong the process unduly.

If this does not resolve the situation, the disagreement about the level should be recorded on the DST along with the reasons for choosing each level and by which practitioner. This information should also be summarised within the recommendation so that LHBs can note this when verifying recommendations.

The practice of moving to the higher level where there is disagreement should not be used by practitioners to artificially steer individuals towards a decision that they have a primary health need where this is not justified. It is important that this is monitored
during LHB audits of recommendations and processes so that individual practitioners found to be using the 'higher level' practice incorrectly can be identified. Discussion may need to take place with these practitioners and possibly further training offered.

If practitioners are unable to reach agreement, the higher level should be accepted and a note outlining the position included within the recommendation on eligibility. As part of LHB governance responsibilities they should monitor occurrences of this issue. Where regular patterns are identified involving individual teams or practitioners this should be discussed with them and where necessary their organisations to address any practice issues.

5.19 Do individuals have to consent to the completion of the DST?

Yes. The multidisciplinary assessment that informs completion of the DST should be carried out with the knowledge and consent of the individual and the individual should be given full opportunity to participate in the assessment. They should also be given the opportunity to be supported or represented by a carer or advocate if they so wish.

5.20 What happens if the individual concerned or their representative disagrees with any domain level when the DST is completed?

Whilst the individual and/or their representative should be fully involved in the process and be given every opportunity to contribute to the MDT discussion, the formal membership of the MDT consists of the practitioners involved. The approach relating to disagreements described above applies to disagreements between practitioners and not when an individual or their representative disagrees with individual domain levels chosen in the completion of the DST.

However concerns expressed by individuals and representatives should be fully considered by reviewing the evidence provided. If areas of disagreement remain these should be recorded in the relevant parts of the DST.

5.21 What does the DST recommendation need to cover?

The recommendation should:

a) provide a summary of the individual's actual needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs and what has changed.

b) provide statements and the evidence about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these concepts provided in section 4 of this guidance.
c) give an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability

d) in the light of the above, give a recommendation as to whether or not the individual has a primary health need (with reference to section 4 of this guidance). It should be remembered that, whilst the recommendation should make reference to all four concepts of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

Although the core responsibility of MDTs is to make a recommendation on eligibility for continuing NHS healthcare, the recommendation could also indicate any particular factors to be considered when commissioning/Securing the placement or care/support package required to meet the individual's needs (whether or not the individual has a primary health need).

Where the outcomes of the individual care domains do not obviously indicate a primary health need (e.g. a priority level in one domain or severe levels in two domains being found), but the MDT is using professional judgement to recommend that the individual does nonetheless have a primary health need, it is important to ensure that the rationale for this is clear in the recommendation.

Where an individual has a deteriorating condition, practitioners need to take this into account in reaching their conclusion on primary health need, considering the approaches set out in Chapter 4 (4.10) of the Framework and being mindful of how that condition and the associated needs are going to progress before the next planned review.

Where an individual has a deteriorating condition but eligibility for continuing NHS healthcare is not presently recommended, consideration should be given to setting an early review date. This should be clearly highlighted in the recommendation to the LHB who should ensure that the review is arranged at the appropriate time.

5.22 How should decisions be communicated to the individual or their representative?

Once the recommendation is approved by the LHB the individual should be informed in writing in an appropriate language or format in a format and language that is meaningful to them as soon as possible (although this could be preceded by verbal confirmation where appropriate), including the reasons for the decision and details of whom to contact if they wish to seek further clarification or request a review of the decision. They should also be sent a copy of the DST.

In most circumstances a fully completed DST with a covering letter confirming the decision and giving the above details will be sufficient for this purpose. Confirmation of the care package to be provided could be included within the letter or, if not known at that stage, should be supplied as soon as available.
5.23 Should the individual or their representative be given a copy of the assessment and DST?

Yes. As the individual or their nominated representative should receive a copy of the DST it is important that it is legible, and free from jargon and abbreviations. A copy of the completed assessment, DST and other documents should be forwarded to the LHB. There may be occasions where the individual or their representatives will not want a copy of the full assessment or DST. In such cases, the offer of the written information and their wish not to receive a copy should be recorded.

5.24 Can the National Decision Support Tool (DST) be changed?

No. The DST and its contents must not be changed, added to or abbreviated in any way. However, LHBs may wish to attach their logo and additional individual identification details if necessary.

5.25 Must LHBs have a fast track process in place?

The Framework at paragraph 5.50 states that LHBs should consider and put in place a fast track process that reduces the amount of information, the time taken to gather information and reduce timescales for making a decision for those individuals who require ‘fast tracking’ i.e. those individuals who have a rapidly deteriorating condition that may be entering a terminal phase.

5.26 What is a fast track assessment?

A fast track assessment is used to gain immediate access to continuing NHS healthcare funding where an individual needs an urgent package of care/support. This assessment reduces the amount of information required and the time taken to gather information. It should only be used for individuals who have a primary health need through a rapidly deteriorating condition that may be entering a terminal phase.

5.27 Who can complete the fast track Assessment?

The Framework makes it clear that the fast track assessment can only be completed by an ‘appropriate clinician’. In the Framework an ‘appropriate clinician’ is described as a person who is:

(i) Responsible for the diagnosis, treatment or care of the person in respect of whom a fast track Pathway Tool is being completed,
(ii) Diagnosing, or providing treatment or care to, that person under the 2006 Act, and
(iii) a registered nurse or is included in the register maintained under section 2 of the Medical Act 1983.

Thus those completing the fast track assessment could include consultants, registrars, GPs and registered nurses. This includes relevant clinicians working in end of life care services within independent and voluntary sector organisations if their organisation is commissioned by the NHS to provide the service.

Whoever the practitioner is, they should be knowledgeable about the individual’s health needs, diagnosis, treatment or care and be able to provide reasons why the individual meets the conditions required for the fast-tracking decision. Others involved in supporting an individual with end of life needs, including those working within wider independent or voluntary sector organisations should, with the individual’s consent, contact the appropriate clinician responsible for that individual’s healthcare to request that a fast track assessment be completed. Alternatively they could approach the relevant LHB and make the request.

5.28 What is the relationship between the fast track assessment and the Decision Support Tool?

Where it is appropriate to use a fast track assessment, this replaces the need for the DST to be completed.

5.29 Do individuals need to consent to a fast track assessment being completed?

Yes. Individuals need to give informed consent to the completion of the fast track assessment and the clinician completing the assessment should sensitively seek this. It may be useful to link the consent to the completion of a DST where there is a possibility of the need for this to be undertaken at a future date.

5.30 What happens if the individual is unable to provide consent to a fast track assessment being completed?

Where an individual is unable to provide consent, the appropriate clinician should make a best interests decision on whether to complete the fast track assessment in accordance with the Mental Capacity Act 2005. This best interests process should be carried out without delay, respecting the intention that the assessment should enable individuals to be in their preferred place of care as a matter of urgency.
5.31 Is the use of the fast track assessment dependent on specific timescales in relation to end of life care?

No. There are no time limits specified and a decision to use a fast track assessment should not be based solely around an individual's life expectancy. The phrase 'rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining. Similarly the phrase 'may be entering a terminal phase' is not intended to be restrictive to only those situations where death is imminent.

Also, someone may currently be demonstrating few symptoms yet the nature of the condition is such that it is clear that rapid deterioration is to be expected before the next planned review. It may therefore be appropriate to use the fast track assessment now in anticipation of those needs arising and agreeing the responsibilities and actions to be taken once they arise, or to plan an early review date to reconsider the situation.

It is the responsibility of the clinician referring an individual to base their decision on the facts of the individual's case and healthcare needs at the time. However, a fast track assessment should be supported by a prognosis and/or diagnosis if known, to help enable staff managing the individual’s future care needs to plan the care/support that is likely to be required.

5.32 What evidence is required when completing the fast track assessment?

The intention of a fast track assessment is that it should enable an individual to access continuing NHS healthcare quickly, with a minimum of delay, and with no requirement to complete a DST. Therefore the completed fast track assessment should have sufficient evidence to establish eligibility.

As it will be necessary to put support services in place promptly, other information about the person’s needs and their preferred model of support will help the LHB to identify the types of services required. Use of the fast track assessment should be carried out as part of overall local end of life care approaches and should reflect the best practice set out in the End of Life Care- All Wales Care Pathway for the Last Days of Life (WHC (2006) 030.

The identification of the individual's preferences as to the services to be delivered and their locations should be identified using recognised models for end of life care. In doing this, it is important to advise the person on the range of options available (e.g. home support, hospice, etc.).
LHBs should support clinicians to have up-to-date knowledge of local service options as part of their overall approach to end of life care so that individuals can make an informed choice on their preferences.

LHBs are responsible for ensuring that a wide range of service options are available. Work with the individual on their end of life care pathway should be taking place regardless of continuing NHS healthcare eligibility and so should facilitate availability of the required information.

Continuing NHS healthcare assessors should work in partnership with local end of life care leads in each individual case to ensure there is a single pathway and care plan agreed with the individual. This should be regularly reviewed and amended to reflect changing needs.

It is helpful if an indication of how the individual presents in the current setting is included with the fast track assessment, along with the likely progression of the individual’s condition, including anticipated deterioration and how and when this may occur. However, LHBs should not require this information to be provided as a prerequisite for establishing entitlement to continuing NHS healthcare. The completed fast track assessment is sufficient in itself to establish entitlement.

It is also important for the LHB to know what the individual or their family have been advised about their condition and prognosis and how they have been involved in agreeing the end of life care pathway.

**5.33 Can an LHB refuse to accept a completed fast track assessment?**

**No.** The Framework makes it clear at paragraph 5.54 that where a recommendation is made for an urgent package of care by an appropriate clinician through the fast track process, this should be accepted and actioned immediately by the LHB. However, the LHB may need additional information.

The purpose of the fast track process is to ensure that the individual receives the support they need as quickly as possible without the need for a full consideration through the continuing NHS healthcare process. An LHB should not require any additional evidence to support eligibility although, as explained above, additional information to help identify the support package required can be helpful.

The individual should not experience a delay in receiving appropriate care just because an LHB questions whether the circumstances of the individual case are appropriate for use of the fast track assessment, i.e. whether an individual’s end of life needs are such that the fast track assessment should have been used.

However, exceptionally, there may be circumstances where the LHB receive a fast track assessment which appears to show that the individual’s condition is not related
to the above criteria at all, for example if a completed assessment 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 LHB 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 assessment.

Where it then becomes clear that the use of the fast track assessment was not appropriate, the clinician should be asked to submit a completed assessment and DST for consideration through the wider eligibility process.

On receipt of the fast track documentation the LHB should arrange for the care package to be commissioned without delay.

5.34 What actions can the LHB take if the fast track assessment is being used inappropriately?

If an LHB has any concerns regarding the way in which particular clinicians/organisations are using the fast track assessment these should be addressed separately and should not delay the provision of appropriate support for the person concerned.

Each individual LHB should monitor and audit the use of the fast track assessment according to locally agreed processes, and take appropriate action if inappropriate use of the assessment is identified. Actions could include targeting training for specific individuals, raising the issue through management actions, or addressing the issue through contracting and performance routes.

5.35 How quickly could a discharge take place following the completion of the fast track assessment?

The LHB must, upon receipt of a completed fast track assessment, decide that the individual is eligible for continuing NHS healthcare. Action should be taken urgently to agree and implement the care package. LHBs should have processes in place to enable such care packages to be implemented quickly. Given the nature of the needs this time period should preferably not exceed 48 hours from receipt of the completed fast track assessment.

LHBs who receive significant numbers of fast track assessments could consider having staff dedicated to implementing fast-track care packages as this will avoid a conflict of time priorities with dealing with non-fast-track applications. Having dedicated staff could also facilitate close working with end of life care teams.

LHBs should also consider wider arrangements that need to be in place to facilitate implementation of packages within 48 hours, such as protocols for the urgent provision of equipment. The LHB coordinator and the referrer should communicate
effectively with each other to ensure well-coordinated discharge/support provision arrangements.

5.36 In which settings can a fast track assessment be used in?

It is expected that the assessment will most often be used in hospital settings. However, it can be used in any setting where an individual satisfies the criteria for the use of the assessment and they require an urgent package of support in their preferred location. This includes individuals who are already in their own home or are in a care home or hospice and wish to remain there.

The setting is not the most important issue but rather that the individual concerned receives the support they need in their preferred place as soon as reasonably practicable.

5.37 Should individuals receiving care via the fast track assessment have their eligibility for continuing NHS healthcare reviewed?

Yes. The aim of the fast track assessment is to get an appropriate funded care package in place as quickly as possible. Once this has happened, it will be important to review needs and the effectiveness of the care arrangements. In doing this, there may be certain cases where the needs indicate that it is appropriate to review eligibility for continuing NHS healthcare funding.

LHBs should make any decisions about reviewing eligibility in fast track cases with sensitivity. Where it is apparent that the individual is nearing the end of their life and the original eligibility decision was appropriate it is unlikely that a review of eligibility will be necessary. LHBs should monitor care packages to consider when and whether a review is appropriate.

Clinicians completing the fast track assessment should sensitively explain the process to the individual (and/or their representative) and make them aware that their needs may be subject to a review and that the funding stream may change subject to the outcome of the review.

Eligibility for continuing NHS healthcare can only be ended by a review through the use of the full MDT-led DST process. LHBs are reminded that any decision to remove eligibility for continuing NHS healthcare should be undertaken jointly involving the LHB and the relevant LA.

Where an MDT cannot reach agreement on whether continuing NHS healthcare eligibility should continue when reviewing a fast track case, the local disputes process should be used to resolve the matter.
There should be a clear written agreement on any transfer of responsibility that ensures continuity of care/support for the individual. The individual affected should be notified of the proposed change in writing and given an opportunity to submit views before the final decision is taken.

When the final decision is made, they should be given details of their right to request an independent review of the decision. There should be as much continuity as possible in the care arrangements, for example by carrying on with use of the same care providers wherever possible.

5.38 Who makes the decision about eligibility, the MDT or the LHB?

The MDT makes the recommendation about eligibility for continuing NHS healthcare but it is the LHB which makes the final decision. The St Helens judgement (see Chapter 3 and annex 3 of the Framework) clarified that the NHS is the primary decision maker on questions of eligibility for continuing NHS healthcare, and it has the final say.

5.39 How is the decision made?

All LHBs will have processes in place to ensure that decisions on eligibility are fair, rational, and consistent and comply with the requirements of the Framework. LHBs will need to have a further stage beyond the MDT assessment at which it will finally determine eligibility.

Most LHBs will have a ‘panel’ to confirm the conclusions of the MDT to ensure at least the consistency and quality of decision making.

5.40 What should the role of the LHB decision-making process be?

The role of LHB decision-making processes, whether by use of a panel or other processes should include:

verifying and confirming recommendations on eligibility made by the MDT
agreeing required actions where issues or concerns arise.

LHB decision-making processes should not have the function of:

- financial gate keeping
- completing/altering DSTs
- overturning recommendations (although they can refer cases back to an MDT for further work in certain circumstances).
5.41 What are the ‘exceptional circumstances’ under which an LHB or panel might not accept an MDT recommendation regarding eligibility for NHS continuing healthcare?

The Framework (paragraph 5.40) states

‘Only in exceptional circumstances, and for clearly articulated reasons, should the LHB not accept the multidisciplinary team’s recommendation. A decision not to accept the recommendation should never be made by one person acting unilaterally.’

The intention is that eligibility decisions should be led by the practitioners who have met and assessed the individual. Exceptional circumstances may therefore include:

- where the DST is not completed fully (including where there is no recommendation)
- where there are significant gaps in evidence to support the recommendation
- where there is an obvious ‘mismatch’ between evidence provided and the recommendation made

In such cases the matter should be sent back to the MDT for the relevant matters to be addressed. Where there is an urgent need for care/support to be provided the LHB (and LA where relevant) should make appropriate interim arrangements without delay.

5.42 Should finance officers be part of the decision making panel?

No. the final decision on eligibility should be about whether or not a person has a primary health need. The Framework states at 5.42 that the final decision on eligibility should be independent of budgetary constraints and therefore, finance officers should not be part of the decision making process.

5.43 How long should the assessment and eligibility decision-making process take?

The assessment and decision-making should take place as soon as reasonably practicable and in most cases within the 6-8 weeks specified in the Framework (from the date the LHB receives the referral to the date that the eligibility decision is made).

The LHB should inform the individual of the decision immediately. It is not acceptable for individuals to be waiting extended periods of time for decisions to be made or given about their future care/support needs, as this is potentially one of the most significant life-changing events for them. Therefore, practitioners need to work closely
together to ensure this process is completed as smoothly and quickly as possible to enable the individual to receive the care package they require.

5.44 What is NHS Funded Nursing Care?

Local authorities cannot provide clinical services because the NHS is responsible for any care that must be provided by a registered nurse. For people in care homes with nursing, registered nurses are usually employed by the care home itself and the NHS makes a payment for registered nursing element of the care provided.

Registered nursing can involve many different aspects of care. Typically those with a need for registered nursing care will receive some of the following:

- Supervision or monitoring of nursing needs
- Planning the care, reviewing individuals needs and making changes to the care plan
- Identifying potential health problems and dealing with them for example, by referring to other healthcare professionals such as doctors, therapists etc
- Monitoring medication

5.45 Do we have to consider CHC and use the DST for individuals who are most likely to meet Funded Nursing Care?

Yes. The assessment for CHC must be carried out first. 3.13 of the Framework states that ‘Eligibility for continuing NHS healthcare must always be considered prior to any consideration of eligibility for NHS Funded Nursing Care.

This was a key message of the Grogan case – the context of that case was that people were being assessed as eligible to receive NHS funded nursing care and no consideration was being given to whether they may be eligible for CHC.

The Framework states that from the 16th of August, anyone being considered for eligibility for CHC will be assessed through an MDT assessment and use of the DST. So, for anyone who has had a comprehensive MDT assessment the DST should be used. As the comprehensive assessment needs to be done for those who may be entering a care home or having a substantial amount of care in the community, the completion of the DST would include those who meet eligibility for FNC.

The user notes on page 68 of the Framework says that the DST should be used following a comprehensive multi disciplinary assessment and that the MDT assessment should be used to assist LHBs and LAs to meet care needs regardless of the outcome.
5.46 Sometimes the MDT may think that the individual’s choices may place them at risk. How should organisations deal openly with issues of risk?

Assessment of risk is central to providing a holistic multidisciplinary assessment of need. A good risk assessment will include listening and observation, talking to the individual and their carers to identify what risks they see and their proposed response to them in the context of their personal and family circumstances, talking to other agencies and providers of services and then listing the key risk factors, for example isolation, self neglect, self harm or aggression. In considering ‘risk’ it is important to establish what particular adverse occurrence might happen and to evaluate both the likelihood and the potential impact of this occurrence.

So long as an individual has mental capacity they are entitled to choose to take risks, even if professionals or other parties consider the decision to be unwise. It is important to work with the person to explain any risks involved and not to make generalised assumptions about these. However, providers and/or commissioners could be exposed to litigation if they place people in a position of risk. There is therefore an important distinction between putting people at risk and enabling them to choose to take reasonable risks.

To put this principle into practice, those involved in supporting individuals have to:

- Help individuals have choice and control over their lives
- Recognise that in individuals making a choice can have some risk
- Respect peoples’ rights and those of their family/carers
- Help individuals to understand their responsibilities and the implications of their choices, including identified risks
- Acknowledge that there will always be some risk, and that trying to remove the risk altogether can outweigh the quality of life benefits for individuals
- Continue existing arrangements for safeguarding people

Where someone lacks the mental capacity to make an informed decision about a course of action, including one involving any level of risk, they will not be able to give consent. In these circumstances, any decision or action should be made on the basis of what is in the person’s best interest, following the requirements of the Mental Capacity Act 2005. In some circumstances, the Court of Protection may need to become involved in certain decisions.

It should be remembered that just because a person wishes to make an unwise decision, this does not in itself mean that they lack capacity to make the decision.
5.47 What is the National Communication Tool and how should it be used?

The Tool is currently being finalised and is designed to help health and social care practitioners and the person undergoing assessment, their family, friends, carers or appointed advocates to understand better the process for Continuing NHS Healthcare (CHC).

The Tool covers such aspects as an explanation of what CHC is, what the role of the care co-ordinator is, what the MDT does etc. At the point where it is clear that Continuing NHS Healthcare should be considered, the guide should be read by the individual together with the health or social care practitioner responsible for coordinating the person's care. A record is kept in the individual's notes to say that they have been assisted to understand the process and a copy of the information is given to them.

This guide should be used to supplement the public information leaflet that provides an overview of the process for assessing individuals for Continuing NHS Healthcare, available from the Welsh Assembly Government.

6. Consent and Capacity- Obtaining consent to assessment and sharing of records

6.1 What specific guidance is there in relation to dealing with confidentiality and does it apply to the NHS and Local Authorities?

The Welsh Assembly Government's Confidentiality Code of Practice for Health and Social Care in Wales applies to both the NHS and local authorities and is applicable to decisions on continuing NHS healthcare eligibility.

The Code states:

"Increasing importance has been placed on both the health and social care services in Wales to develop clear guidance on protecting the confidentiality of patients and service users whilst allowing the appropriate exchange of information. Service provision, service development, and the maintenance of full, clear and accurate records all require that information be shared to a greater or lesser extent....

Patients and service users have a right to be informed of the intended use of their information and be given the choice to provide or withhold their consent (as appropriate). They also have an expectation that their information will be held securely and shared only with those directly associated with their care. The four main requirements to maintain and improve a confidential service are:
**PROTECT** - look after the patient’s or service user’s information

**INFORM** - ensure that individuals are aware of how their information is used

**PROVIDE CHOICE** - allow individuals to decide, where appropriate, whether their information can be disclosed or used in particular ways

To support these three requirements, there is a fourth:

**IMPROVE** - always look for better ways to protect, inform, and provide choice

For more information, refer to the Confidentiality: Code of Practice for Health and Social Care in Wales as mentioned above.

6.2 What happens if an individual with mental capacity refuses to give consent to being considered for continuing NHS healthcare eligibility?

Chapter 6 of the Framework explains the formal position in relation to refusal of consent. If an individual refuses to consent to the completion of a continuing NHS healthcare assessment it should be clearly explained that this could potentially affect the ability of the NHS and the LA to provide appropriate services. The reasons for their refusal should be explored. It should be explained that, if they are found to be eligible for continuing NHS healthcare, the NHS has responsibility for funding the support necessary to meet their assessed health and social care needs.

It is important to document clearly the efforts made to resolve the situation, including information and explanations given to the individual and his/her representative (where applicable).

Every effort should be made to encourage the individual to be considered for eligibility for continuing NHS healthcare, dealing with any concerns that they may have about this. For example, their reason for refusing consent could be a concern about losing an existing or potential direct payment or Independent Living Fund arrangement, or that the level of funding available to support them might be reduced. The individual should be advised on what the LHB can do to give them as much control as possible.

If there are significant concerns that the individual does have ongoing needs and the level of support required to meet them could be affected by their decision not to consent then the LHB and LA should jointly agree the way forward at a senior management level, taking into account their powers and duties and obtaining legal advice where appropriate. If an LA decides that the absence of consent means that services can no longer be provided they should give reasonable notice and clear reasons to the individual/family and give them the opportunity to request a review of the decision or take it through the complaints process.

Although refusal of consent only occurs in a minority of cases, LHBs and LAs should consider developing jointly agreed protocols on the processes to be followed. These processes should provide clarity regarding approaches such as the use of existing
assessment and other information to determine each organisations responsibilities and the most appropriate way forward. The aim should be for practitioners to be clear on their responsibilities and how to escalate the case if necessary, and the individual affected can make an informed decision on future support options as quickly as possible.

6.3 Even if all of the above has been attempted, where does the LHB stand if the individual still refuses a continuing NHS healthcare assessment?

If the individual refuses to give consent to be assessed, this means that the NHS cannot then become responsible for providing and paying for the entire individual’s care. However, it will still provide NHS services to the individual e.g. district nurse or GP input. Local authorities can provide such services as they are empowered to provide and individuals may be charged for such local authority provided services.

An individual is free to change their mind at any time in the process. If they do change their mind about being assessed, the reasons they have changed their mind will need to be recorded.

If the individual refuses to co-operate in an assessment of their health needs, the LHB will need to undertake an assessment of the risk of their needs not being met.

6.4 What if the individual has consented to the assessment but then refuse the care package offered by the NHS?

If an individual has been assessed as being eligible for CHC but then decides they do not want to accept the care package, this means that the NHS cannot be responsible for providing and paying for all the individuals care.

Their needs may be able to be met by both the NHS and local authority through a joint care package. This individual must be informed that they may be charged for some of the local authority services. This would be the same if they refused to be assessed for eligibility for CHC.

6.5 Would the Local Authority become totally responsible for the individual in the above events?

No. Any care plan that is put in place must not require a local authority to provide services which are beyond its powers to provide. Neither the LHB nor the local authority can dictate what the other organisation can provide.
6.6 Whose responsibility is it to provide advocacy for individuals going through the eligibility decision-making process?

Any individual is entitled to nominate an advocate to represent their views or speak on their behalf and this could be a family member, friend, a local advocacy service or someone independent who has an advocacy role.

It is not appropriate for either an NHS or LA member of staff to act as a formal advocate in this sense as there could be a conflict of interest, although staff should always seek to explain the individual’s views alongside their own.

LHBs and LAs have varying arrangements to fund independent advocacy services in their locality, some being jointly funded whereas others are funded by a single agency or rely on voluntary contributions.

The Framework says (paragraph 6.21 and 6.22) that:

‘LHBs and local authorities should ensure that individuals are made aware of local advocacy services that may be able to offer advice and support. (LHB’s also need to consider whether any action should be taken to ensure adequacy of advocacy services for those who are eligible or potentially eligible for CHC).

In addition, an individual may choose to have a family member or other person (who should operate independently of LHB’s and local authorities) to act as an advocate on their behalf’.

The latter could be achieved by the LHBs having protocols with local advocacy services about how they will support individuals around continuing NHS healthcare and making sure that the services have sufficient capacity to meet likely demand.

6.7 Do individuals need to have legal representation during the continuing NHS healthcare eligibility process?

No, although individuals are free to choose whether they wish to have an advocate present, and to choose who this advocate is. The Framework sets out a national system for determining eligibility for continuing NHS healthcare. The eligibility process is focused around assessing an individual’s needs in the context of the Framework rather than being a legal or adversarial process.

If the individual chooses to have a legally qualified person to act as their advocate, that person would be acting with the same status as any other advocate nominated by the individual concerned. The MDT process is fundamentally about identifying the individual’s needs and how these relate to the Framework.
Health and social care practitioners should be confident of their knowledge and skill in dealing with most queries that arise about the MDT process and the appropriate completion of the DST. Where wider issues are raised by advocates (such as legal questions) they should, if appropriate, be asked to raise these separately with the LHB outside the MDT meeting.

6.8 What information is available to give to members of the public about NHS continuing healthcare?

A public information leaflet, entitled continuing NHS healthcare has been developed. LHBs should make these available to members of the public, for example through local NHS websites, hardcopies on hospital wards, and through primary care outlets and local voluntary sector organisations.

Any individual being considered for continuing NHS healthcare should be given a copy of the leaflet along with any relevant local information including the Communication Tool which outlines the processes and contact arrangements.

The LHB has overall responsibility for communicating with the public regarding continuing NHS healthcare and should consider the need to make information available in alternative formats and languages to ensure that it is accessible to all who may need it.

6.9 How do the principles of Mental Capacity relate to Continuing NHS Healthcare

Paragraph 6.3 of the Framework addresses the need to apply the principles of the Mental Capacity Act 2005 when dealing with issues of capacity and consent in relation to continuing NHS healthcare. The following paragraphs give further guidance on how the principles of the Act should be applied.

6.10 What if there are concerns that the individual may lack capacity to consent to the completion of the DST?

An individual is presumed to have capacity unless it is established that they lack capacity to make the particular decision in question at the time that it needs to be made. Where there is concern that the person may lack capacity in respect of the particular decision, consideration first needs to be given to whether there is any form of help (for example with communication) that would enable them to make the decision.

A capacity test should be made and recorded in accordance with the Mental Capacity Act. Where it has been established that someone lacks mental capacity on a
significant issue it is essential that a third party takes responsibility for making a ‘best interests’ decision.

Carrying out an assessment for consideration for continuing NHS healthcare eligibility is a ‘welfare decision’ in the context of the Mental Capacity Act and therefore the decision as to whether or not an assessment is in the person’s best interests is the responsibility of the person carrying out the assessment or related process.

Where the LHB, in accordance with the expectations of the Framework, has appointed a coordinator for the continuing NHS healthcare eligibility process, this person will usually have the responsibility. Where an assessment e.g. a specialist assessment is being completed, responsibility will usually lie with the person completing that assessment.

LHBs and LAs should ensure that all staff involved in continuing NHS healthcare assessments are appropriately trained in Mental Capacity Act principles and responsibilities. Where the assessor is not familiar with Mental Capacity Act principles and the person appears to lack capacity they should consult their employing organisation and ensure that appropriate actions are identified.

An exception to the above is where a third party has been appointed as a ‘personal welfare attorney’, i.e. has been given personal welfare lasting power of attorney (LPA) by the person when they had mental capacity or has been appointed as a ‘personal welfare deputy’ by the Court of Protection after the person lost capacity. If someone states that they have such authority the assessor should ask to see a copy of the certified Deputyship Order or registered and certified LPA and check the wording of the order to confirm that the person does have the relevant authority stated.

Where a person has been appointed as attorney or deputy in relation to the person’s property and financial affairs only, they would not have authority to make decisions about health and welfare.

If they do have the appropriate authority then the assessment cannot continue if the personal welfare attorney or deputy refuses consent. Under these circumstances if the assessor believes that the deputy/attorney’s decision is contrary to the best interests of the person, or would seriously compromise them, consideration should be given to raising this concern through the local Safeguarding Adults procedure.

In appropriate circumstances the Court of Protection can overrule the decision or withdraw the welfare decision-making authority from the person. Where the third party does not provide a copy of the order or LPA to be checked then decision-making responsibility remains with the assessor (although, dependent upon the urgency of the case, the third party should be given reasonable opportunity to provide the order or LPA if they do not have it with them when requested).

In accordance with the Mental Capacity Act, where a best interests decision needs to be made, the decision-maker should consult with any relevant third party who has a genuine interest in the person’s welfare. This will normally include family and friends.
but can include care workers and paid professionals. In making this decision it is essential that the individual is directly involved in the process, taking into account their views and wishes, including any advance statements (verbal or written).

The decision-maker should take account of the views of those consulted in the best interests’ process in reaching their final decision. However, those consulted, including family members, do not have the authority to consent to or refuse consent to the actions proposed as a result of the best interests’ process. The responsibility for the decision rests with the decision-maker, not with those consulted. Where there is a difference of opinion between the decision-maker and those consulted, every effort should be made to resolve this informally. However, this process should not unduly delay timely decisions being made in the person’s best interest.

Those making best interests decisions should be aware that the Framework advises that everyone who is potentially eligible for continuing NHS healthcare should have the opportunity to be considered for eligibility.

There may be circumstances when a person presents with fluctuating capacity or a temporary loss of decision-making capacity. In these circumstances a decision needs to be made as to whether it would be in the person’s best interests to delay seeking consent until capacity is regained. If this is the case, the best interests’ decisions to be made may also include whether to provide an interim care/support package.

6.11 When is it appropriate to involve an Independent Mental Capacity Advocate (IMCA)?

The Framework reminds NHS bodies and LAs that they have a duty under the Mental Capacity Act 2005 to instruct and consult an IMCA if an individual lacks capacity in relation to particular decisions in their life and has no family or friends that are available (or appropriate) for consultation on their behalf. Where there is no one else appropriate to consult with (other than paid workers) an IMCA should be appointed where the decision relates to serious medical treatment (as defined in the Mental Capacity Act), hospital admission for longer than 28 days, a permanent change in the person’s current residence or a temporary one that will last more than eight weeks.

In the context of an assessment for continuing NHS healthcare eligibility an IMCA should be appointed as soon as a preliminary view is taken that the outcome of the assessment is likely to result in the statutory criteria for an IMCA being met. In most cases this will be because the preliminary view is that a permanent change in residence is likely (e.g. a move to a care home) irrespective of who subsequently accepts funding responsibility.

Whilst an IMCA can be appointed by either a decision-maker in an LA or the NHS, where full consideration for eligibility for continuing NHS healthcare is being undertaken it would be best practice for the LHB to appoint the IMCA. Where an IMCA
has been appointed a permanent decision should not be made on the issue in question until the IMCA report has been submitted and considered by the decision-maker.

Referrals for an IMCA should be made in accordance with local processes. It is important that decision-makers remember that separate referrals need to be made for different decisions, e.g. someone facing a potential accommodation move and a serious medical treatment decision will require separate referrals by the two relevant decision-makers.

7. Care Planning and Care Provision

7.1 Whose responsibility is it to plan and manage the care for individuals who are eligible for continuing NHS healthcare?

It is the responsibility of the LHB to plan, specify outcomes, procure services, and manage demand and provider performance for all services that are required to meet the needs of individuals who are eligible for CHC. The services secured should include an ongoing case management role for those entitled to CHC as well as for the NHS component of a joint care package, including an assessment and review of individual patient needs.

7.2 How are purchasing arrangements, both on a strategic and an individual basis met?

The key to high quality cost-effective care is through robust purchasing and contracting arrangements.

Achieving this could, for example, involve:

- use of activity and other monitoring data together with information from individual assessments and joint strategic needs assessments to forecast future patterns of demand
- joint analysis of needs with the LA through strategic needs analysis processes
- a coordinated approach between the LA and LHB at all levels of commissioning, brokerage and purchasing to provide a single and coherent interface with the market
- consideration of regional commissioning for cost-effective specialist provision, though care needs to be taken to ensure models that enable appropriate choice, particularly for socially excluded, vulnerable and hard to reach groups
- liaising with local providers and providing information about likely future demand, possibly through a joint provider forum with the relevant LA and by having an identified LHB lead for liaison with providers.
7.3 **If an individual is eligible for CHC and resides in a care home, can the Local Authority monitor the contract on behalf of the LHB?**

No. As with all NHS service contracts, LHBs are responsible for monitoring quality, safety, access and patient experiences within the context of provider performance. The ultimate responsibility for arranging and monitoring the services required to meet the needs of those with CHC rests with the LHB. Additionally, LHBs should ensure that there is clarity on the respective responsibilities of the LHB and providers for CHC.

7.4 **Who is responsible for the care plan for an individual who meets the eligibility for continuing NHS healthcare and when should this be agreed?**

The NHS has the responsibility for planning the care of an individual who is eligible for continuing NHS healthcare. The decision on the provision of each service is determined by the assessment of the needs of the individual. Once the needs have been assessed by the MDT, then a care plan should be written which shows how the needs will best be met and by whom.

When it has been determined that a person is eligible for CHC, it is the responsibility of the NHS to make the necessary arrangements for the care of the patient irrespective of setting. The NHS will take the lead role in working with the other organisations to establish an appropriate package of care, accommodation and support.

The CHC package to be provided is that which the LHB assesses is appropriate for the individual's needs. LHBs are encouraged to consider the local authority's assessment or its contribution to a joint assessment as these will be important in identifying the individual's needs and, in some cases, the options available for meeting them.

7.5 **Can other agencies be involved in continuing NHS healthcare provision?**

Yes. As indicated in the Framework, while the overall responsibility for the care provision for those individuals who are eligible for CHC will lie with the LHB there will be ways in which other agencies, such as (but not only) social services may become involved, for example:

- through ongoing responsibilities for meeting related needs, such as those of carers;
- through ongoing social work services;
- through agreed delegated responsibility for purchasing or providing care;
through agreed delegated or shared responsibility for providing ongoing assessment and/or care management;
through locally developed joint service provision;
through their housing, education and leisure services responsibilities, local authorities have a corporate role in enabling people to have fulfilling lifestyles and to participate in and contribute to the wider community;
through the provision of equipment

7.6 How should care planning be approached for a person entitled to continuing NHS healthcare?

It is important that the services commissioned and provided for a person in receipt of continuing NHS healthcare are based on supporting the outcomes identified in a care plan jointly developed and agreed with the individual and regularly updated and reviewed.

Clearly most people who are eligible for continuing NHS healthcare have a long-term condition or other long-term health need. Even for those who qualify for other reasons, the following principles should apply to the care planning process;

- puts the individual, their needs and choices that will support them to achieve optimal health and well-being at the centre of the process
- focuses on goal setting and outcomes that people want to achieve, including carers
- is planned, anticipatory and proactive with contingency planning to manage crisis episodes better
- promotes choice and control by putting the person at the centre of the process and facilitating better management of risk
- ensures that people, especially those with more complex needs, the socially excluded and particularly vulnerable or those approaching the end of life, receive coordinated care packages, reducing fragmentation between services
- provides information that is relevant and timely to support people with decision making and choices
- provides support for self care so that people can self care/self manage their condition(s) and prevent deterioration
- facilitates joined-up working between different professions and agencies, especially between health and social care, and
- results in an overarching, single care plan that is owned by the person but can be accessed by those providing direct care/services or other relevant people as agreed by the individual, e.g. their carer(s). The important aspect of this is that the care planning discussion has taken place with an emphasis on goal setting, equal partnership, negotiation and shared decision making.
7.7 What should be considered if agreeing the location of care for an individual eligible for continuing NHS healthcare?

While many persons who are eligible for CHC will remain in hospital or move into a care home or hospice, there will be circumstances where the appropriate and preferred option will be the patient’s own home, or the home of a relative or friend in the community.

In any location, care planning should be responsive to the age, living circumstances, geographic location, gender, culture, faith, personal relationships and lifestyle choices of the assessed individuals as well as their health needs. Care planning also needs to be informed by assessments of risk to patient, carers and staff and the availability of the appropriate services.

The choice of location for those individuals who meet eligibility for CHC will have differing implications for the involvement of other agencies. Where a person is placed in a hospital or care home, the NHS will arrange and fully fund the care, including the accommodation and personal care. Where a person returns to their own home (or that of a carer) the LHB fully funds the cost of their health and personal care needs but not the accommodation, food or general household support.

7.8 Can individuals still receive Continuing NHS Healthcare if they live in a residential home?

Whilst in principle people can be eligible for CHC in any setting, including a residential care home, there are a number of factors to consider.

It is likely that a person who is eligible for CHC would have significant health needs. An individual who is eligible for CHC and who wishes to continue living in a residential home does not necessarily mean that the home is in breach of the regulatory conditions that prevents the home providing nursing care, but the LHB would need to ensure that the assessed healthcare needs of the individual are appropriately met in a residential setting. This could include the direct intervention of district nurses, specialist nurses, allied health professionals etc which would ensure the home is not in breach of the regulatory conditions.

7.9 Who is responsible for case management once an individual is eligible for continuing NHS healthcare?

Once an individual has been found eligible for continuing NHS healthcare, the LHB is responsible for their case-management, including monitoring the care they receive and arranging regular reviews. This could be through joint arrangements with LAs, subject to local agreement. LHBs should ensure arrangements are in place for an
ongoing case-management role for all those entitled to continuing NHS healthcare, as well as for the NHS elements of joint packages.

Case-management should be person-centred. The individual should be encouraged to have an active role in their care, be provided with information or signposting to enable informed choices, and supported to make their own decisions. In the context of continuing NHS healthcare case-management necessarily entails management of the whole package, not just the healthcare aspects. The key elements of the role include:

a) ensuring that a suitable care plan has been drawn up for and with the individual—this might best be done initially by the MDT involved in their care, in consultation with the person concerned or their representative

b) ensuring that the care/support package meets the individual’s assessed needs and agreed outcomes and is appropriate to achieve the identified intended outcomes in the care plan

c) where the care plan includes access to non-NHS services, for example leisure services, ensuring that the arrangements for these are in place and are working effectively

d) monitoring the quality of the care and support arrangements and responding to any difficulties/concerns about these in a timely manner

e) acting as a link person to coordinate services for the individual

f) ensuring that any changes in the person’s needs are addressed,
g) reviewing the situation on a regular planned basis, and if necessary undertaking additional unplanned reviews where circumstances require.

Reviews need to consider not just whether the individual is still eligible for continuing NHS healthcare but also the effectiveness and appropriateness of the care/support arrangements.

7. 10 Can an LHB use an external agency to carry out the commissioning of continuing healthcare services or for negotiation with providers?

LHBs hold the statutory responsibility for commissioning NHS services for their populations, including continuing NHS healthcare. Whilst LHBs may reach arrangements with other organisations to carry out functions on their behalf, LHBs retain statutory responsibility.

LHBs can make arrangements with LAs or other bodies/organisations in relation to continuing NHS healthcare commissioning. For the LA to commission continuing NHS
healthcare on the LHB’s behalf requires a transfer of appropriate powers using section 33 of the NHS (Wales) Act 2006.

Other arrangements, such as integrated teams of LHB and LA staff commissioning for individuals with high support needs in an integrated manner are also possible. In all cases, LHBs retain ultimate responsibility for continuing NHS healthcare commissioning. Any such arrangements should reflect the LHB’s responsibilities to fund the assessed health and social care needs of individuals entitled to continuing healthcare and that continuing healthcare, as with most other NHS services, is free at the point of delivery to the individual.

LHBs should ensure that there is clarity in arrangements with external organisations on the respective responsibilities of the LHB and of the external organisations in relation to the above roles. The approaches of the external organisation to the functions they carry out on behalf of the LHB should reflect the best practice set out for LHBs in this practice guidance and in the Framework. The external organisation should operate within the LHB's strategic approaches and policies in relation to continuing NHS healthcare commissioning including in relation to the range of providers and the choice available to individuals.

7.11 What if the individual or their carer is unhappy with the care plan?

If the individual/relative or their carer is not satisfied with the care plan which has been developed, they will need to raise this with the person responsible for it in the first instance. They may request a re-assessment of their needs and review of the care plan. If they continue to be dissatisfied, they will need to consider making use of the complaints process.

7.12 What limits (if any) can be put on individual choice where, if followed, this would result in the LHB paying for a very expensive care arrangement? Under what circumstances can the LHB decline to provide care in the preferred setting of the individual?

The Framework says (paragraph 7.5) that ‘the CHC package to be provided is that which the LHB assesses is appropriate for the individual’s needs’.

In many circumstances there will be a range of options for packages of support and their settings that will be appropriate for the individual’s needs. The starting point for agreeing the package and the setting where continuing NHS healthcare services are to be provided should be the individual’s preferences.

Individuals will not always be aware of the models of support that it is possible to deliver (for example, they may assume that it is only possible to receive support in a care home). Those involved in working with individuals to plan their future support
should advise them of the options and the benefits and risks associated with each one. LHBs should be aware of the models of support offered by partners and by other LHBs and of evidence about their benefits and risks so that the options offered are maximised and that generalised assumptions are avoided.

In some situations a model of support preferred by the individual will be more expensive than other options. LHBs can take comparative costs and value for money into account when determining the model of support to be provided but should consider the following factors when doing so:

a) The cost comparison has to be on the basis of the genuine costs of alternative models. A comparison with the cost of supporting a person in a care home should be based on the actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care home cost.

b) Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual’s assessed needs and agreed desired outcomes. For example, individuals can sometimes be described as needing 24-hour care when what is meant is that they need ready access to support and/or supervision. LHBs should consider whether models such as assistive technology could meet some of these needs.

c) Where individuals are assessed as requiring nursing care, LHBs should identify whether their needs require the actual presence of a nurse at all times or whether the needs are for qualified nursing staff or specific tasks or to provide overall supervision. The willingness of family members to supplement support should also be taken into account, although no pressure should be put on them to offer such support. LHB’s should not make assumptions about any individual, group or community being available to care for family members.

d) Cost has to be balanced against other factors in the individual case, such as an individual’s desire to continue to live in a family environment.

7.13 Who has the lead role when an individual is not eligible for continuing NHS healthcare?

Where it has been determined that a person is not eligible for CHC and an alternative package of care is required (e.g. NHS Funded Nursing Care in a care home, or a joint package of care in the community), the lead role will normally lie with the local authority, or, as agreed between agencies, in their local care management arrangements. The NHS will work alongside the local authority to develop and implement an appropriate care plan.

If an individual is eligible for Funded Nursing Care and resides in a care home with nursing, the LHB has a duty to monitor the nursing care provision alongside the local authority.
What are joint packages of care?

Where an individual’s care/support package is supported by both the NHS and the LA this is known as a ‘joint package of care’. The Framework advises that if an individual does not qualify for fully funded continuing NHS healthcare the NHS may still have a responsibility to contribute to meeting that individual’s healthcare needs. Even where a person is eligible for CHC the local authority may need to continue to be involved in a number of ways – see paragraph 7.4 for the Framework.

The respective powers and responsibilities of each organisation should be identified by considering the needs of the individual. Where there are overlapping powers and responsibilities, a flexible, partnership-based approach should be adopted based on the most appropriate organisation to meet the specific need.

Practitioners should draw on their knowledge and skills regarding the assessed needs and their organisation’s powers to meet them, and work together to agree respective responsibilities for care provision in a joint package of care. In a joint package of care the LHB and the LA can each contribute to the package by:

a) delivering direct services to the individual
b) commissioning care/services to support the care package, or
c) transferring funding between their respective organisations

Joint care packages can be provided in any setting. Examples can include:

- someone in their own home with a package of support who does not have a primary health need but has a package of support comprising both health and social care elements
- someone in a care home with nursing who has nursing or other health needs that, whilst not constituting a primary health need, are clearly above the level of needs intended to be covered by NHS-funded nursing care
- someone in a care home (without nursing) who, although not eligible for continuing NHS healthcare, has some specific health needs beyond the power of the LA to meet, requiring skilled intervention or support where these needs cannot practically be met by community nursing services.

Joint/coordinated LHB and LA reviews should be considered for any joint package in order to maximise effective care and support for the individual.

Practice Example – Joint Package of Care (Reference DoH Practice Guidance)

A PCT in England and a LA have developed a tool to assist in dividing responsibilities and costs in joint packages of care where the individual is not eligible for NHS
continuing healthcare but nonetheless has significant healthcare/nursing needs.

This tool draws on the same domains as the DST and asks for each whether the needs identified can lawfully provided by the LA or whether they should be provided by the LHB through existing mainstream provision or through an additional service.

Jim is a 78-year-old man who has had a stroke. After rehabilitation he has residual weakness in his left arm and leg. He can manage the one step into and out of his ground floor property and is able to walk independently and safely around his home with a tripod walking stick. He gets in and out of his bed and armchair independently.

Jim can walk to his local shop (about 100 metres) in good weather but needs to stop frequently for short rests. For longer journeys he uses a wheelchair.

Jim has reduced dexterity of fine motor movements in his hand but is able to hold his stick securely. He has difficulty with buttons and zips. He is able to wash his predominantly affected side but finds it difficult and occasionally painful to wash his other side. He can manage his own toilet needs and has adapted clothing to manage his difficulty with zips and buttons.

Jim’s main problem is that his speech and swallowing have not fully recovered and he is advised not to take food by mouth. He therefore has a peg feed fitted and receives four bolus feeds a day. He chooses to have tasters of food – two to three teaspoons at his breakfast and evening meal times. The dietician has given detailed instruction on the food consistency, the portion size and how he is to have these tasters.

Jim is realistic about his needs and faithfully follows the instructions about his food intake. Between meals he uses foam applicators to cleanse his mouth with cool water. Jim has no behavioural or cognitive problems, though he becomes upset at times when he reflects on his current health condition.

On assessment it was agreed that Jim does not have a primary health need, but it was considered appropriate to provide him with a joint package of care. His daily care package comprises:

a) half an hour social care (LA funded) each morning to help with dressing and showering
b) one-and-a-half hours health care (NHS funded) each morning for:
   > preparation of appropriate consistency food and to observe Jim while he enjoys his tasters
   > encouraging the correct double swallow prescribed by the speech therapist
   > bolus feeding and liquid paracetamol via his peg
   > observing him for thirty minutes as he had on some occasions posited back small amounts of the diet. This needs no intervention other than to assist him to expectorate or take appropriate emergency action if needed. Also to report all extended coughing episodes to the district nurse
c) one hour healthcare at lunch for bolus feed and medication
d) one-and-a-half hours healthcare in the early evening for bolus feed and medication

e) one hour healthcare late evening for bolus feed and medication

f) half an hour social care each evening for personal care.

In addition Jim receives four hours social care (LA funded) per week for shopping, banking, socialisation, etc. when care staff accompany him, push him in his wheelchair, and provide him with assistance in making himself understood. Jim also has one hour social care per week for housework and laundry. He employs someone privately to do his ironing, windows and small garden area, as this is his choice.

N.B. this division of responsibilities reflects what was locally agreed. Different models of sharing responsibility may be possible.

7.15 What can key agencies do to improve partnership working in relation to continuing NHS healthcare?

Continuing NHS healthcare can only be delivered successfully through a partnership approach at both organisational and practitioner levels between the LHB, LA, and other provider organisations. Local protocols covering the areas where agreement is needed on policy and processes relevant to continuing NHS healthcare may be helpful in ensuring consistency and developing relationships.

Trust between organisations is developed by actions that are trustworthy and transparent, and by an approach that is based on everyone seeking to apply the eligibility criteria fairly and objectively rather than seeking to move responsibility to another organisation. Amongst other things, good partnership working involves:

- LHBs and LAs, as far as possible, adopting similar approaches to the ranges and models of care/support they commission so that there is no perceived advantage or disadvantage to being funded by one agency rather than the other
- LHBs and LAs developing similar approaches to risk and enablement
- LHBs, LAs and providers supporting their staff to adopt creative, flexible approaches that reflect best practice
- practitioners across all sectors being supportive, open and honest with one another
- practitioners respecting each other’s professional judgement, knowledge and experience and working together to obtain the best outcome for the individual
- dealing with genuine disagreements between practitioners in a professional manner without inappropriately drawing the individual concerned into the debate
• practitioners being clear with each other what services can be commissioned by their respective organisations so as to give accurate information to the individuals concerned.

Examples of good partnership working include:

• The LHB and LA having unified commissioning/contracting arrangements,
• Joint brokerage arrangements between the LHB and LA
• Joint delivery of CHC training
• Joint arrangements for hospital discharge
• Co-ordinators based in acute hospitals to ensure good communication, correct processes and to streamline CHC decision making
• Reciprocal agreements around ‘funding without prejudice’
• Joint tendering for domiciliary care
• Secondment/joint post arrangements whereby social care staff work alongside LHB staff to undertake continuing NHS healthcare assessments
• Arrangements to review jointly those receiving continuing NHS healthcare
• LHBs working with existing Transition Teams to ensure screening and planning occurs for young people approaching adulthood who may become eligible for continuing NHS healthcare
• Joint funding of advocacy services by LHBs and LAs

7.16 How can the voluntary sector support multi disciplinary care provision?

For people who have low levels of need and are unlikely to require complex care, it may be appropriate to consider the use of support schemes developed and run by voluntary agencies. In addition, voluntary organisations may contribute support services as part of more complex multi-agency care provision.

The need for these services should be considered by commissioners when ensuring a full range of services is provided to meet need. If voluntary organisations are to provide support on discharge they must be involved in the assessment and care planning process.

7.17 What is the Independent Living Fund and what can it be used for?

The Independent Living Fund (ILF) is an Executive Non-Departmental Public Body of the Department for Work and Pensions. It awards payments to severely disabled people to support the cost of their personal care and/or domestic assistance. To get payments from the ILF you have to meet certain conditions.
Service users use Independent Living Funds to meet complex needs. They are expected to contribute half of the care component of their Disability Living Allowance and all of their Severe Disability Premium. These benefits are fully restored once ILF is removed and can be used to purchase domestic support by the service user.

The local authority social worker will assess and develop a care package in consultation with the individual using all the funds available from the local authority, Independent Living Funds, health and the service user or any other third party. The Independent Living Fund will appoint an assessor usually a social worker who meets the applicant along with the local authority social worker. The ILF assessor must be satisfied that the care package proposed will meet any identified needs and minimise risks over a twenty four hour period.

ILF Funds are used to pay the cost of employing personal assistants or a care agency to enable the disabled person to live independently. The payments are intended to pay for support and services such as personal care and/or domestic assistance. ILF can be used to support the following:

- Cleaning and other domestic duties
- Cooking and preparing food and drink
- Laundering and ironing
- Shopping
- Personal and grooming
- Dressing
- Eating
- Drinking
- Physical movement such as turning or walking.
- Supervision in order to avoid substantial danger to him or herself or to others.

ILF is usually in payment to the most profoundly disabled and vulnerable people in society to maximise independence, wellbeing and choice. The individual has control of the monies and can decide how their care and support needs will be met.

ILF is often used to complement the local authority care package e.g. providing night cover, additional daytime calls, additional carers, monitoring, social interaction including holidays. The individual however can retain complete control of the ILF monies and choose not to cooperate with the local authority. This occurs infrequently as there is a co-dependent relationship between the service user and the local authority who both wish to maintain the ILF payment.
7.18 Can the Independent Living Fund be used to support CHC packages?

No. ILF cannot be used to fund health or nursing services therefore once Continuing NHS Health care is approved or a person is admitted to hospital or a nursing home, social services must inform ILF and their contribution to the care package ceases. If the individual is an extension fund user (pre 1993) a request can be made to ILF for support with domestic activities only.

Any contribution from health can be used in development of a non CHC care package but this financial contribution cannot be used as a qualification for ILF funding in the same way as the local authority contribution.

7.19 What happens if someone is receiving ILF at the time they are being assessed for CHC?

Community care packages provided with a combination of local authority funding and ILF continue whilst the quality assurance process is completed, eligibility is agreed and services are commissioned via Continuing NHS Healthcare. The individual will be required to pay an assessed charge to the local authority during this period.

7.20 What are Direct Payments?

Direct payments are local council payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the local council. A person must be able to give their consent to receiving direct payments and be able to manage them even if they need help to do this on a day-to-day basis.

The money is for individuals to use to pay for the services and equipment which will meet the needs the local council has assessed them as having. As a general principle, councils should let individuals choose how best to meet their assessed needs as long as they are satisfied that agreed support arrangements are being met. The direct payment will usually reflect the charge that would have been payable for the equivalent direct services from the local authority.

7.21 Can Direct Payments be used to support CHC packages?

No. NHS services cannot be provided through Direct Payments. As this may lead to a loss of control or choice over the care for an individual, the impact that eligibility for CHC has on Direct Payments should be discussed with the individual by the social worker.
8. Reviews

8.1 What do we say to individuals if they ask why a review is necessary?

The LHB’s responsibility to provide or commission care (including CHC) is not indefinite as needs might change. The outcome of a review will determine whether the individual’s needs have changed, which then determines whether the package of care needs to be revised or the funding responsibilities altered. This should be made clear to the individual and their family or carer at the time of the initial assessment and at each subsequent review and confirmed in writing.

8.2 Once an individual is found eligible for continuing NHS healthcare, how often should be reviews be undertaken?

Reviews should follow the format of an assessment, consider all the services received and be tailored to the individual.

As a minimum there should be an initial review of the care plan within 6 weeks and a further review at 3 months of services first being provided. Thereafter reviews should be at least annually.

Where an individual’s condition is anticipated to deteriorate, more regular review may be necessary. Frequency of such reviews will be determined by the individual’s assessed needs or if there is a change in circumstances. Where there is an obvious deterioration in circumstances reviews should also be held within 2 weeks, and acted upon appropriately.

8.3 Should individuals and their carers be involved in the review process?

Yes. The individual, and where appropriate, those who care for them, must be central to the review process. They should be informed of why the review is taking place, when it will be undertaken, where and who will be involved.

Prior to undertaking the review they should be offered to reassess their own needs and offered appropriate support to do so. If a member of their family is contributing to the care package, practitioners should consider whether a further carer’s assessment is required.
8.4 What role should the local authority play in the review process?

If the local authority is responsible for any part of the care, both the LHB and the local authority will have a requirement to review needs and the service provided. In such circumstances, it would be beneficial to conduct a joint review.

Even if all the services are the responsibility of the NHS, it would be beneficial for the review to be held jointly by the NHS and the local authority especially as any decision affecting CHC will require input from both sectors. Some cases will require a more frequent case review, in line with clinical judgement and changing needs.

8.5 What information needs to be recorded after the review and how should the information be used?

The review should be recorded in the individual’s notes, describe who was involved, those individuals not involved and reasons why, location and method of review and issues that the individual (or carer/advocate) raised.

The review information should be used to inform the individual’s care plan. A copy of the review and care plan should be drafted, agreed and given to the service user. Subject to the constraints of confidentiality, the findings of the review and changes to the care plan should also be shared with those involved in the individual’s care.

8.6 What if the review determines that some services are no longer required?

Where, following a review, services are to be discontinued, the review report should clearly state the reasons for this withdrawal. There should be an evaluation and record of the extent to which the objectives and outcomes were achieved and the name of the professional that the individual can contact if needs and circumstances change.

Neither the LHB nor the local authority should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual and without first consulting one another and the individual about the proposed change of arrangement. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If joint agreement cannot be reached upon the proposed change, the local disputes procedures (see Chapter 11 of the Framework) should be invoked and current funding arrangements should remain in place until the dispute has been resolved.
What about Funded Nursing Care reviews?

When reviewing the need for NHS Funded Nursing Care, potential eligibility for continuing NHS healthcare must always be considered and a full assessment should be carried out, where necessary.

9. Links to Other Policies

9.1 What is the relationship between continuing NHS healthcare and section 117 after-care under the Mental Health Act?

Services for needs that fall to be met as after-care services under section 117 of the Mental Health Act 1983 should be provided under that legislation rather than as continuing NHS healthcare. Only needs that are not section 117 after-care needs should be considered for continuing NHS healthcare eligibility in the usual way. For example, the individual might have or develop physical health needs which are distinct from the section 117 needs, and which separately constitute a primary health need. Whether section 117 services are being funded by an LHB or a LA there should be no charge to the individual.

Section 117 is a free-standing joint duty and the NHS LHBs and LAs have been advised to have in place local policies detailing their respective responsibilities (see for example Mental Health Act 1983 Code of Practice Chapter 31).

It is preferable for an LHB to have separate budgets for funding section 117 and continuing NHS healthcare. Where they are funded from the same budget they still continue to be distinct and separate entitlements.

9.2 Do the Deprivation of Liberty Safeguards affect consideration of continuing NHS healthcare?

No. The Mental Capacity Act 2005 contains provisions that apply to a person who lacks capacity and who, in their own best interests, needs to be deprived of their liberty in a care home or hospital, in order for them to receive the necessary care or treatment. The fact that a person who lacks capacity needs to be deprived of his or her liberty in these circumstances does not affect the consideration of whether that person is eligible for continuing NHS healthcare.
9.3 Does the CHC Framework and the DST only determine eligibility for adults? If so, what about children?

The 2010 Framework and the DST should be used to determine eligibility and what CHC services people aged 18 years or over should receive from the NHS. A separate policy for those less than 18 years of age will be issued later.

The legislation and the respective responsibilities of the NHS, social services and other services are different in child and adult services. The term ‘continuing care’ also has different meanings in child and adult services. It is important that young people and their families are helped to understand this and its implications right from the start of transition planning.

9.4 How should organisations deal with the issue of children who may transfer to adult continuing NHS healthcare services in the future?

All LHBs should ensure that they are actively involved with their partners in the strategic development and oversight of their local transition planning processes, and that their representation includes those who understand and can speak on behalf of adult CHC. LHBs should also ensure that adult CHC is appropriately represented at all transition planning meetings to do with individual young people whose needs suggest that there may be potential adult CHC eligibility.

Local authorities and LHBs should have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a young person who, on reaching adulthood, may have a need for services from the other organisation.

It is best practice that future entitlement to adult CHC should be clarified as early as possible in the transition planning process, especially if the young person’s needs are likely to remain at a similar level into adulthood.

9.5 When should planning for transition start?

Planning for transition to adult CHC services should commence when the child is aged 14. At the age of 17, eligibility for adult CHC should be determined in principle by the relevant LHB, so that, wherever applicable, effective packages of care can be commissioned in time for the individual's 18th birthday (or later, if it is agreed that it is more appropriate for responsibility to be transferred then). If needs could change, it may be appropriate to make a provisional decision, and then to recheck it by repeating the process as adulthood approaches.

Entitlement to adult CHC should initially be established using the decision-making process set out in the 2010 Framework, including the DST. The decision on eligibility should be made using the relevant LHB’s usual CHC decision-making processes. The
health plans and other assessments and plans developed as part of the transition process will provide key evidence to be considered in the decision-making process. Any entitlement that is identified by means of these processes before a young person reaches adulthood will come into effect on their 18th birthday, subject to any change in their needs.

9.6 What if, after assessing eligibility against the adult Framework as described above, the young person is found not to be eligible for continuing NHS healthcare?

Even if a young person is not entitled to adult CHC, they may have certain health needs that are the responsibility of the NHS. In such circumstances, LHBs should continue to play a full role in transition planning for the young person, and should ensure that appropriate arrangements are in place for services that meet these needs to be commissioned or provided. The focus should always be on the individual’s desired outcomes and the support needed to achieve these.

A key aim is to ensure that a consistent package of support is provided during the years before and after the transition to adulthood. The nature of the package may change because the young person’s needs or circumstances change. However, it should not change simply because of the move from children’s to adult services or because of a switch in the organisation with commissioning or funding responsibilities. Where change is necessary, it should be carried out in a phased manner, in full consultation with the young person. No services or funding should be withdrawn unless a full assessment has been carried out of the need for adult health and social care services, including the funding responsibilities.

9.7 What is ‘Challenging Behaviour’?

A definition most used by the agencies has been provided by Emerson E (1995) who suggests that challenging behaviour may be caused by a number of factors, including biological (pain, medication, the need for sensory stimulation), social (boredom, seeking social interaction, the need for an element of control, lack of knowledge of community norms, insensitivity of staff and services to the person’s wishes and needs), environmental (physical aspects such as noise and lighting, or gaining access to preferred objects or activities), psychological (feeling excluded, lonely, devalued, labelled, disempowered, living up to people’s negative expectations) or simply a means of communication.

Behaviours that challenge typically start in early childhood or adolescence and endure over time. Individuals with challenging behaviour will therefore be found in family settings, schools, local authority and voluntary sector provision, as well as in services provided by the National Health Service.
9.8  Is an individual described as having challenging behaviour ‘automatically’ eligible for continuing NHS healthcare?

**No.** Challenging behaviour may be caused by a number of factors including biological, social, environmental, and psychological or as a means of communication. Therefore, the task of meeting the needs of people with complex behavioural needs may need to be owned by a wide variety of agencies, services and professionals.

9.9  How should we work jointly with individuals who have a learning disability?

The Statement on Policy and Practice for adults with a learning disability announced in March 2007, sets out the Welsh Assembly Government’s values and vision underpinning support for people with learning disabilities. The 1983 All Wales Mental Handicap Strategy and 1994 Revised Guidance required local authorities to develop strategic planning in partnership with local stakeholders.

It is essential that people with a learning disability, their carers and other stakeholders should be active and equal participants and contributors in all service planning, development, monitoring and evaluation processes. All stakeholders need to be committed to the process to maximise the benefits of joint working.

Such joint service planning should be responsive to local needs, taking into account the demographics of the local area and likely future requirements as well as ensuring that they meet individual needs identified via the Unified Assessment Process.

Planning for the delivery and future development of services for people with a learning disability must take account of and be included in local Health Social Care and Well-being Strategies and Implementation Plans. Other strategies such as Community Plans should also be considered for their relevance and the opportunities they can provide for people with a learning disability and their families.

9.10  Are those individuals in receipt of continuing NHS healthcare still entitled to access core NHS services?

**Yes.** Those in receipt of continuing NHS healthcare are still entitled to access the full range of primary, community, secondary and other health care services regardless of their care setting.

If an individual who is eligible for continuing NHS healthcare resides in a care home, LHBs must ensure that their contracting arrangements with care homes that provide nursing care clarify the responsibilities of the nursing staff employed in the care home and of the community nursing services respectively. There should be no gap in service provision between these two sectors.
9.11 Who is responsible for equipment and adaptations if someone is eligible for continuing NHS healthcare and is in their own home?

The focus of continuing NHS healthcare should be on enabling the delivery of the desired outcomes of the individual and promoting their physical and psychological well-being. Care planning should therefore consider the need for equipment to assist with activities of daily living and the provision of healthcare, personal care, social care support and wider housing adaptation needs.

As set out in the Framework (paragraph 9.21), those in receipt of continuing NHS healthcare should have access to local joint equipment services on the same basis as any other patient of their LHB. Local agreements on the funding of joint equipment services should take into account the fact that the NHS has specific responsibilities for meeting the support needs of those entitled to continuing NHS healthcare.

Some individuals will require bespoke equipment (and/or specialist or other non-bespoke equipment that is not available through joint equipment services) to meet specific assessed needs identified in their continuing NHS healthcare care plan. LHBs should make appropriate arrangements to meet these needs.

For larger adaptations, Disabled Facilities Grants (DFGs) may be available from local housing authorities towards the cost of housing adaptations that are necessary to enable a person to remain living in their home (or to make a new home appropriately accessible). DFGs are means-tested. However, housing authorities, LHBs and LA social services authorities all have discretionary powers to provide additional support where appropriate.

Whether or not such integrated services are in place, LHBs should consider having clear arrangements with partners setting out how the adaptation needs of those entitled to continuing NHS healthcare should be met, including referral processes and funding responsibilities.

LHBs should be aware of their responsibilities and powers to meet housing-related needs for those entitled to continuing NHS healthcare:

- a) LHBs have a general responsibility under section 3(e) of the NHS (Wales) Act 2006 to provide such after-care services and facilities as they consider appropriate as part of the health services for those who have suffered from illness.
- b) LHBs may make payments in connection with the provision of housing to housing authorities, social landlords, voluntary organisations and certain other bodies under sections 194 and 195 of the above Act.
- c) LHBs also have a more general power to make payments to LAs towards expenditure incurred by the LA in connection with the performance of any LA function that has an effect on the health of any
individual, has an effect on any NHS functions, is affected by any NHS function or are connected with any NHS functions.

d) Housing can form part of wider partnership arrangements under section 33 of the above Act.

LAs continue to have responsibilities under section 47 of the NHS and Community Care Act 1990 and under section 2 of the Chronically Sick and Disabled Persons Act 1970 to those in receipt of continuing NHS healthcare. However, in deciding whether it is necessary to provide services under these provisions the LA should take into account services that are/will be provided by the NHS, either as continuing NHS healthcare or as other NHS services.

LAs may also continue to have some responsibilities for those in their own homes entitled to continuing NHS healthcare where the services needed are not ones that the Welsh Ministers require the NHS to provide. This can include support for housing-related needs where appropriate.

When carrying out an assessment for a property adaptation or the provision of equipment for someone receiving continuing NHS healthcare, LAs should respond positively to requests for a community occupational therapy assessment to assist and advise the individual and LHB on deciding on appropriate equipment/adaptation and whether or not the adaptation is essential to meet the agreed continuing NHS healthcare outcomes.

Whilst LAs and LHBs have some overlapping powers and responsibilities in relation to supporting individuals eligible for continuing NHS healthcare in their own home, a reasonable division of responsibility should be negotiated locally. In doing this LHBs should be mindful that their responsibility under continuing NHS healthcare involves meeting both health and social care needs based on those identified through the MDT assessment.

Therefore, whilst LHBs and LAs and have overlapping powers, in determining responsibilities in an individual case, LHBs should first consider whether the responsibility to meet a specific need lies with them as part of their continuing NHS healthcare responsibilities. LAs should be mindful of the types of support that they may provide in such situations.

9.12 How does continuing NHS healthcare fit with hospital discharge procedures?

Arrangements for applying the Framework should form an integral part of local hospital discharge policies, and should be implemented in such a way that delays are minimised. Timely assessments will prevent whole system delays within the acute hospital sector.
People being discharged from hospital are entitled to expect and receive a smooth transition from one stage of care to the next. A lack of co-ordinated and person centred planning for discharge can lead to poor outcomes for patients, possibly jeopardising health and safety or leading to inappropriate readmission to hospital. From a wider perspective poor discharge planning not only contributes to delays in the discharge process and extended and inappropriate lengths of stay in hospital, but can also lead to premature discharge and possible readmission.

Planning for hospital discharge is part of an ongoing process and must begin at - or sometimes, as in the case of elective admissions prior to - admission to hospital. The key to ensuring good patient outcomes relies on:

- the ability of organisations to conduct timely, appropriate person centred assessments
- and the responsiveness of services to meet identified needs.

If either of these factors is not actively managed discharges can occur too soon, be delayed or be affected to an unsafe or unsuitable environment.

For adults, assessments undertaken to support hospital discharge need to be within the context of Unified Assessment (including the Care Programme Approach for psychiatric settings). The Unified Assessment approach to assessment will facilitate the sharing of information between health and social care professionals and should be co-ordinated by a care co-ordinator. The assessment should build a rounded picture of the patient and carer’s needs culminating in a service delivery plan which will provide the framework of care and support for discharge. Further detail and implementation timescales on Unified Assessment is provided within WHC(2002)32/NAFWC 09/2002 Creating a Unified and Fair System for Assessing and Managing Care. Where relevant, it is important that information obtained from service providers is considered to inform the overall assessment and care planning process.

The Welsh Assembly Government’s Hospital Discharge Planning Guidance (NAFWC 17/2005) points out that many patients discharged from hospital will not require ongoing care from either NHS or social care agencies and the discharge arrangements can be considered simple in nature. However, some patients will require further support, either on a short-term basis to support rehabilitation and recovery, or on a longer-term basis to meet ongoing care needs. These more complex discharge arrangements are likely to be lower in number but will require effective planning and co-ordination utilising Unified Assessment as the tool to identify the nature and complexity of the care required to ensure a positive outcome.

The Framework says at 5.24 that assessments in acute settings can sometimes poorly represent an individual’s capacity to maximise their potential. To make sure that unnecessary stays on acute wards are avoided, it should be considered whether
further NHS funded therapy and/or rehabilitation might make a difference to the potential of the individual in the following few months.

9.13 How does continuing NHS healthcare link with intermediate care?

Intermediate Care involves the provision of targeted services based on comprehensive individual assessment. The planning of these services will require a joint approach to both the commissioning and the provision of a range of services designed to prevent avoidable hospital stays, maximise people’s rehabilitation and recovery after illness and minimise dependence on long term health and social care services. It is likely to involve inputs from a range of services in the NHS, social services, housing, independent and voluntary sectors. It certainly relies upon effective joint planning arrangements within local areas and dovetailing of planning requirements and cycles between health and its partner agencies, especially social services.

Intermediate care is aimed at people who would otherwise face unnecessary prolonged stays or inappropriate admissions to acute or longer term inpatient or residential care and should form a pathway of support. For example, intermediate care may be an appropriate care package where a person has received other residential rehabilitation support following a hospital admission and, although having improved, continues to need support for a period when they return to their own home.

It should be used where a person is at risk of entering a care home and requires their needs to be assessed in a non acute setting with rehabilitation support provided where needed. This is irrespective of current or potential future funding streams, but is clearly important in the context of consideration for continuing NHS healthcare.


10. Training

10.1 Is there an expectation that staff working in continuing NHS healthcare will be trained to understand and implement the Framework?

YES. Based on the principles of the UACM the Welsh Assembly Government has developed with stakeholders an All Wales continuing NHS healthcare training programme which will link with the National Leadership and Innovation Agency for Healthcare (NLIAH) and the Social Services Improvement Agency (SSIA).

This requires the NHS and their partners to ensure relevant guidance and procedures are in place, and that all relevant staff in the health and social care system are aware of them through appropriate training. This will include all members of the multi-
disciplinary team in hospital involved in hospital discharge, as well as community-based professionals involved in assessing the need for, and planning of, long term care.

11. Dispute Resolution.

11.1 What are the different types of disputes that may arise in continuing NHS healthcare?

There are two different kinds of dispute that may arise in relation to continuing NHS healthcare:

a) Disputes between an LHB and an LA regarding eligibility (which could also have additional complications arising from the two organisations being from different geographical areas).

b) Challenges (including requests for reviews) by the individual or their representative in relation to the process or decisions made.

On some occasions LHBs may receive requests for an independent review or other challenge from a close relative, friend or other representative who does not have LPA or deputy status.

Where the individual has capacity the LHB should ask them whether this request is in accordance with their wishes, and where they do not have capacity, a best interests process should be used to consider whether to proceed with the request for an independent review or other challenge.

11.2 How will disputes about eligibility for continuing NHS healthcare between organisations be resolved?

LHBs and local authorities should have in place locally agreed procedures/protocols for dealing with any disputes about eligibility for CHC and/or about the apportionment of funding in jointly funded care packages.

Disputes should not delay the provision of care and the protocol should make clear how funding will be provided pending the resolution of the dispute. Where disputes relate to the NHS and local authorities in different geographical areas, the relevant NHS body and local authority should agree a dispute resolution process to ensure resolution in a timely manner. This should include agreement on how funding will be provided during the dispute, and arrangements for reimbursement to the relevant organisations once the dispute is resolved.

Disputes should be resolved between appropriate officers and staff, as close to the problem as possible. In the event that a dispute cannot be resolved in this way,
arrangements should be established for appropriate senior managers from each organisation jointly to address the problem. Use of bodies or persons to act as mediators should be a last resort. The aim will be to resolve any disputes in the minimum time. This is particularly the case where the dispute affects the care of individuals. All stages of disputes procedures will normally be completed within two weeks. All stages will be appropriately documented.

11.3 How should the dispute process work in practice?

The Framework illustrates a disputes process between the LHB and a Social Services Department of a local authority in relation to assessments and funding eligibility: it may be developed for other disputes/agencies in this context. It is critical to the successful working of these arrangements that disputes about assessments are resolved at a level as close to the patient as possible, and as quickly as possible. In the interests of avoiding delays, it is important to apply the procedure fully at each level before proceeding to a higher level.

It will be down to the LHB and local authority to nominate the appropriate staff/appointed deputies at each stage of the dispute process.

| Level 1 | The case will be fully considered by the appropriate officer of the NHS organisation and Social Services, together with the members of the multi-disciplinary teams. This is likely to take the form of a case conference and every effort should be made to resolve matters at this level. The outcome of discussions must be formally recorded and given to all relevant persons. All relevant comprehensive assessments should be brought to this meeting |
| Level 2 | If the case is not resolved at Level 1, the case will be referred to the appropriate senior officers of the NHS and Social Services. The officer responsible for referring the case to Level 2 will ensure that all necessary documents are submitted, together with any other information which may be relevant to the decision making process at Level 2. The outcome of discussions at Level 2 must be formally recorded and given to all relevant persons - this meeting should not include previous members to ensure objectivity. |
| Level 3 | If the case is not resolved at Level 2, details including the reasons for failure to agree between the agencies concerned will be submitted in writing to the appropriate Director of Social Services and the Chief |
Executive of the LHB. The decision made at this level would be final and the agency deemed to be responsible for the provision of funding would be instructed to proceed.

11.4 Can this process be the same for disputes relating to Funded Nursing Care?

Yes. These procedures may also be used in relation to Funded Nursing Care.

11.5 What issues should be considered at the DST stage of the decision-making process to avoid or resolve disputes?

The advice set out in the user notes for the DST addresses many of the key issues that may arise in its completion, such as the approaches to take when MDT members cannot agree on individual domain levels.

By practitioners working in partnership, and by following this practice guidance it should be possible to resolve many disagreements regarding eligibility recommendations through the normal MDT process without the need to invoke formal dispute resolution procedures. However, the Framework requires each LHB and LA to have a jointly-agreed disputes resolution process for eligibility for NHS continuing NHS healthcare. Where agreement cannot be reached through the normal eligibility decision-making processes, the formal dispute resolution process should be followed.

Where an individual and/or their representative expresses concern about any aspect of the MDT or DST process, the LHB coordinator should discuss this matter with them and seek to resolve their concerns. Where the concerns remain unresolved, these should be noted within the DST so that they can be brought to the attention of the LHB making the final decision.

11.6 What factors need to be considered in local disputes processes?

It is important that local disputes processes include levels of escalation of the disputes, for example, by the matter initially being considered further by team managers from the LHB and LA and then moving up to senior management involvement as necessary. Disputes processes should also include a level by which the matter has to be finally resolved. Dispute resolution and level of disputes can be found on pages 44 and 45 of the Framework.

LHBs and LAs should carefully monitor the use of their disputes process. Disputes should be reviewed after resolution for learning points and these should be fed back.
to those involved in the decision-making process in the case and also built into the training of MDT members as appropriate.

11.7 What if the dispute crosses LHB/LA borders?

Where a dispute occurs between an LHB and LA in different areas (and therefore without a shared disputes resolution agreement) it is recommended that the local process applying to the LHB involved in the case is used. Where a dispute involves two LHBs, good practice is to use the disputes process for the LHB area where the individual resided at the outset of the relevant decision-making process.

11.8 What if the individual wishes to challenge the final eligibility decision made by the LHB?

If the individual or their representative wishes to dispute the decision made and/or the process used to reach it, they can request an independent review through the LHB as set out in the Framework. However, LHBs should always work with the individual and their representatives to seek to resolve the matter informally without the need for an Independent Review Panel (IRP). Even when an IRP has been requested, LHBs should continue to seek to resolve the matter informally. When an LHB receives an IRP request they should contact the relevant MDT to establish what efforts have been made to achieve local resolution. LHBs can consider asking the MDT to attempt further local resolution prior to the IRP hearing.

LHBs may receive requests that are outside the remit of the IRP process (i.e. that are not about the application of the eligibility criteria or the process followed to reach the decision). The eligibility criteria themselves are set nationally and so are not a matter for local review or complaints processes.

If LHBs receive review requests about other non-IRP matters (for example, the nature of the care package to be provided) they should advise the individual to pursue the matter through the NHS complaints process by writing to the LHB.

LHBs and LAs should consider agreeing and publishing local processes and timescales for responding to complaints and concerns relating to continuing NHS healthcare on issues that fall outside of the IRP process.

Top Ups

11.9 Is it legal for an LHB to allow ‘top ups’ for those eligible for continuing NHS healthcare?

‘Topping-up’ by third parties is permissible in residential LA social care in defined circumstances but is not permissible under in the NHS in Wales. For this reason there
are some circumstances where the LHB may propose a move to different accommodation or a change in care provision.

11.10 Can an individual ‘top-up’ their care package to pay for higher-cost services or accommodation?

The funding provided by LHBs in continuing NHS healthcare packages should be sufficient to meet the needs identified in the care plan, based on the LHB’s knowledge of the costs of services for the relevant needs in the locality where they are to be provided. It is also important that the models of support and the provider used are appropriate to the individual’s needs and have the confidence of the person receiving the services.

It will not be permissible for individuals who meet the criteria for CHC to pay for higher-cost services and/or accommodation. However, there may be circumstances where the LHB should consider the case for paying a higher-than-usual cost. For example, where an individual indicates a desire to pay for higher-cost accommodation or services, the relevant LHB should liaise with them to identify the reasons for the preference. Where the need is for identified clinical reasons (for example, an individual with challenging behaviour wishes to have a larger room because it is identified that the behaviour is linked to feeling confined, or an individual considers that they would benefit from a care provider with specialist skills rather than a generic care provider), consideration should be given as to whether it would be appropriate for the LHB to meet this.

11.11 What happens if an individual becomes eligible for continuing NHS healthcare when they are already resident in a high cost nursing home?

In some circumstances individuals become eligible for continuing NHS healthcare when they are already resident in care home accommodation for which the fees are higher than the relevant LHB would usually meet for someone with their needs. This may be where the individual was previously funding their own care or where they were previously funded by an LA and a third party had ‘topped up’ the fees payable.

In such situations, LHBs should consider whether there are reasons why they should meet the full cost of the care package, notwithstanding that it is at a higher rate, such as that the frailty, mental health needs or other relevant needs of the individual mean that a move to other accommodation could involve significant risk to their health and well being.
11.12 What happens if an individual is in an out-of-area placement and then becomes eligible for continuing NHS healthcare?

There may be circumstances where an individual in an existing out-of-area placement becomes entitled to continuing NHS healthcare and where, although the care package is of a higher cost than the responsible LHB would usually meet for the person’s needs, the cost is reasonable taking into account the market rates in the locality of the placement. LHBs should establish this by liaison with the LHB where the placement is located.

In such circumstances LHBs should consider whether there are particular circumstances that make it reasonable to fund the higher rate. This could be because the location of the placement is close to family members who play an active role in the life of the individual or because the individual has resided in the placement for many years so that they have strong social links with the area and it would be significantly detrimental to the individual to move them.

LHBs should deal with the above situations with sensitivity and in close liaison with the individuals affected and, where appropriate, their families, the existing service provider and the local authority if they have been funding the care package. Where an LHB determines that circumstances do not justify them funding an existing higher cost placement or services that they have inherited responsibility for, any decisions on moves to other accommodation or changes in care provider should be taken in full consultation with the individual concerned and put in writing with reasons given. Advocacy support should be provided where this is appropriate.

11.13 How should LHB’s handle those situations where an individual is already in a high cost placement or has a high cost community care package before becoming eligible for continuing NHS healthcare?

Where an individual become entitled to continuing NHS healthcare and has an existing high-cost care package LHBs should consider funding the full cost of the existing higher-cost package until a decision is made on whether to meet the higher cost package on an ongoing basis or to arrange an alternative placement.

11.14 What if an individual disputes the decision by the LHB not to pay costs that are higher than would normally be paid?

Where an individual wishes to dispute a decision not to pay for higher-cost accommodation, they should do this via the NHS complaints process. The letter from the LHB advising them of the decision should also include details of the complaints process and whom to contact if the individual wishes to make a complaint.
The new accommodation and/or services should reflect the individual’s assessed needs as identified in their care plan, including taking into account personal needs such as proximity to family members. Individuals should be provided with a reasonable choice of providers. A transition care plan should be developed by the existing and new provider that identifies key needs and preferences, including how any specific needs and risks in the transition process should be addressed.

The LHB should keep in regular liaison with the new provider and with the individual during the initial weeks of the new services to ensure that the transition has proceeded successfully and to ensure that any issues that have arisen are being appropriately addressed.

12. Independent Review Panel and Complaints

12.1 What is the purpose of an Independent Review Panel?

The independent review panel procedure (see Annex 4 of the Framework) is an additional safeguard for individuals who require ongoing support from health and/or social services and who consider that the eligibility criterion for CHC (the primary health need approach) has not been correctly applied in their case, or that appropriate procedures have not been followed.

12.2 Can the Independent Review Panel be used to deal with disputes of the care plan?

No. The Independent Review Panel is not designed to review the content of care plans, only the decision-making process as to whether a person is eligible for continuing NHS healthcare.

12.3 Whose responsibility is it to manage this process?

The LHB will administer the procedure on behalf of all persons residing within the area for which it is responsible. The procedure is also available for reviewing decisions on NHS Funded Nursing Care (NHSFNC). LHBs must ensure that arrangements are in place for:

- the establishment and operation of independent panels (see further guidance in Annexes 4 and 5 of the Framework)
- access to independent clinical advice, taking into account the range of medical, nursing and therapy needs in each case. Advisors will provide an opinion on judgements as to whether the primary health need approach and this Framework have been followed, and will not have a role in
providing a second opinion on diagnosis, management or prognosis of the individual. Arrangements should avoid conflicts of interest between clinicians giving advice and organisations from which the patient has been receiving care

- allocation of responsibility for review panels to a designated officer, who will ensure efficient operation of the process, check that appropriate steps have been taken to resolve the case informally and collect the factual evidence for the review panel

12.4 Can individuals insist that their case is considered at an Independent Review Panel?

Individuals can request this. However, NHS organisations should deal promptly with any request to reconsider decisions about eligibility for CHC and should, in the first instance, work closely with the individual to resolve the situation informally.

They should ensure that appropriate assessments have been undertaken, and have been applied and recorded, including the application of the Decision Support Tool to support the decision on eligibility for CHC. Where the patient still wishes to contest the decision, the LHB will consider whether it is appropriate to convene the review panel.

12.5 What if an individual wishes to make a complaint about decision making?

If an individual is dissatisfied with the decision at this stage (or the decision-making process at any stage) they may make use of the NHS Complaints Procedure.

12.6 How do individuals not in the direct care of the NHS e.g. in nursing homes make a complaint?

If an individual wishes to make a complaint about NHS funded services, they should initially speak to the service provider, if possible, or to the Local Health Board. Following the implementation of the Care Standards Act in April 2002 individual complaints about the provision of care will be considered by regulated establishments via their own procedures; local authorities will consider complaints relating to the commissioning process (such as the appropriateness of a type of placement); and the Care and Social Services Inspectorate for Wales (CSSIW) has discretionary powers to investigate complaints where that complaint may inform its role as a regulator of care homes.

Information on all relevant complaints procedures should be available in all service provision settings. The need for advocacy should be considered where appropriate.
12.7 Is there a need to inform the local authority of a complaint if an individual is in receipt of continuing NHS healthcare?

It is good practice for the NHS and local authorities to make each other aware of complaints received to speed up their resolution, and to pinpoint the main issue to be addressed to improve services. The regulations relating to Partnership Agreements also allow for a joint approach to complaints procedures. Further information is contained in the NHS Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000.

It is important to remember that any agency receiving a complaint needs to consider whether a referral should be made in line with procedures for the protection of vulnerable adults.

12.8 What role does the Public Service Ombudsman have in investigating complaints?

Individuals who are dissatisfied with the way in which the NHS, a local authority or the CSSIW investigates their complaint may complain to the Public Services Ombudsman Wales. However, the Ombudsman will normally expect complainants to have tried to resolve their concerns through the relevant procedure before he considers taking a case. The Ombudsman does not have to investigate every complaint submitted, but may well investigate if there is evidence of hardship or injustice where an investigation may be of benefit.