Continuing NHS Healthcare

The National Framework for Implementation in Wales

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Key Messages

K1. Continuing NHS Healthcare (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. The issue is one of need. The diagnosis, condition, the individual’s financial position, the cost of providing the required care or its setting does not determine eligibility for CHC.

K2. CHC is just one part of a continuum of services that local authorities and NHS bodies need to have in place to support people with health and social care needs.

K3. The sole criterion for eligibility for CHC is whether there is a primary health need. This replaces the separate criteria in the framework and guidance that this document replaces.

K4. It is Welsh Ministers’ policy:

- To put much greater effort into developing models of service which help to prevent or delay the need for more intensive health and social care services or facilitate a return to lower level support (for example through prevention, re-ablement or rehabilitation). This Framework is therefore intended to compliment and support existing joint strategies not replace them.
- To ensure that the available resources are used effectively in accordance with this strategic approach.
- To foster a much more collaborative approach across health and social services in these areas and to avoid local disputes.
- For those who may be eligible for CHC to put in place a sound national Framework, good decision tools, training and review arrangements to ensure speed, consistency and fairness in decisions.

K5. Within this context, this Framework sets out a process for the NHS, working together with local authority partners, to assess health needs, decide on eligibility for CHC where that is appropriate and provide the right care. See also the national tool to support decision-making: the “Decision Support Tool” (DST) at Annex 6.

K6. The NHS is responsible for assessing, arranging and funding a wide range of services, both short and long term, to meet the health needs of the population. Local authorities have the primary responsibility for the delivery of community social care services. They provide a range of services to support their local population, including services to people whose lives are affected by disability, accident or illness. These include accommodation, personal and social care, education, leisure and other services. Local authorities may charge for some of these services.

K7. 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.
K8. 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.

K9. 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.

K10. Where CHC is provided in a person’s own home, it means that the NHS funds all the care that is required to meet their assessed health and social care needs to the extent that this is considered appropriate as part of the health service. This does not include the cost of accommodation, food or general household support. In care homes, it means that the NHS also has a contract with the care home and pays the full fees for the person’s accommodation as well as their care.

K11. The NHS is the primary decision maker on questions of eligibility for CHC. While it will take account of all relevant matters, it has the final say.

K12. Where a person is eligible for CHC, local authorities still have continuing responsibilities, including, for example, a role in assessment and review, social work services, support for carers, and the meeting of housing and educational needs.

K13. Where a person is not eligible for CHC:

- Relevant organisations should have arrangements in place to provide a comprehensive care plan appropriate to need. Any such care plan must consider who can provide that care but must not require a local authority to provide services which are beyond its powers.

- The NHS may still have responsibility to contribute to that person’s health needs as part of a joint package of care, for example through the NHSFNC in a care home setting, but there are other models including health care in a person’s own home.

K14. Decision making must be based on the outcomes of an appropriate multi-disciplinary assessment process, engaging the appropriate staff, using appropriate validated assessment tools and includes the clinical opinion of the consultant or GP who has responsibility for the individual. The approach to assessment must be holistic and person centred. Carers and relatives must be involved and kept informed throughout the process.

K15. The Decision Support Tool (Annex 6) that accompanies this Framework is designed to assist and support the comprehensive multi-disciplinary assessment process. The tool should be used following a comprehensive multi-disciplinary team (MDT) assessment of an individual’s care needs as a way of bringing together and recording the various needs in a single, practical format, to facilitate logical and consistent decision-making. It cannot directly determine eligibility. Professional judgement is needed.
K16. The review panel procedure is intended as an additional safeguard for patients who require ongoing support from health and/or social services and who consider that the primary health need approach for CHC has not been correctly applied in their case, or that appropriate procedures have not been followed.

K17. NHS organisations will need to have in place procedures/protocols for dealing with any disputes between local authorities and the NHS and care providers in relation to CHC. Disputes should be resolved between appropriate officers and staff, as close to the problem as possible.
Chapter 1: The National Framework

Nature and Purpose

1.1 The Welsh Assembly Government has produced this 2010 Framework (referred to throughout this document as the “Framework”) for Continuing NHS Healthcare (CHC). It sets out the Welsh Assembly Government’s policy for eligibility for CHC, and the responsibilities of NHS organisations and local authorities under the Framework and related matters.

1.2 The effective date for this Framework is 16th August 2010. From that date NHS organisations will be required to follow it.

1.3 From its effective date this 2010 Framework replaces the following guidance and circulars:

- WHC (2004) 54 and NAFWC 41/2004 (Guidance)
- NAFWC 41a/2004 (CHC Framework)

1.4 This Framework sets out a process for the NHS, working together with local authority partners, to assess health needs, decide on eligibility for CHC and provide appropriate care. It is to be read with the national tool to support decision-making: the “Decision Support Tool” at Annex 6. This Framework and the Tool will be supported by appropriate training.

1.5 The purpose of the Framework is to provide a consistent foundation for assessing, commissioning and providing CHC for adults across Wales. This is to ensure that there is a consistent, equitable and appropriate application of the process for determining eligibility. This framework is not intended to replace existing joint commissioning strategies.

1.6 The assessment of and provision for care for children and young people will be addressed in detail in a separate document.

Action

1.7 NHS organisations should:

- Confirm to the Welsh Assembly Government by 16th August 2010 that the principles and processes in this Framework are used throughout their organisations.
- Ensure all relevant staff are fully conversant with the procedures for deciding on and arranging CHC including the application of the Decision Support Tool, the necessary multi-disciplinary assessment and decision making process, and the relevant documentation, through an agreed multi agency training programme.
• Ensure appropriate information in a range of formats is available to persons in need of care, their families and carers about:
  - how procedures for assessment and decision-making for CHC will work;
  - valid consent with regard to the assessment and provision of care
  - the local arrangements for hospital discharge and ongoing health and social care support;
  - Review panels and complaints procedures.

• Review their current assessment, training, quality assurance and discharge processes to ensure they comply with this Framework.

1.8 **Local authorities should:**

• Read this Framework and consider how their current practice fits with the responsibilities set out in this Framework and make any necessary changes.

1.9 **NHS bodies and local authorities should:**

• Work together in a partnership approach when reviewing existing processes and services to ensure best outcomes for individuals.
• Consider where CHC responsibilities require clear arrangements to be made with provider organisations and ensure that these are built into purchasing and contracting processes.
• Comply with their responsibilities as set out within this Framework.

1.10 The Welsh Assembly Government gives a commitment to review the Framework after one year of implementation.
Chapter 2: Background

Continuing NHS Healthcare (CHC) in context

2.1 Continuing NHS Healthcare (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.

2.2 CHC is just one part of a continuum of services that local authorities and NHS 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.

Responsibilities of the NHS and Local Authorities

2.3 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.

2.4 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.

2.5 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.

2.6 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.

2.7 If an individual does not meet CHC eligibility 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.
Chapter 3: Legal Framework

Legislation

3.1 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.
   ii The prevention, diagnosis and treatment of illness.

The Duties of the NHS and Local Authorities

3.2 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”\(^1\). 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.

3.3 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.

3.4 Each local authority is under a duty to assess fully any person who appears to it to be in need of community care services\(^2\). 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\(^3\) as well as domiciliary and community-based services enabling people to continue to live in the community.

3.5 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)).

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\(^1\) section 3, particularly section 3(1)(e) of the National Health Service (Wales) Act 2006.

\(^2\) National Health Service and Community Care Act 1990, Section 47.

\(^3\) National Assistance Act 1948, Section 21.
3.6 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.

**Extent of Local Authorities’ Powers**

3.7 Section 21(8) of the National Assistance Act 1948 states that nothing in section 21 authorises or requires a local authority to make any provision that is authorised or required to be provided under the National Health Service (Wales) Act 2006 (formerly the NHS Act 1977). This was considered by the Court of Appeal in *Coughlan* where it was held that a local authority is excluded from providing services if the NHS has, in fact, decided to provide those services (see paragraph 3.11 below for more on the Coughlan judgment)

“[Section 21] should not be regarded as preventing a local authority from providing any health services. The subsection’s prohibitive effect is limited to those health services which, in fact, have been authorised or required to be provided under the 1977 Act. Such health services would not therefore include services which the Secretary of State legitimately decided under section 3(1) of the 1977 Act it was not necessary for the NHS to provide.”

3.8 Local authorities also have the function of providing services under section 29 of the National Assistance Act 1948 (which includes functions under the Chronically Sick and Disabled Persons Act 1970)

4. Section 29(6)(b) of the National Assistance Act 1948 prohibits local authorities from providing services under section 29 which are “required” to be provided under the National Health Service (Wales) Act 2006 so excludes only those services which must, as a matter of law, be provided under the National Health Service (Wales) Act 2006.

3.9 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”.

**Case Law**

3.10 Deciding on the balance between local authority and health service responsibilities with respect to long-term care has been the subject of key court judgments.

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4 Chronically Sick and Disabled Persons Act 1970, Section 2.
5 Health and Social Care Act 2001, Section 49.
3.11 The decision of the Court of Appeal in R v North and East Devon Health Authority ex parte Coughlan [1999] considered the responsibilities of Health Authorities and local authority social service provision, in particular the limits on the provision of nursing care by local authorities (in a broad sense, i.e. not just registered nursing). This case was decided before the enactment of section 49 of the Health and Social Care Act 2001. The key points from this judgment are set out at Annex 3. The Court referred to a very general indication of the limit of local authorities provision in the context of a person living in residential accommodation, saying that if the nursing services are:

i. Merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide pursuant to section 21; and

ii. Of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide, then such nursing services can be provided under section 21 of the National Assistance Act 1948.

3.12 However, since the enactment of the Health and Social Care Act 2001, care from a registered nurse cannot be provided by the local authority as part of community care services. Such care is now provided within NHS Funded Nursing Care. Persons who have been assessed as not having a primary health need, and therefore as not eligible for continuing NHS healthcare may be assessed as requiring care which can now be provided within NHS Funded Nursing Care.

3.13 Eligibility for CHC must always be considered prior to any consideration of eligibility for NHS Funded Nursing Care. The interaction between Continuing NHS Healthcare and NHS funded Nursing Care was further considered by the High Court in R v. Bexley NHS Trust, ex parte Grogan [2006]. The key points from this judgment are set out at Annex 3.

3.14 In St Helens Borough Council v Manchester Primary Care Trust (PCT) (2008), the Court of Appeal considered a dispute between a PCT and a local authority regarding the funding of a care package by a service user. The Court ruled that the NHS (in this case the PCT) is the primary decision maker when it comes to deciding whether a person has a primary health need. The Court also noted that the duty under section 3 (1) (e) of the 2006 Act gave the Secretary of State [and by analogy the Welsh Ministers] “a degree of judgment as to what [he] considers necessary, reasonable and appropriate”

Equality and Human Rights Legislation

3.15 The Equality Act 2010 (the Act) brings together discrimination law introduced over four decades through legislation and regulations. It replaces most of the previous discrimination legislation, which is now repealed. The Act covers discrimination because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These categories are known in the Act as ‘protected characteristics’.

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6 See Annex 3.
7 See Annex 3.
8 See Annex 3.
3.16 The Act received Royal Assent on 08.04.2010 and is expected to come into force from October 2010. The Equality and Human Rights Commission are due to publish a Code of Practice which will cover discrimination in services and public functions as set out in Part 3 of the Act.

3.17 Part 3 is based on the principle that people with the protected characteristics defined in the Act should not be discriminated against when using any service provided publicly or privately, whether that service is for payment or not.

3.18 Public authorities also have a duty under the Human Rights Act 1998 (HRA) to act compatibly with rights under the European Convention for the Protection of Fundamental Rights and Freedoms (the Convention). It is unlawful for public authorities to breach Convention rights in any area of their activity, including service provision or employment and work-related activities.

3.19 Human rights issues can arise in relation to the exercise of any public function or the provision of any public service where a person’s dignity, personal freedom or other Convention right is at stake. If a public authority or any other body discriminates when carrying out a function of a public nature, this can amount to a breach of the HRA because discrimination in the enjoyment of Convention rights is a breach of the Convention (under Article 14). Where such discrimination is based on a characteristic protected under the Equality Act it is likely also to be a breach of the Equality Act.

3.20 LHB’s and Local Authorities have statutory duties to have due regard to the need to promote equality and human rights which should be integral to the way in which health and social care is prioritised and delivered, allowing people to enjoy quality of life and to be treated with dignity and respect. Such objectives will be supported by:

- **Equality of access to care and support**, meaning that LHB’s and local authorities should not preclude anyone from having an assessment for community health and social care services, if their needs appear to be such that they may be eligible for support.

- **Equality of outcomes from care and support**, meaning that within the same area people with similar levels of needs should expect to achieve similar quality of outcomes, although the type of support they choose to receive may differ depending on individual circumstances.

- **Equality of opportunity**, meaning that the NHS and local authorities should work together with individuals to identify and overcome any barriers to economic and social participation within society.
Chapter 4: Primary Health Need

Sole Criterion for Eligibility

4.1 The policy of Welsh Ministers on eligibility for CHC is based on whether a person’s primary need is a health need (this is known as the “primary health need approach”). The sole criterion for determining eligibility for CHC is now whether a person’s primary need is a health need. This replaces the separate criteria in the documents referred to in paragraph 1.3.

Determining a Primary Health Need

4.2 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:

- **Nature**: This describes the particular characteristics of an individual’s needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type (‘quality’) of interventions required to manage them.

- **Intensity**: This relates both to the extent (‘quantity’) and severity (‘degree’) of the needs and to the support required to meet them, including the need for sustained/ongoing care (‘continuity’).

- **Complexity**: This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual’s response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.

- **Unpredictability**: This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person’s health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

4.3 Each of these characteristics may alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual’s needs. The totality of the overall needs and effects of the interaction of needs should be carefully considered.
4.4 The diagnosis of a particular disease or condition does not, of itself, determine eligibility. Eligibility is not determined or influenced by the setting where the care is provided or by the characteristics of the person who delivers the care or any of the following factors:

- Changes in the competence and the ability of the care provider to manage care.
- The use (or not) of NHS employed staff to provide the care.
- The need for/presence of ‘specialist staff’ in care delivery.
- The existence of other NHS funded care.
- The number of staff delivering the care.
- The cost of the care package.
- Changes made to an existing package of care.
- Any other input-related (rather than needs related) matters.

4.5 The assessment process that determines whether an individual has a primary health need should take into account all the relevant health care needs. The fact that somebody has a health need that is well managed does not mean that it should be disregarded in the assessment.

4.6 Where, following a comprehensive assessment of all needs, a person’s 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).

4.7 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, they 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.

4.8 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 as part of the health service. 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.

4.9 Where an individual not previously assessed as eligible for CHC on the basis of need has a rapidly deteriorating condition entering a terminal phase, the rate of deterioration will indicate a primary health need and will require CHC services to enable their needs to be urgently met (e.g. to allow them to go home to die or to allow appropriate end-of-life support to be put in place). Assessment and the
provision of relevant services will need to be put in place quickly and considered as part of the ‘end of life care pathway’.

4.10 It is also important that deterioration is taken into account when considering eligibility, including circumstances where deterioration might reasonably be regarded as likely in the near future. In these circumstances, although the individual may not have a primary health need at the time of assessment, an earlier review should be considered. This can be reflected in the following ways:

- Where it is considered that deterioration can reasonably be anticipated to occur before the next planned review i.e. individuals who have a rapidly deteriorating condition, this should be documented and taken into account. The Multi Disciplinary Team (MDT) needs to consider whether the anticipated deterioration could be indicative of complex or unpredictable needs.
- Where eligibility is not established at the present time, the likely deterioration could be reflected in a recommendation for an early review, to establish whether the individual then satisfies the eligibility criteria.

4.11 Where it has been determined that a person is not eligible for CHC, any care plan put in place must not require a local authority to provide services which are beyond its powers to provide. However, neither the LHB nor the local authority can dictate what the other organisation can provide.

4.12 Where a person is not eligible for CHC but has health needs which are different from, or additional to, those supported by NHS Funded Nursing Care, the NHS may still have a responsibility to meet those needs as part of a “joint package” in so far as these health needs are beyond the powers of the local authority to provide.

4.13 There should be no gap in the provision of care. People should not find themselves in a situation where neither the NHS nor the relevant local authority (subject to the person meeting the relevant means test and having needs that fall within the appropriate Fair Access to Care eligibility criteria) will fund care, either separately or together.

9 WHC (2006) 030 End of Life Care – All Wales Care Pathway for the Last Days of Life.
Chapter 5: Assessment and Eligibility for CHC

Person-centred Assessment

5.1 Establishing that an individual’s primary need is a health need requires a clear, reasoned decision which is based on evidence of needs from a comprehensive assessment. In all cases, the process of assessment and decision-making must be person-centred. This means placing the person, their perception of their support needs and their preferred models of support at the heart of the assessment and care-planning process. The person’s wishes and expectations as to how and where the care will be delivered must be documented and taken into account. The individual and (where appropriate) their representative should be enabled to play a central role in the assessment process. The individual’s wishes should be taken into account in assessing the health care needs of the individual, how those needs could be best met, the risks of different types of provision and fairness of access to resources.

5.2 The assessment of an individual’s needs informs the assessment of whether or not that individual is entitled to CHC. However, regardless of whether an individual is entitled or not to CHC, LHBs and local authorities must always consider whether the assessment of needs has identified care needs that require immediate action to be taken. For example, an individual may have significant nutritional difficulties and referral to a dietician will need to be considered.

5.3 Access to assessment, decision making and provision should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, or type of health need (for example, whether the need is physical, mental or psychological). LHB’s are responsible for ensuring that discrimination does not occur and should use effective auditing to monitor this matter.

5.4 All assessments and the consideration of eligibility for and delivery of CHC should be organised so that the person who is undergoing an assessment and their family and/or carers understand the process and receive advice and information in a timely manner to enable them to participate in informed decisions about future care.

Types of Assessment

5.5 Many people pass through the health care system, whether in hospital or the community, without requiring a comprehensive assessment of their needs. Hospital Discharge Planning Guidance10 should be considered when planning any hospital discharges. Additionally, the hospital discharge guidance11 issued by the National Leadership and Innovation Agency for Healthcare, indicates when a more detailed or broader assessment is necessary. When people appear as new patients or clients in hospital or the community, health and social care professionals will identify the appropriate levels of assessment to be offered at the right time to the individual concerned. Decisions on the level of assessment must be clearly documented.

10 WHC(2005)035 Hospital Discharge Planning Guidance.
11 “Passing the Baton – a practical guide to effective discharge planning”, NLIAH, June 2008.
5.6 The guidance document ‘Creating a Unified and Fair System for Assessing and Managing Care’ (National Assembly for Wales 2002)\textsuperscript{12} provides the basis for determining the types and levels of assessment that will be appropriate in particular circumstances. All assessments will be undertaken within the context of that guidance document. The Unified Assessment guidance states how decisions on assessment should be made and the subsequent procedures. Such assessments not only identify health, social care and other needs, but also help to determine how the needs will be met and the appropriate eligibility and arrangements for the funding of care.

5.7 This Framework focuses primarily on the determination of a primary health need and eligibility for CHC and its consequences and builds on, rather than replaces “Creating a Unified and Fair System for Assessing and Managing Care.”

5.8 The decision on what types of assessment are required may be made by any number of people involved in a person’s care: this may include the multi-disciplinary team in the hospital; social workers and community nurses; or primary care staff. This has training implications for relevant staff - these are considered in Chapter 10. It is essential that all relevant documentation contains guidance and timescales on when and how such assessments will be undertaken.

5.9 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.

5.10 People with mental health problems will additionally be assessed following the Care Programme Approach guidance\textsuperscript{13}.

5.11 The assessment for people with a learning disability will follow the Person Centred Planning guidance. Person centred planning includes a range of approaches or tools that are used to help individuals or families to think about their lives. Specific guidance on Person Centred Assessments has been produced for people with a learning disability and has been formally integrated as Annexe 11 to the Creating a Unified and Fair System for Assessing and Managing Care Guidance.

**Assessment Process**

5.12 The Unified Assessment and Care Management System (UACM) recognises that many people have health and social care needs, and that agencies need to work together so that the assessment and subsequent care planning is person centred, effective, co-ordinated, fair and have standardised eligibility criteria. UACM should lead to:

- A co-ordinated process of assessment and care planning which will address a person’s health and social care needs.

\textsuperscript{12} Creating a Unified and Fair System for Assessing and Managing Care, National Assembly for Wales 2002.
\textsuperscript{13} The Care Programme Approach for Mental Health Service Users, Welsh Assembly Government, February 2003.
• The scale and depth of an assessment being in proportion to the person’s needs.
• Agencies not duplicating each other’s assessments, as there will be effective joint working between health and social care agencies within which professionals will contribute their knowledge and expertise.
• Reduced repetition in providing the information from the point of view of the person involved, giving a more seamless service.

5.13 The purpose of assessment is to evaluate the effect of an individual’s presented need on their independence, daily functioning and quality of life, so that appropriate action can be planned. Assessment should be carried out so that individuals can:

• Identify the options that are available for managing their own lives.
• Identify the outcomes required from any help that is provided.
• Understand the basis on which decisions are reached.
• Be involved in the decision making process.
• Be empowered to determine the level of risk they are prepared to take.

5.14 During the assessment individuals should be actively encouraged to access advocacy or representation as required. The views of the individual and their carers should be actively sought and their views kept central through the process. Carers are to be identified and offered an assessment in their own right as well as being part of the assessment and care planning process for the individual. Consent should be sought to share information from the outset of the assessment, it should be checked to ensure it has not been withdrawn.

5.15 There are 4 broad types of assessment:

• **Contact assessment**:

  When significant needs are first described or suspected a contact assessment collects basic information, explores the nature of the presented problem and wider care needs. Agencies should agree what information is collected and implement a common format. In collecting and sharing information agencies must work to the principles of informed consent. At this level, the nature of the enquiry, presenting problems and any risks to independence are investigated further.

• **Overview assessment**:

  An overview assessment may be undertaken where more intensive help is required or requested. This level can build up on the contact assessment and will look at further establishing needs. An overview assessment may be started immediately and will determine actual needs and whether further specialist/in depth assessment is indicated. A single NHS or social services professional may complete an overview assessment. Local agencies should agree who is competent to carry out the overview assessment.
• **Specialist assessment:**

This level will commence if the contact or overview assessment has indicated actual or potential needs in a domain, where a health or social care professional looks in more depth at identified needs. Referrals to a specialist may occur soon after enquiry, where the key issues identify a clear need. A specialist assessment should confirm the presence, extent, cause and likely development of a problem or health condition. The assessments will be carried out by appropriately qualified and experienced professionals such as nurses, occupational therapists etc.

• **Comprehensive assessment:**

Comprehensive assessments should be completed where the amount of support and treatment likely to be offered is intensive or prolonged, including permanent admission to a care home, intermediate care packages or substantial packages of home care. No decisions on where individuals are best supported should be made before all information from a comprehensive assessment has been evaluated, including information from medical assessments and a thorough exploration or rehabilitation potential.

**Co-ordinating the CHC Assessment**

5.16 The role of the Care Co-ordinator is pivotal to ensuring continuity and consistency in the assessment and care planning process. Ideally, one member of staff should have a co-ordinating role to oversee an individual’s care package. Often the role is best handled by practitioners with a long term role with the individual. Where needs are mainly health related, a nurse or other health worker should act as co-ordinator. Where social care needs are to the fore, a social worker might be expected to co-ordinate.

5.17 Involving social services colleagues as well as health professionals in the assessment process is essential and will make decision-making more effective and consistent. The assessment process for CHC is usually co-ordinated by a health professional although in some circumstances it may be appropriate for another professional e.g. a social worker from an integrated team, to undertake this role. The assessment must include the clinical opinion of the consultant or GP who has responsibility for the patient, so that the medical needs are considered alongside all other care needs and will also include appropriate specialists with expertise in CHC assessment (which may be the same people).

5.18 Agencies should agree local protocols for care co-ordination. Criteria identifying who should be a co-ordinator can include:

- Individual choice.
- The person mainly responsible for assessment and care planning.
- A professional person who is best known to the service user.
The Care Co-ordinator during a hospital admission will often be the named or lead nurse on the ward but this does not have to be the case. The role can be undertaken by the professional with the largest contribution to the discharge process. This could also therefore be a Discharge Liaison Nurse, Physiotherapist, Occupational Therapist or other allied health professional.

5.19 The person and their carers must be fully involved in the assessment process. They should be provided with all the necessary information they need to participate effectively. At this stage it is particularly important that patients are aware of their right to be considered for CHC and also of the right to have the decision making process reviewed. Written and verbal information provided at this stage should make this clear. Information should also make it clear that the assessment of eligibility for CHC is subject to reassessment, that people may move in and out of eligibility, depending on their changing health care needs, and that this can impact on how care is funded. The involvement of the patient/carer/family does not mean that they can veto a decision.

5.20 If the outcome of the enquiry/contact assessment is that a referral for a full consideration for CHC is necessary, the result and the reasons should be communicated clearly to the individual, and their carers or representatives where appropriate, verbally and in writing, as soon as reasonably practicable. Once an individual has been referred for a full consideration for CHC an individual, or individuals (in most cases a health professional) should be identified by the LHB to co-ordinate the process. This role will involve taking responsibility for the whole process until the decision about funding has been made and a care plan has been written. The CHC assessment should be completed within 6 weeks of the referral.

5.21 Establishing whether an individual’s primary need is a health need requires a clear, reasoned decision based on evidence of needs from a comprehensive assessment. The CHC assessment should be conducted only by staff that have the required skills for assessing need and for determining eligibility. LHBs must ensure that all appropriate staff including primary health care staff have received relevant training to manage and understand the CHC assessment process.

5.22 The evidence concerning eligibility and the decision making process should be accurately and fully recorded and supported by the Decision Support Tool. [See Annex 6]

5.23 The multi disciplinary team (MDT) carrying out an assessment for CHC should always consider whether all available interventions that may impact on health needs have been implemented and whether there is further potential for rehabilitation and regaining independence and how the outcome of any treatments or medication may affect ongoing needs.

5.24 Assessments in acute settings can sometimes poorly represent an individual’s capacity to maximise their potential. Similarly, assessments conducted in poor quality care environments may also artificially inflate health care needs. To help avoid this and to ensure 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.
The Decision Support Tool (DST)

5.25 From the date that this 2010 Framework takes effect, people being considered for eligibility for CHC will be assessed using this document and the Decision Support Tool (DST) at Annex 6. Routine reviews should also be carried out against this Framework and using this Tool.

5.26 To minimise variation in interpretation of these principles and to inform consistent decision-making, the person co-ordinating the assessment process and eligibility consideration must liaise with the multi-disciplinary team members themselves to complete the DST.

5.27 The DST is not an assessment in itself. It should be used following a comprehensive multidisciplinary assessment of an individual’s health and social care needs and their desired outcomes. If a multidisciplinary assessment has recently already been completed, this may be used; but care should be taken to ensure that it provides an accurate reflection of current need.

5.28 The MDT assessment that informs the completion of the DST should be undertaken with the full knowledge and consent of the individual, and they should be given every opportunity to participate in the assessment. The individual should be given the option of being supported or represented by a carer or advocate if they so wish (see Chapter 6).

5.29 The assessment process should draw on those who have direct knowledge of the individual and their needs. It should also make use of specialist assessments and, where necessary, referral to other specialists to inform the whole assessment should be made.

5.30 The DST is designed to ensure that the full range of factors which have a bearing on an individual’s eligibility are taken into account in making decisions. The tool includes the domains in unified assessment but has been amended to reflect CHC. The tool provides practitioners with a framework to bring together and record the various needs in eleven ‘care domains’, or generic areas of need. The domains are sub-divided into statements of need representing low, moderate, high, severe or priority levels of need, depending on the domain.

5.31 The result of completing the DST should be an overall picture of the individual’s needs, which captures their nature, and their complexity, intensity and/or unpredictability and thus the quality and/or quantity (including continuity) of care required to meet the individual’s needs.

5.32 There may be circumstances, on a case-by-case basis, where an individual may have particular needs which are not easily categorised by the care domains described in the DST. In this situation, it is the responsibility of the NHS assessors to determine and record the extent and type of this need (and record it in the 12th Domain), and take that need into account when deciding whether a person has a primary health need.
5.33 As described in the DST, the multidisciplinary team should use this tool to set out the evidence to allow them to consider not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments.

5.34 Although the DST supports the process of determining eligibility, and ensures consistent and comprehensive consideration of an individual’s needs, it cannot directly determine eligibility.

5.35 Indicative guidelines as to a threshold are set out in the tool (for example, if one area of need is at priority level, then this demonstrates a primary health need) but these are not to be viewed prescriptively. Professional judgement should be exercised in all cases to ensure that the individual’s overall level of need is correctly determined.

5.36 Every decision on whether an individual is eligible for CHC or not and the basis of the decision must be recorded and signed:

   a) In the person’s clinical records.
   b) In the person’s Personal Care Plan.
   c) In the formal record of the MDT meeting.

The documentation should be organised to ensure the decision can be easily identified.

5.37 If the outcome of the assessment process is that a referral for a full consideration for CHC is unnecessary, this decision together with the reasons for it, should be communicated clearly to the individual, and their carers or representatives where appropriate, and recorded in the individual’s notes. They may still request a full assessment from the LHB, and the LHB should give this request due consideration, taking into account all the information available including additional information from the individual or carer. Care planning for those individuals with ongoing needs, including the consideration of need for registered nursing care, will still be necessary.

5.38 If following a full assessment someone is not eligible for CHC but has some health care needs, a jointly arranged and funded package of care provided by both the NHS and social services will be appropriate. The delivery of shared care packages is essential to the management of the continuum of care, and appropriate assessment will identify those people with complex care needs who require services provided on a shared basis by both the NHS and local authorities to meet those needs. In addition to social services departments, other local government departments may need to be involved such as education, housing, leisure and community support facilities.

**Decision Making**

5.39 All LHBs will have processes in place to ensure that decisions on eligibility are fair, rational, consistent and comply with the requirements of this Framework. The St Helen’s judgement (see Chapter 3 and Annex 3) clarified that the NHS is the
primary decision maker on questions of eligibility for CHC. The LHB will therefore need to have a further stage beyond the multi-disciplinary assessment at which the LHB will finally determine eligibility.

5.40 Some LHBs have a panel to confirm the conclusions of the MDT to ensure, at least, the consistency and quality of decision-making. Only in exceptional circumstances and for clearly articulated reasons should the LHB not accept the multidisciplinary team's recommendations. A decision not to accept the recommendation should not be made by one person acting unilaterally.

5.41 LHBs may request the MDT to carry out further work for example, if the DST is incomplete or if there is significant inconsistency between the evidence in the assessment, the DST and the recommendation made. However, LHBs should not refer a case back or decide not to accept a recommendation simply because the MDT has made a recommendation that differs from one that the those who are involved in the final decision making would have made, based on the same evidence.

5.42 Furthermore, LHBs should not make decisions in the absence of the recommendations on eligibility from the MDT, except where it is necessary for an urgent decision to be made. Because the final decision on eligibility should be independent of budgetary constraints, finance officers should not be part of the decision making panel.

5.43 LHBs may wish to improve practice and ensure a consistent application of the Framework by reviewing the pattern of recommendations of the MDTs. However, this should be carried out separately from the approval of recommendations in individual cases.

**Timescales**

5.44 An individual may require services from the NHS and/or local authority. Both the NHS and local authority therefore have responsibilities to ensure that assessment of eligibility for and provision of, CHC takes place in a timely and consistent fashion. The consideration for CHC must always be made first.

5.45 The time taken for assessments and agreeing a care package may vary but should be completed in six to eight weeks from initial trigger to agreeing a care package. In some cases much speedier decisions should be taken in the person's best interests: for example in terminal illness (the End of Life Care Pathway\(^{14}\) should expedite this process).

5.46 In exceptional circumstances time scales may be more protracted taking into account the number of services prescribing care, resources and the position of the patient i.e. an acute ward, community setting. The care co-ordinator should ensure that time scales, decisions and rationales relating to eligibility are transparent from the outset for individuals, carers, family and staff.

\(^{14}\) End of Life Care- All Wales Care Pathway for the last days of life WHC (2006)030.
5.47 There should be no delay in a full consideration of eligibility and the communication of CHC decisions to the individual and their carers or representative where appropriate. Any exceptions should be monitored locally and actioned as appropriate. When there are valid and unavoidable reasons for the process taking longer, time scales must be clearly communicated to the individual/relatives and their carers in writing and a record made of this.

5.48 The timescale for the provision of care following assessment can vary between the remainder of an individual’s life and episodes of care; people may move in and out of eligibility for CHC. Patients, their families and carers, and other care purchasers and providers, must be made fully aware of the financial and practical implications of this as part of the information provided to support the assessment process.

**Fast Track Assessments**

5.49 Occasionally, individuals with a rapidly deteriorating condition who may be entering a terminal phase will require ‘fast tracking’ for immediate provision of CHC so that they can be supported in their preferred place of care as quickly as possible without waiting for the full CHC eligibility process to be completed.

5.50 LHBs should therefore consider and put in place a fast track process that reduces the amount of information required, the time taken to gather information and reduce timescales for making a decision for those individuals who require ‘fast tracking’. However, streamlined processes should still provide enough information to support the need for fast tracking and for the decision makers to agree a package of care.

5.51 Fast track assessment should be completed by an appropriate clinician who should give the reasons why the individual meets the conditions requiring a fast track decision to be made. ‘Appropriate clinicians’ are those who are, pursuant to the National Health Service (Wales) Act 2006, responsible for an individual’s diagnosis, treatment or care who are registered nurses or medical practitioners. The clinician should have an appropriate level of knowledge and experience of the type of health needs to decide on whether the individual has a rapidly deteriorating condition that may be entering a terminal phase.

5.52 Although an NHS professional must co-ordinate the fast track assessment, appropriate clinicians contributing to that assessment can include professionals employed in the voluntary and independent sector organisations that have a specialist role in end of life care e.g. hospice nurses, providing they are offering services pursuant to the National Health Service (Wales) Act 2006. Others involved in supporting those with end of life needs, including wider voluntary and independent sector organisations may identify the fact that the individual has needs for which the fast track process should be considered. In these cases, they should contact the NHS co-ordinator.

5.53 The completed fast track assessment should be supported by a prognosis. However, strict time limits that base eligibility on some specified expected length of
life remaining should not be imposed. It is the responsibility of the assessor to make a decision based on the relevant facts of the case.

5.54 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. Disputes about the fast track process should be resolved outside of the care delivery.

5.55 No individual who has been identified through the fast track process should have their care package removed without their eligibility being reviewed in accordance with the review process set out in Chapter 8. The review should include completion of the DST by the MDT, including a recommendation on future eligibility. This overall process should be carefully and sensitively explained to the individual and, where appropriate, their representatives. Sensitive decision making is essential in order to avoid the undue distress that may result from an individual moving in and out of CHC eligibility within a very short period of time.

5.56 CHC fast track assessments, care planning and commissioning for those with end of life needs should be carried out in an integrated manner in line with the individual’s overall end of life care pathway, with full account being taken of the individual’s preferences.
Figure 1: illustrates the process of determining eligibility for Continuing NHS Healthcare.

ELIGIBILITY CONSIDERATION FLOWCHART

Discharge planning, review or other trigger

Other NHS Funded Services

Could NHS services enable improvements that could alter the outcome of eligibility

Screen for possible eligibility for CHC

Possible Eligibility

DST—Full consideration for CHC

Establish Primary Health Needs

Care Planning

No Eligibility

Care Planning: Consider need for joint NHS/LA package including need for registered nurse

NHS Funded Nursing Care:

Written rationale for decision—communicate to individual and representative

NHS CHC Funded Care Package

Joint Care Package

Review

Review

Other care Packages: NHS and LA Contributions
Chapter 6: Consent and Capacity

6.1 As with any examination or treatment, the individual’s informed consent should be obtained and documented before the process of determining eligibility for CHC begins and before any decisions are made.

6.2 Many patients likely to be offered a CHC Assessment have significant health care needs. Their ability to participate in the consenting process can often be impaired by their mental capacity or physical ill-health that affects their ability to communicate their decision.

6.3 If there is a concern that the individual may not have capacity to give their consent or to participate effectively in the decision–making process, this should be determined in accordance with the Mental Capacity Act 2005 and the associated Code of Practice The five key principles of the Mental Capacity Act 2005 (section 1) to be considered are:

- **A presumption of capacity**: every adult has the right to make his or her own decisions and must be presumed to have capacity to do so, unless it is proved otherwise.
- **Individuals being supported to make their own decisions**: a person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- **Unwise decisions**: just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- **Best interests**: an act done or decision made under the Act for or on behalf of a person who lacks capacity must be in their best interests.
- **Least restrictive option**: anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

6.4 Because an individual may have significant difficulty in expressing their views it does not in itself mean that they lack capacity. Appropriate support and adjustments should be made available in compliance with the Mental Capacity Act 2005 and with disability discrimination legislation

6.5 If an individual lacks the mental capacity either to consent or refuse an assessment, a ‘best interests’ decision should be taken as to whether or not to proceed with the assessment for eligibility for CHC. This decision must be recorded. Those making this decision should bear in mind the expectation that everyone who is potentially eligible for CHC should have the opportunity to be considered for eligibility. A third party cannot give or refuse consent for an assessment of eligibility for CHC on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (LPA- Welfare) or they have been appointed a Welfare Deputy by the Court of Protection.
6.6 Where a ‘best interests’ decision needs to be made, the LHB must consult with any relevant third party who has a genuine interest in the person’s welfare. This will normally include family and advocates.

**Valid Voluntary Consent**

6.7 To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the patient either to accept or refuse the assessment. Such pressure can come from partners or family members as well as health or social care professionals. Professionals should be alert to this possibility and, where appropriate, should arrange to see the patient on their own to establish that the decision is truly that of the patient. Where there are concerns about undue influence these should be documented on the consent form.

6.8 For consent to be valid, the patient must:

- Have capacity to agree to the assessment
- Have received sufficient information to take an informed decision to proceed with the assessment
- Give consent voluntarily and not under any form of duress or undue influence from professionals or family members and in practice, be able to communicate their decision.

When a patient has capacity, then only the patient can give consent – no-one else can give it on their behalf.

6.9 When a patient gives valid consent to the assessment that consent remains valid during the current assessment process unless it is withdrawn by the patient. If a further assessment is to be carried out in the future, consent will need to be obtained on that occasion.

6.10 Consent has to be obtained before a health or social care professional starts a CHC assessment. All staff involved in screening must therefore be trained in the consent process. The clinician/professional providing the assessment is responsible for ensuring that the patient has given valid consent before the assessment begins.

6.11 The CHC assessment has a number of component processes involving a team of professionals, at least a nurse, doctor and social worker. A multidisciplinary approach is required whereby each professional involved should seek consent to either conduct the screening assessment or undertake their specialist assessment.

**Refusal to Consent to the CHC Assessment (see fig:2)**

6.12 An adult with capacity is entitled to refuse an assessment. If after providing relevant information and discussing all the options and consequences, a patient refuses an assessment, this fact should be documented on the consent form and patient notes. LHB’s should take into account the Guidance ‘Patient Consent to Examination and Treatment’15. Although focussed on examination and treatment issues, the principles of the guidance should be taken into account when consenting to an assessment.

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6.13 If the patient has already signed a Consent Form, but then changes their mind, this should be noted on the form and preferably signed by the patient. Professionals should ensure that the patient realises that they are free to change their mind and accept the assessment at a later stage.

6.14 If an individual does not consent to an assessment of eligibility for continuing NHS healthcare, or changes their mind following an assessment, the individual and/or their family must be informed of the potential effect this will have on the ability of the NHS or local authority to provide appropriate services.

6.15 The key consequence of refusing an NHS CHC Assessment is that the NHS cannot become responsible for arranging and funding the patient’s entire care package and therefore providing care services that are free to the patient. The patient’s long term care requirements may be met by the NHS and local authority sharing responsibility and, as a result, the patient may be charged for a contribution to the local authority arranged services. They must be advised of this and this advice recorded.

6.16 Consenting to the CHC assessment process is not a pre-commitment to accepting any subsequent offer of CHC funding. This offer will be made by the LHB to the patient following an assessment and if they are found to be eligible. At this point the patient can decline to accept the offer. In these circumstances the LHB cannot become solely responsible for arranging and funding the patient’s future care because the patient has not agreed to it.

6.17 When a person has the capacity to make a health care decision and has decided to refuse an assessment or care package, it is good practice to provide the information in writing afterwards, for their reconsideration. Follow-up should be arranged with the relevant specialist, so that the person has the opportunity to have a change of mind. The general practitioner should be told that an assessment or care package was offered and refused.

6.18 A clear, precise and legible record is therefore very important. The final opinion and its rationale should be recorded in the notes. It is important to record also the nature of any mental disorder or, where there is none, what steps were taken to exclude disorder. In the case of patients lacking capacity, it is important to record whether treatment of their mental disability might restore their capacity to make the decision and how long this might be expected to take.

6.19 Where there are concerns that an individual may have significant ongoing needs, and that the level of appropriate support could be affected by their decision not to give consent, the appropriate way forward must be considered jointly by the LHB and the local authority, taking into account each organisation’s statutory legal powers and duties. Where necessary, each organisation should seek legal advice.

6.20 Although refusal of consent only occurs in a minority of cases, LHB’s and local authorities should consider developing jointly agreed protocols on the processes to be followed. These should provide clarity regarding approaches such as the use of existing assessments and other information to determine each organisation’s responsibilities and the appropriate way forward.
Advocacy

6.21 The Independent Mental Capacity Advocate (IMCA) is a statutory service, whose purpose is to help vulnerable individuals who lack capacity and who are facing important decisions made by the NHS and local authorities. This may include serious medical treatment or change of residence, for example, moving into a care home. LHB’s and local authorities have a duty under the MCA to instruct and consult an IMCA if those concerned are people who lack capacity in relation to the decision being made and who have no family or friends available (or appropriate) for consultation on their behalf.

6.22 Where an individual does not meet the criteria for the support of an IMCA, and regardless of whether or not they lack capacity, they may still wish to be supported by an advocate. LHBs and local authorities should ensure that individuals are made aware of local advocacy services that may be able to offer advice and support. (LHBs 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 LHBs and local authorities) to act as an advocate on their behalf.

Carers

6.23 Where informal carers are being asked, or are offering, to provide support, LHBs and local authorities should bear in mind that a carer who provides a substantial care on a regular basis has a right to have their needs as a carer assessed. LHBs and local authorities must inform carers 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. It should never be assumed that the carer is able or willing to continue to assume the role. Which legislative basis is used will depend on individual circumstances and what is in the best interests of the service user and carer. For further information on assessment refer to Carers UK briefing on Policy Guidance and Practitioners Guide on the Carers and Disabled Children Act 200016.

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Refusing Consent for CHC Assessment
(Narrative in Chapter 6)

*This process can be followed where an assessment has been undertaken and the individual then changes their mind or refuses a CHC Care Package*
Chapter 7: Care Planning and Care Provision

Care Provision

7.1 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 As with all 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. LHB’s should ensure that there is clarity on the respective responsibilities of the LHB and providers for CHC.

Where a Person is eligible for CHC

7.3 A range of services may be required to support individuals (whether or not they are eligible for CHC) including, reablement, rehabilitation, palliative care, respite care etc. 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 multi-disciplinary team, then a care plan should be written which shows how the individual’s needs will best be met.

7.4 When it has been determined that a person is eligible for CHC, it is the responsibility of the health service 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. As indicated earlier in this 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.
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.

There should be one eligibility decision only – whether or not a person is eligible for CHC. Once it has been decided that a person is eligible, the services they receive, and where they receive them, should be considered at the care planning stage. Different eligibility criteria should not be applied to different services provided to a patient who is eligible for CHC.

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.

Where a person is not eligible for CHC

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.

Care Planning and Care Management

UACM provides guidance on the arrangements for ongoing monitoring and management of care for adults. In particular it:

- Emphasises the importance of monitoring and review of both needs and effectiveness of services, in order to confirm, amend or close personal plans of care.
- Indicates the necessity to review continued eligibility for CHC as their needs change.
7.11 Care planning should involve the person, their family, their carers and professionals in discussions about how the assessed needs can best be met and agreed goals achieved. This will require dialogue between professionals who have responsibilities for assessment and care planning and know the persons, and those who provide services, as well as between professionals and patients and their carers as appropriate.

7.12 Care planning is about meeting needs appropriately, taking into account the identified needs and the services or other support potentially available to meet those needs. The comprehensive assessment will provide a full picture of the needs to be met. Care planning is necessarily influenced by the type, range and availability of services locally and agreed policies for providing these. Those involved in care planning should ensure that plans are realistic and that recommended services can be provided. This has implications for staff training and the availability of information to both staff and people needing services. Where it is clear that additional types or amounts of services are required that cannot currently be provided, this information should be used to inform future service planning.

7.13 All relevant information must be recorded on Personal Plans of Care, as described in the UACM. Information on needs and how they are to be met will also be contained in any care plans produced within care home or hospital settings.

7.14 Clarity of responsibility for funding and implementation should inform, rather than prevent, any joint arrangements that may be established e.g. lead commissioning, pooled budgets.

7.15 While there is currently no legal obligation on the NHS to offer choice of treatment or health care, it improves the individual’s experience, dignity and respect and increases the opportunity to make shared and sustainable decisions. Research studies indicate that patients and their carers want to share in decisions about the treatment and care that is appropriate to them and that this results in improved outcomes.

7.16 Every effort should be made therefore to enable the person to participate in decisions about how and where their care needs are to be met. Where there are limitations to the person’s capacity to be involved, or their ability to consent to the nature and location of their treatment and/or care arrangements should be made to ensure that their interests are protected and represented, including considering the need for advocacy (See Chapter 6).

7.17 The risks and benefits to the individual of a change of location or support (including funding) should be considered carefully by the MDT before any move or change is confirmed.

7.18 The MDT must ensure that decisions on where, how and by whom care will be provided are based on assurance that the right level and type of service, and by the right provider (i.e. NHS/local authority/registered providers) is available in the agreed setting. The provision of care is thus dependent on the effective planning and contracting of appropriate services, both on an individual level, a joint level and on
broader planning strategies. Any care package plans must consider funding streams and arrangements for such services as:

- Accommodation.
- Medical input- in/out of hours.
- Nursing input- in/out of hours.
- Therapy services.
- Pharmacy services.
- Equipment.
- Diagnostics/Investigations.
- Transport.
- Social Care.
- Domestic Care.
- Respite Care.

**Joint Packages of Health and Social Care**

7.19 If an individual is **not** entitled to CHC but has some healthcare needs, they should receive a package of health and social care. There will be some individuals who, although they are not entitled to CHC, have needs identified through the DST that are not of a nature that a local authority can solely meet or are beyond the powers of a local authority to solely meet. LHBs should therefore work in partnership with the local authority to agree their respective responsibilities in joint care packages.

7.20 Apart from NHS Funded Nursing Care, additional services may also be funded by the NHS if these are agreed as part of an assessment and individual care plan. The range of services that the NHS can be expected to arrange and fund includes (but is not limited to):

- Primary healthcare.
- Assessments involving doctors and registered nurses.
- Rehabilitation and recovery (where this forms part of an overall package of NHS care as distinct from intermediate care).
- Community health services.
- Specialist support for healthcare needs.
- Additional support for episodic higher needs in joint care packages e.g. additional registered nurse input into behaviour management assessment/care planning.
- Palliative care and end of life care.
- Specialist transport (i.e. ambulances).
7.21 While any health services are provided free of charge, the person may be expected to contribute towards the cost of care services provided by the local authority.

7.22 Social Security and other welfare benefits (e.g. Independent Living Fund) available to support the person’s living costs may be affected by eligibility for CHC. The impact of benefit changes on care arrangements must be discussed with the service user.

7.23 According to each local authority’s ‘Fair Access to Care’ eligibility criteria, they will be responsible for providing such social care, including personal care, as can lawfully be provided.
Chapter 8: Reviews

8.1 An individual’s eligibility for CHC is subject to review. Reviews should follow the format of an assessment, consider all the services received and be tailored to the individual.

8.2 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 Review timescales should be identified and communicated to the individual and their relatives verbally and in writing.

8.4 The individual should be central to the review process. Prior to the review, they should be offered the opportunity to re-assess their own needs and be offered appropriate support to do so. It will also be necessary to consider whether a further carer’s assessment should be undertaken at this time.

8.5 If the local authority is also 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.

8.6 Care providers who monitor their own service effectiveness should contribute this information to the review of the whole plan of care. The review should be recorded, 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.

8.7 The LHB’s responsibility to provide or commission care (including CHC) is not indefinite as needs might change. 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.

8.8 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. The outcome of a review does not necessarily indicate the same outcome should have been reached with a previous assessment, provided that the previous assessment was properly carried out and the decision taken was based on sound reasoning.

8.9 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.

8.10 If the person/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.

8.11 The CHC Independent Review Panel (see Chapter 12) is not designated to review the content of care plans, only the decision-making process relating to the application of the primary health need approach.

8.12 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.

8.13 Providers must be made aware, within the contract documentation, of their responsibilities to notify the funding body of any marked deterioration or any other issues affecting the delivery of care.

8.14 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.

8.15 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) should be invoked and current funding arrangements should remain in place until the dispute has been resolved.
Chapter 9: Links to Other Policies

Links to Mental Health Act 1983 After Care Services

9.1 Under section 117 of the Mental Health Act 1983 (the 1983 Act) health and social services authorities have a duty to provide after-care services for individuals who have been detained under certain provisions of the 1983 Act, until they are satisfied that the person is no longer in need of such services.

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

9.3 There are no powers to charge for services provided under section 117 of the 1983 Act, regardless of whether those services are provided by the NHS or local authorities. Accordingly, the question of whether services should be “free” NHS services rather than potentially charged-for social services does not arise. It is not appropriate to assess eligibility for CHC if all the services in question are to be provided as after-care under section 117.

9.4 However, a person in receipt of after-care services under section 117 may also have needs for continuing care which are not related to their mental disorder and which may therefore fall outside the scope of section 117. An obvious example would be: a person who was already receiving continuing care in relation to physical health problems before being detained under the 1983 Act and whose physical health problems remain on discharge. Where such needs exist, it may be necessary to carry out a CHC assessment.

Deprivation of Liberty Safeguards

9.5 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 CHC.

The Transition from Child to Adult Services

9.6 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.

9.7 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.
9.8 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 LHB’s 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.

9.9 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.

9.10 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.

9.11 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.

9.12 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.

9.13 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.
Joint working for adults with a Learning Disability

9.14 The Statement on Policy and Practice for adults with a learning disability announced in March 2007, sets out the Welsh Assembly’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.

9.15 The Welsh Assembly Government believes that 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.

9.16 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.

Challenging Behaviours

9.17 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.

9.18 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.

Entitlement to other NHS Funded Care

9.19 Those in receipt of CHC continue to be entitled to access to the full range of primary, community, secondary and other health care services regardless of care setting.

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17 Emerson E (1995) 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.
9.20 LHBs should ensure that their contracting arrangements with care homes that provide nursing care clarify the responsibilities of nurses within the care home and of community nursing services respectively. There should be no gap in service provision between these two sectors.

**Community Equipment**

9.21 Where individuals are in receipt of CHC and they require equipment to meet their care needs, there are a number of routes by which this may be provided:

- If the individual is, or will be, supported in a care home setting, the care home may be expected to provide certain equipment as part of regulatory standards or as part of the contract with the LHB.
- Individuals who are in receipt of CHC have an entitlement to joint equipment services. LHBs should ensure that the availability to those in receipt of CHC is taken into account in planning, commissioning and funding arrangements for these services.
- Some individuals will require bespoke equipment (or other non bespoke equipment that is not available through the routes above) to meet specific assessed needs identified in their CHC assessment and care plan. LHBs should make appropriate arrangements to meet these needs.

LHBs should ensure that there is clarity about which of the above arrangements is applicable in each individual case.
Chapter 10: Joint Training

10.1 Based on the principles of the UACM the Welsh Assembly Government will develop 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).

10.2 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.

10.3 UACM 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:

- Philosophy and purpose of assessment.
- Policies in relation to long term care.
- The CHC Framework.
- Health and social care boundaries and their respective responsibilities in meeting long term needs.
- The range of patients involved.
- Person Centred Assessment.
- Capacity and consent.
- The role and responsibilities of the MDT.
- Development of competencies using appropriate assessment tools.
- Procedures and responsibilities for assessment, care planning and decision-making.
- Effective recording of assessments and decisions.
- Achieving validity, reliability, transparency and equity.
- Implications and outcomes for patients’ holistic care management.
- Working in multi disciplinary teams.
- The protection of vulnerable adults.
- Understanding the role of advocacy.

10.4 This training programme will be multi-disciplinary/agency in its approach and health and social care organisations will be expected to release relevant staff to participate.

10.5 LHBs will need to review their current assessment, training, quality assurance and discharge processes to ensure they comply with this Framework.
Chapter 11: Dispute Resolution

Dispute Challenges to Eligibility Decisions between Organisations

11.1 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.

11.2 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.

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

11.4 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. Decisions about care should not be delayed unnecessarily whilst disputes are being resolved and should not delay the provision of the care package. All stages of disputes procedures will normally be completed within two weeks. All stages will be appropriately documented.

11.5 The following 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:

11.6 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.

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.

Dispute Challenges to Eligibility Decisions from Individuals

11.7 The formal responsibility for informing individuals of the decision about eligibility for CHC and of their right to request a review lies with the LHB. Whether or not it is considered that an individual has a primary health need, the LHB must give clear reasons for its decisions, setting out the basis on which the decision was made.

11.8 Where a full assessment has been undertaken of potential eligibility and a decision has been reached, an individual may apply to the relevant LHB for an independent review of the decision if they are dissatisfied with:

- The procedure followed by the LHB in reaching its decisions around the individuals eligibility for CHC.
- The application of the primary health need consideration.

11.9 Individuals may ask the LHB to reconsider its decision and LHB’s should give this request due consideration, taking into account all the information available, including any additional information from the individual and/or carer.

11.10 LHBs should deal promptly with any request to review decisions about eligibility for either CHC or NHS Funded Nursing Care. A clear and written response should be given including the individual’s rights to complain under the NHS Complaints Procedure (See Chapter 12).

11.11 Each LHB should agree local review processes, including timescales, which is available publicly. These local review processes should set out the stages involved in dealing with any requests for a review.

11.12 Once local procedures have been exhausted, the case should be referred to the Independent Review Panel. (See Annex 5).
11.13 If the original decision is upheld and the individual still wishes to challenge the decision, the individual has access to the Public Services Ombudsman.

11.14 The individual’s rights under the existing NHS Complaints procedures and their existing right to refer their case to the Ombudsman remains unaltered by the panel arrangements. In particular, where an individual is dissatisfied with issues other than the points outlined in 11.6 above the matter should be considered through the appropriate complaints procedure.
Chapter 12: Independent Review Panel and Complaints

Independent Review Panel

12.1 The independent review panel procedure (see Annex 4) is intended as 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 The Independent Review Panel is not designated to review the content of care plans, only the decision-making process relating to the determination of whether a person is eligible for continuing NHS healthcare.

12.3 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).

12.4 When reviewing the need for NHSFNC, potential eligibility for CHC should always be considered and a full assessment carried out where necessary.

12.5 LHBs must ensure that arrangements are in place for:

- The establishment and operation of independent panels (see further guidance in Annexes 4 and 5).
- 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.

12.6 NHS organisations should deal promptly with any request to reconsider decisions about eligibility for CHC. They 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.

12.7 A number of LHBs may wish to co-operate in the establishment and operation of the review panel process. Each LHB will, however, ensure that it has allocated responsibility for overview of the proper and efficient operation of the process in their area to a designated officer.
12.8  See Annex 4 for an example of a checklist of issues to be considered before referring a case to review panel.

Complaints

12.9  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.

12.10 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. Any agency receiving a complaint needs to consider whether a referral should be made in line with procedures for the protection of vulnerable adults.

12.11 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.

12.12 Information on all relevant complaints procedures should be available in all service provision settings. The need for advocacy should be considered where appropriate.

12.13 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 will normally do so if there is evidence of hardship or injustice and that an investigation may be of benefit.

Chapter 13: Governance

13.1 LHBs have a role in establishing and maintaining governance arrangements for CHC eligibility considerations and purchasing and securing care, as they do in other policy areas of health care.

13.2 LHB’s are responsible for:

- Ensuring consistency in the application of the national Framework on eligibility for continuing NHS healthcare.
- Promoting awareness of continuing NHS healthcare.
- Implementing and maintaining good practice, ensuring quality standards are met and sustained.
- Providing training and development opportunities for practitioners.
- Identifying and acting on issues arising in the provision of CHC.
- Informing commissioning arrangements, both on a strategic and individual basis.
- Ensuring best practice in assessment and record keeping.
- Provision of strategic leadership and organisational and workforce development, and ensuring local systems operate effectively and deliver improved performance.

13.3 LHB’s may therefore find it helpful to have in place a database to record:

- Individuals in receipt of continuing NHS healthcare.
- Number of assessments undertaken.
- Timing of assessments.
- Outcome of assessments undertaken.
- The costs of continuing NHS healthcare packages.

13.4 It is important that any such system should clearly identify those receiving continuing NHS healthcare as a distinct group from those being supported via joint packages or any other funding routes. This will help LHBs to monitor care more efficiently and to ensure that the data are accurate and consistent.

13.5 LHB’s who contract with other organisations and, in particular the independent sector, are responsible for ensuring that the quality and range of services are sufficient to meet the individual’s assessed needs.

13.6 Arrangements must be in place to ensure regular reviews are undertaken.

13.7 Performance indicators for CHC may be introduced for NHS organisations at some point in the future.
Annex 1: Glossary of Terms

Assessment

The process whereby the needs of an individual are identified and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned. Assessment involves both professionals and those with the needs thinking through different explanations for how needs have arisen, and how different needs interact with each other. Further information on assessment is contained in the guidance ‘Creating a Unified and Fair System for Assessing and Managing Care’ (NAW 2002).

Care Co-ordinator

An identified NHS clinical professional or social care professional that takes the lead in ensuring that an individual’s package of care is properly managed and monitored. In addition the care co-ordinator ensures that the individual is kept informed of the process and involved in discussions about their care.

Care Home

An establishment registered under the Care Standards Act 2000 to provide accommodation, together with nursing or personal care, for certain categories of persons.

Care Management

A process whereby an individual's needs are identified and evaluated, eligibility for services is determined, Personal Plans of Care are drafted and implemented, and needs are monitored and re-assessed. ("Case management" is an alternative term.)

Care Package

A combination of support and services designed to meet individual’s assessed needs.

Care Plan

A document recording the reason why support and services are being provided, what they are, who provides them and what outcomes they seek.

Care Planning

A process based on an assessment of an individual's needs that involves working with the individual to identify the level and type of support to meet those needs, and the potential outcomes that can be achieved.
Carers

Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is usually unpaid. Carer – For the purposes of the Carers and Disabled Children Act 2000 the term "carer" includes people (age 16 and over) who may or may not be a relative and who may or may not be living with the person for whom they are caring. The 2000 Act excludes from the definition of a carer, paid care workers and volunteers from a voluntary organisation. Children and young people affected by caring situations should be considered and assessed as children in need under the Children Act 1989.

For the purposes of this Framework Carers means someone over the age of 16 who may or may not be a relative and who provides a substantial amount of care to an individual and who may or may not be living with the person they are caring for. This excludes paid care workers and volunteers.

Care Worker

Care workers provide paid support to help people manage the day-to-day activities of living. Support may be of a practical, social care nature or to meet a person’s healthcare needs.

Challenging Behaviour

Challenging behaviour is defined as "culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities.

Cognition

The higher mental processes of the brain and the mind including memory, thinking, judgement, calculation, visual spatial skills etc.

Cognitive impairment

Cognitive impairment applies to disturbances of any of the higher mental processes, many of which can be measured by suitable psychological tests. Cognitive impairment, especially memory impairment, is the hallmark and often the earliest feature of dementia.
Commissioning

The means to secure the best care and the best value for the population. It is the process of specifying and procuring services for individuals and the local population, and involves translating their aspirations and needs into services that:

Comprehensive Assessment

This refers to assessments in which most or all of the domains of the unified assessment process have been triggered and explored through the use of specialist /in-depth assessments. (See 'Creating a Unified and Fair System for Assessing and Managing Care' (NAW 2002)). All people entering care homes or likely to be eligible for continuing NHS health care services should have received a comprehensive assessment. This will include a medical assessment.

Contact Assessment

This refers to a first assessment involving the older person and professional, and establishing the nature of the presented problem and whether or not there are potential wider health and social care needs. Basic personal information will also be collected, or verified if previously collected, at contact assessment.

Continuing NHS Healthcare

A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need. Continuing NHS healthcare can be provided in any setting. In a person’s own home, it means that the NHS funds all the care that is required to meet their assessed health and social care needs to the extent that this is considered appropriate as part of the health service. This does not include the cost of accommodation, food or general household support. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the person’s accommodation as well as their care.

Domain/sub-domains

These refer to the content of the unified assessment.

End of Life Care

Care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes the management of pain and other symptoms, and the provision of psychological, social, spiritual and practical support.

General Household Support

Such services as cleaning, laundry, meal preparation, shopping, cooking, collecting benefits, sitting with or accompanying on social outings.
Intermediate Care

The term ‘intermediate care’ has been defined as a “range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living”. (NSF for Older People, DOH, June 2002). This type of service is usually provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation. Its aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care.

LHB

Local Health Board.

Long Term Care

This is a general term that describes the care which people need over an extended period of time, as the result of disability, accident or illness to address both physical and mental health needs. It may require services from the NHS and/or social care, and can be provided in a range of settings, such as a NHS hospital, a care home (providing either residential or nursing care), hospice, and in people's own homes. Long term care should be distinct from intermediate care (which has specific time limited outcomes for rehabilitation, reablement or recuperation) and transitional/interim care (where the care setting is temporary and different from where people are expected to receive any long term care they need).

Long-term Conditions

Those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies.

Mental Capacity

The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is explained in Section 2 of the Mental Capacity Act 2005: ‘A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain’.

Mental Disorder

Mental disorder is defined in section 1(2) of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) as meaning ‘any disorder of disability of the mind’.

Multi-disciplinary
Multi-disciplinary refers to professionals across health and social care and the third sector who work together to address the holistic needs of their patients/clients in order to improve delivery of care and reduce fragmentation.

**Multi-disciplinary assessment**

Multi-disciplinary assessment is an assessment of an individual’s needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.

**Multi-disciplinary team**

A team usually from both health and social care backgrounds. It does not refer only to an existing multidisciplinary team such as on an acute ward. It should include those who have an up-to-date knowledge of the individual’s needs, potential and inspirations.

**Near Future**

Refers to needs that are reasonably considered by the multidisciplinary team to be likely to arise before the next planned review of the individual.

**NHS**

National Health Service.

**NHS Funded Nursing Care**

The provision of NHS Funded Nursing Care derives from Section 49 of the Health and Social Care Act, 2001, which excludes nursing care by a registered nurse from the services which can be provided by local authorities. Section 49 was partially implemented with effect from December 2001, introducing NHS Funded Nursing Care for self-funders and those residents who paid the majority of their care costs themselves. The full implementation of Section 49 extends the scope of NHS Funded Nursing Care to cover all those persons currently assessed as requiring care by a registered nurse in care homes who were formerly the responsibility of local authorities.

**Overview assessment**

This refers to situations where all or most of the domains of the unified assessment process are explored. Overview assessment may be able to fully identify and describe needs; if not, it should indicate or trigger where specialist assessment is required.

**Palliative Care**

The active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social, spiritual and practical support. The goal of palliative care is the achievement of the best quality of life for patients and their families.
Personal Information

The term "personal information" should be taken to include, where appropriate, "sensitive personal information" (e.g. health information). Those terms have the same meaning as "personal data" and "sensitive personal data" in the Data Protection Act.

Reablement

The term 'reablement' refers to the active process of regaining skills, confidence and independence. This may be required following an acute medical episode or to reverse or halt a gradual decline in functioning in the community. It is intended to be a short-term intensive input.

Registered Nurse

A nurse registered with the Nursing and Midwifery Council. Within the UK all nurses, midwives and specialist community public health nurses must be registered with the Nursing and Midwifery Council and renew their registration every three years to be able to practise.

Rehabilitation

A programme of therapy and reablement designed to maximise independence and minimise the effects of disability.

Social Care

Social Care is care provided to support an individual’s social needs. It refers to the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships. Social care services are provided for people who need help/assistance to live their lives as independently as possible in the community (either at home or in a care setting), people who are vulnerable and people who may need protection. Local authorities, the voluntary sector and the independent sector can provide social care.

Social Services

Primary responsibility for the delivery of community social care services rests with local authorities. Social Services are provided by 22 local authorities in Wales. Individually and in partnership with other agencies, they provide a wide range of care and support for people who are deemed to be in need.

Social Work

Social work is a professional activity/service provided by a Registered Social Worker. It is an activity that can enable individuals, families and groups to identify personal, social and environmental difficulties adversely affecting them. It is a range of activities that can provide supportive, rehabilitative protective or corrective action. This can include care management, social care assessment and planning and counselling.
Specialist/in depth Assessment

This refers to further exploration of assessment domains that have been triggered by contact or overview assessment. Specialist assessment will usually be carried out by clinicians or other qualified professionals who specialises in a branch of medicine or care, for example, stroke, cardiac etc and may require the use of scales. It will result in detailed knowledge and insights about particular needs.
Annex 2: Relevant Guidance and Documents

Pre 2002

- WHC (95) 52 Arrangements between Health Authorities and NHS Trusts and Private and Voluntary Sector Organisations for the Provision of Community Care Services.
- Flexibilities for Joint Working between Health and Local Government (National Assembly for Wales, 2000).
- 'In Safe Hands’ (Social Services Inspectorate for Wales 2000).
- Improving Health in Wales: a Plan for the NHS with its Partners (National Assembly for Wales, 2001).
- Adult Mental Health Services for Wales, ‘Equity, Empowerment, Effectiveness and Efficiency’ (National Assembly for Wales, 2001).
- Adult Mental Health Services for Wales, ‘Equity, Empowerment, Effectiveness and Efficiency’ (National Assembly for Wales, 2001).

2002

- Creating a Unified and Fair System for Assessing and Managing Care. (National Assembly for Wales, 2002).
- Intermediate Care Guidance (National Assembly for Wales, 2002).
- Building Strong Bridges: Strengthening partnership working between the Voluntary Sector and the NHS in Wales (National Assembly for Wales, 2002).
- Community care: six weeks support at home for vulnerable people - guidance circular on the scheme and grant available for 2001-02 and 2002-03 (NAFW Circular 05/02).
- Fairer Charging Policies for Home Care and other non-residential Social Services (National Assembly for Wales July 2002).


Promoting Partnership in Care – Commissioning across Health and Social Services (National Assembly for Wales, 2003).

Promoting Partnership in Care – Commissioning across Health and Social Services (National Assembly for Wales, 2003).

Promoting Partnership in Care – Commissioning across Health and Social Services (National Assembly for Wales, 2003).

The Strategy for Older People in Wales (National Assembly for Wales, 2003).

A Strategic Direction for Palliative Care Services in Wales (National Assembly for Wales, 2003).

Health, Social Care & Well-being strategies – Preparing a Strategy (National Assembly for Wales 2003).


NHS Planning and Commissioning Guidance (National Assembly for Wales, 2003).

NHS Funding for Long Term Care (Health Services Ombudsman February 2003).


NHS Funded Nursing Care in Care Homes - Guidance 2004 (National Assembly for Wales, 2004).


NAFWC 28/2004 Revised National Minimum Standards for Care Homes for Older People.
• NAFWC 24/2006 Commencement of Regulations and National Minimum Standards for Domiciliary Care Agencies in Wales (18.03.2004).
• Learning Disability Strategy Section 7 Guidance on Service Principles and Responses Aug 2004.

2005

• NAFWC 17/2005 Hospital Discharge Planning Guidance.
• NAFWC 12/2005 Expenditure grant to increase capacity to care for people at home and in the community (“Capacity Grant”) (Choice of Accommodation) Directions 1993.
• WHC(2005)035 Hospital Discharge Planning Guidance.
• NAFWC 09/2005 Strategy for Older People in Wales.

2006

• End of Life care – All Wales Care Pathway for the Last Days of Life (WHC (2006) 030.
• NAFWC 35/06 Stronger Partnerships for Better Outcomes.
• NAFWC 13/2006 National Service Framework (NSF) for Older People in Wales.
• National Health Service Act 2006.

2007

• ‘Fulfilled lives, Supportive communities’: A Strategy for Social Services in Wales Over the Next Decade (2007).
• One Wales: A Progressive Agenda for the Government of Wales.
• NAFWC 18/2007 National Assistance (Assessment of Resources and Sums for Personal Requirements (Amendment) (Wales) Regulations 2007.
• NAFWC 11/2007 Fairer Charging Policies for Home Care and other non-residential Social Services- Revised Guidance for Local Authorities.
• NAFWC 06/2007 Capital Grant for the Integration and Modernisation of Equipment Services in Wales.
• Statement on Policy and Practice for Adults with a Learning Disability.
2008

- Passing the Baton - A practical guide to effective discharge planning-National Leadership and Innovation Agency for Healthcare (NLIAH).
- WAGC 08/2008 Promoting Independence and Well being Grant Scheme 2008- 2011.

2009

- Charging for Residential Accommodation Guidance (CRAG), Amendment 25.
- Guidelines for Developing and Integrating Community Services in Wales 2009.
- Escalating Concerns With and Closures of Care Homes Providing Services for Adults Guidance 2009.
Annex 3 Legal Judgements

The Coughlan judgment

(R v. North and East Devon Health Authority ex parte Pamela Coughlan)

A3.1 Pamela Coughlan was seriously injured in a road traffic accident in 1971. Until 1993 she received NHS care in Newcourt Hospital. When the Exeter Health Authority wished to close that hospital and to move Miss Coughlan and other individuals to a new NHS facility at Mardon House the individuals were promised that Mardon House would be their home for life. In October 1998, the successor Health Authority (North and East Devon Health Authority) decided to withdraw services from Mardon House, to close that facility, and to transfer the care of Miss Coughlan and other disabled individuals to social services. Miss Coughlan and the other residents did not wish to move out of Mardon House and argued that the decision to close it was a breach of the promise that it would be their home for life and was therefore unlawful.

A3.2 The arguments on the closure of Mardon House raised other legal points about the respective responsibilities of the Health Service and of Social Services for nursing care. The Court of Appeal’s judgement on this aspect has heavily influenced the development of continuing care policies and the National Framework. The key points in this regard are as follows:-

1. The NHS does not have sole responsibility for all nursing care. Local authorities can provide nursing services under section 21 of the National Assistance Act as long as the nursing care services are capable of being properly classified as part of the social services’ responsibilities.

2. No precise legal line can be drawn between those nursing services which are and those which are not capable of being provided by a local authority: the distinction between those services which can and cannot be provided by a local individual case.

3. As a very general indication as to the limit of local authority provision, if the nursing services are:-

   i. Merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide pursuant to section 21.

   ii. Of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide.

they can be provided under section 21 of the National Assistance Act 1948.

4. By virtue of section 21(8) of the National Assistance Act a local authority is also excluded from providing services where the NHS has in fact decided to provide those services.
5. The services that can appropriately be treated as responsibilities of a local authority under section 21 may evolve with the changing standards of society.

6. Where a person’s primary need is a health need, the responsibility is that of the NHS, even when the individual has been placed in a home by a local authority.

7. An assessment of whether a person has a primary health need should involve consideration not only the nature and quality of the services required but also the quantity or continuity of such services.

8. The Secretary of State’s duty under section 3 of (what is now) the National Health Service Act 2006 is limited to providing the services identified to the extent that he or she considers necessary to meet all reasonable requirements: in exercising his or her judgement the Secretary of State is entitled to take into account the resources available to him or her and the demands on those resources. (NB the Welsh Ministers have similar duties under the National Health Service (Wales) Act 2006).

9. In respect of Ms Coughlan, her needs were clearly of a scale beyond the scope of local authority services.

The Grogan Judgment

(R v. Bexley NHS Care Trust ex parte Grogan)

A3.3 Maureen Grogan had multiple sclerosis, dependent oedema with the risk of ulcers breaking out, was doubly incontinent, a wheelchair user requiring two people for transfer, and had some cognitive impairment. After the death of her husband her health deteriorated, she had a number of falls and, following an admission to hospital with a dislocated shoulder, it was decided that she was unable to live independently and she was transferred directly to a care home providing nursing care. Subsequent assessments indicated that Mrs Grogan’s condition was such that she did not qualify for fully funded Continuing NHS Healthcare.

A3.4 She was initially determined to be in the medium band of NHS-funded nursing care, and remained in this band with the exception of one determination which placed her in the high band from April to October 2004. Mrs Grogan argued that the decision to deny her full NHS funding was unlawful, since the eligibility criteria put in place by South East London SHA were contrary to the judgment in the Coughlan case. She also submitted that the level of nursing needs identified in the RNCC medium and high bandings (in which she had been placed) indicated a primary need for health care which should be met by the NHS.

A3.5 The Court concluded that in assessing whether Mrs Grogan was entitled to Continuing NHS Healthcare, the Care Trust did not have in place or apply criteria which properly identified the test or approach to be followed in deciding whether her primary need was a health need. The Trust’s decision that Mrs Grogan did not qualify for Continuing NHS Healthcare was set aside and the question of her entitlement to Continuing NHS Healthcare was remitted to the Trust for further consideration. There was no finding, or other indication, that Mrs Grogan in fact met the criteria for Continuing NHS Healthcare.
The St Helens Judgement

(St Helens Borough Council v Manchester Primary Care Trust - Court of Appeal – August 2008)

A3.6 This case concerned a dispute between a PCT and a local authority as to the funding of a care package needed by a service user (PE) suffering from Dissociative Identity Disorder (DID).

A3.7 The Multi Disciplinary Team concluded that PE’s care needs were not primarily health needs and they recommended that the costs of her care should be shared between St Helens Borough Council (“St Helens”) and Manchester Primary Care Trust (“the PCT”). A review by the PCT assessment panel, confirmed that PE’s needs were not primarily for health care and that, except for physiotherapy and other specific health care matters, the PCT should not fund her care.

A3.8 Challenge in the High Court

St Helens challenged this decision by way of judicial review on a number of grounds:

1. That the recommendation of the MDT was flawed.
2. That the panel’s approach to the criteria was flawed.
3. That the panel’s approach to sharing funding responsibility was based on a misapplication of its own criteria.
4. That the conclusion that PE’s needs were not the responsibility of the PCT was “irrational.”

A3.9 The High Court rejected the claim at the permission stage and upheld the PCT’s decision.

Appeal to the Court of Appeal

A3.10 St Helens were allowed to appeal to the Court of Appeal on one ground only: St Helens argued that this was a case where there were conflicting decisions of two public authorities each exercising statutory powers and that the Court should decide for itself whether PE’s care needs were the responsibility of St Helens or the PCT.

A3.11 The Court of Appeal dismissed the appeal on the grounds that the NHS (in this case the PCT) is the primary decision maker when it comes to deciding whether a person has primary health care needs. The National Health Service Act 2006 is the dominant Act and the decision under it is the determinative decision.

A3.12 In giving judgment, Lord Justice May stated:

“It is of course correct that the Secretary of State’s decision, through the PCT, will determine (subject to challenge on public law grounds) whether the care needs are to be provided by the PCT or the social services authority.”

(para 35).
A3.13  Lord Justice May also referred to the duty under section 3 (1) (e) of the 2006 Act which requires the Secretary of State to provide to the extent that he considers necessary to meet all reasonable requirements, in addition to hospital accommodation and other services which are obviously health care,

“such other 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 as he considers are appropriate as part of the health service”.

A3.14  He noted that this gives the Secretary of State “a degree of judgment as to what he considers necessary, reasonable and appropriate”.

Example of a checklist of issues to be considered before referring a case to a review panel

Assessment of need

- Has there been an appropriate assessment of the patient’s needs irrespective of location?
- Has this included appropriate specialists with knowledge of continuing NHS healthcare assessment?
- Has the need for a second clinical opinion been considered?
- Has the primary health need approach and decision support tool been considered by the multi disciplinary team?
- Has proper account been taken of the patient’s clinical prognosis – is the patient likely to die in the very near future so that discharge from NHS care may be inappropriate?
- Were the patient’s needs for a period of rehabilitation or recovery properly considered, bearing in mind that older people may need longer to reach their full potential for recovery?
- Does the multi-disciplinary team agree that the patient does not have a primary health need and is not eligible for continuing NHS healthcare?
- Has the multi-disciplinary team reviewed its decision?

Information for the patient and carer

- Has the patient/relative, and carer been made fully aware of the process adopted to reach the decision on eligibility for continuing NHS healthcare.
- Has the patient/relative and carer received the following:
  - Clear written information about how hospital discharge procedures will operate, and what will happen if ongoing care is needed.
  - The necessary information, where appropriate in writing, to enable them to take any decisions about their future care.
  - Written details of the likely cost of any option which they have been asked to consider by Social Services (including where possible and appropriate the availability of Social Security benefits and financial assistance from Social Services.
  - A written care plan including a clear statement of which aspects of care will be arranged and funded by the NHS and which by Social Services.
Participation

- Have the views of the patient and carer been taken into consideration as part of the assessment process?
- Has the possibility that the patient might need an advocate been considered?
Annex 5: Setting up a Review panel

Establishment of review panels

A.5.1 Local Health Boards must have access to a standing panel, comprising as a minimum an independent chair, representative of a Local Health Board and a local authority. It will also have access to expert opinion. Local Health Boards may choose to join together to establish a panel extending over a number of Local Health Boards.

A.5.2 The chair should be selected following an open recruitment process. The person chosen must have a clear understanding of the panel's purpose and be able to communicate this to the patient, their family and any carers concerned.

A.5.3 The appointment of representatives of the Local Health Board(s) and local authority (ies) will be on the basis of nomination by those organisations. They should take account of the professional and other skills, which will be relevant to the work of the panel.

A.5.4 Each Local Health Board should designate an individual to maintain the review procedure and collect information for the panel by interviewing patients, family members and any relevant carer.

A.5.5 Each Local Health Board should aim to ensure that the review procedure is completed within two weeks of the request being received, where possible. This period starts once any action to resolve the case informally has been completed, and should be extended only where unavoidable because of exceptional circumstances.

A.5.6 Each LHB must ensure that arrangements are in place to support the work of the panel through the provision of relevant information and clinical advice.

The purpose and scope of review panels

A.5.7 The purpose of the review procedure is:

- To check that proper procedures have been followed in reaching decisions about the need for continuing NHS healthcare and NHS Funded Nursing Care.
- To ensure that the primary health need approach in determining eligibility for continuing NHS healthcare and NHS Funded Nursing Care are properly and consistently applied.

A.5.8 The review procedure does not apply where patients or their families and any carer wish to challenge:

- The content, rather than the application, of the Local Health Board’s eligibility criterion.
- The type and location of any offer of NHS funded continuing NHS healthcare or NHS Funded Nursing Care services.
The content of any alternative care package which they have been offered.
Their treatment or any other aspect of the services they are receiving or have received.

These would more properly be dealt with through the complaints procedure (see Chapter 12 for details).

A.5.9 A review should not proceed until the LHB has, in the first instance, worked with the individual to resolve the situation informally. They should ensure that appropriate assessments have been undertaken, care plans produced, that the proper procedures and criteria have been applied, and that the patient has been provided with all relevant information.

A.5.10 If the case cannot be resolved by informal means, the patient, his or her family or any carer may ask the LHB where the patient is normally resident to review the decision that the patient is not eligible for continuing NHS healthcare. The expectation is that the LHB in reaching a view will seek advice from an independent panel (See paragraph 7). Before doing so it should ensure, having regard to paragraphs 5.7-5.8 above, that the decision is one to which the review procedure applies.

A.5.11 The LHB has the right to decide in any individual case not to convene a panel. It is expected that such decisions will be confined to those cases where the patient falls well outside the eligibility criteria or where the case is very clearly not appropriate for the panel to consider. Before taking a decision the Local Health Board should seek the advice of the chairman of the review panel. In all cases where a decision not to convene a panel is made, the Local Health Board should give the patient, his or her family or carer a full written explanation of the basis of its decision, together with a reminder of their rights under the NHS complaints procedure.

A.5.12 While the review procedure is being conducted any existing care package, whether hospital care or community health services, should not be withdrawn until the outcome of the review is known.

Operation of the panel

A.5.13 The designated Local Health Board is responsible for preparing information for the panel. The panel should have access to any existing documentation, which is relevant, including the details of the patient’s original assessment. They should also have access to the views of key parties involved in the case including the patient, his or her family and any carer, health and social services staff, and any other relevant bodies or individuals. It will be open to key parties to put their views to the Local Health Board officer. This will normally be managed by the production of written statements prepared by the Local Health Board’s designated responsible officer.

A.5.14 A patient may have a representative act on their behalf if they choose, or are unable or have difficulty in presenting their own views.
A.5.15 While the patient or their representative will normally provide information to the designated Local Health Board officer, they may request direct representation at the panel hearing. This does not include a lawyer acting in a professional capacity.

A.5.16 The panel must maintain patient confidentiality.

A.5.17 The panel will require access to independent clinical advice, which should take account of the range of medical, nursing and therapy needs involved in each case.

A.5.18 The role of the panel is advisory. However, while its decisions will not be formally binding, the expectation is that its recommendations will be accepted. If a Local Health Board decides to reject a panel’s recommendation in an individual case, it must put in writing to the patient and to the chairman of the panel its reasons for doing so.

A.5.19 In all cases the Local Health Board must communicate in writing to the patient the outcome of the review, with reasons. All relevant parties (NHS, consultant, GP and other clinician(s), local authority where appropriate) should also receive this information.

A.5.20 The patient’s rights under the existing complaints procedures and their existing right to refer the case to the Public Services Ombudsman Wales, remain unaltered by the panel arrangements.
Annex 6- Decision Support Tool

Key Principles and User Notes.

1. The purpose of the Decision Support Tool (DST) is to support the application of the Welsh Assembly Government National Framework for Continuing NHS Healthcare and inform consistent decision making in line with the primary health need approach. An individual will be eligible for continuing NHS healthcare where it can be said that their ‘primary need is a health need’. Using the DST correctly should ensure that all needs and circumstances that might affect an individual’s eligibility are taken into account in making this decision.

2. The DST should be used following a comprehensive multidisciplinary assessment of an individual’s health and social care needs and their desired outcomes. Where a multidisciplinary assessment has been recently completed (within the last 3 months), this may be used, but care should be taken to ensure that this remains an accurate reflection of current need. The tool is not an assessment in itself. Rather it is a way of bringing together and applying evidence in a single practical format to facilitate consistent evidence-based decision making on CHC eligibility.

3. The multidisciplinary assessment of needs should be in a format that also can be used to assist LHBs and local authorities to meet care needs regardless of the outcome of the assessment for CHC. The assessment of needs process should be carried out in accordance with other relevant existing guidance, including the Unified Assessment Care Management Process (UACM), the Common Assessment Framework and the Care Programme Approach. It should include referral for specialist assessments and also make use of such assessments wherever it is appropriate to the individual’s care needs.

4. 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 a full opportunity to participate in the assessment (see Chapters 5 and 6). The individual should be given the opportunity to be supported or represented by a carer or advocate if they so wish. The assessment process should draw on those who have direct knowledge of the individual and their needs.

5. The DST asks multidisciplinary teams (MDTs) to set out the individual’s needs in relation to 11 care domains. Each domain is broken down into a number of levels, each of which is carefully described. For each domain MDTs are asked to identify which level description most closely matches the individual’s needs. MDTs are then asked to make a recommendation as to whether the individual should be entitled to continuing NHS health care. This should take into account the range and levels of need recorded in the DST and what this tells them about whether the individual has a primary health need. This should include consideration of the nature, intensity, complexity or unpredictability of the individual’s needs. Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual’s needs.
6. It is very important that the guidance notes are read in full and that those completing DSTs have an understanding of the Framework for continuing NHS healthcare.

7. Completion of the tool should be carried out in a manner that is compatible with wider legislation and national policies where appropriate, including the End of Life Care, long-term conditions and the Mental Capacity Act 2005.

8. Although the tool supports the process of determining eligibility, and ensures consistent and comprehensive consideration of an individual’s needs, it cannot directly determine eligibility. Professional judgement will be necessary in all cases to ensure that the individual’s overall level of need is correctly determined and the appropriate decision made.

**Process**

9. Once an individual has been referred for a full assessment for continuing NHS healthcare (by use of the UACM or, if this is not used in an individual case, by direct referral for a full assessment for continuing NHS healthcare) then, irrespective of the individual’s setting, the LHB has responsibility for coordinating the whole process until the decision about funding has been made and a care plan has been agreed. The LHB should identify an individual, or individuals, to carry out this coordination role. The coordinator may be an LHB member of staff or may be an NHS professional from an external organisation by mutual agreement, e.g. by an NHS professional who is not directly working in the LHB area.

10. The coordinator should identify the appropriate individuals to comprise the multidisciplinary team (MDT) and liaise with them to undertake the assessment and complete the DST. This involves matching, as far as possible, the extent and type of the individual’s specific needs with the descriptions in the DST that most closely relate to them. This approach should build up a detailed analysis of needs and provide the evidence to inform the decision regarding eligibility.

11. As with any examination or treatment, the individual’s consent should be obtained before the process of completing the DST commences (See Chapter 6). The individual should be made aware that the DST is to be completed, have the process explained to them, and be supported to play a full role in contributing their views on their needs. It should be made explicit to the individual whether their consent is being sought to a specific aspect of the assessment for continuing NHS healthcare (i.e. completion of the DST) or to the full process. It should also be noted that individuals can withdraw their consent at any time in the process.

12. The individual should be invited to be present or represented wherever possible. The individual and their representatives should be given sufficient notice of completion of the DST to enable them to arrange for a family member or other advocate to be present. Where the individual would find it practically difficult to make such arrangements (such as when they are in hospital or their health needs make it difficult for them to contact relevant representatives), the LHB should offer to make the arrangements for them, in accordance with their wishes.
13. Even where specific circumstances mean that, in a limited range of situations, it is not practicable for the individual to be present or represented, the views of the individual and/or their representative should be obtained and actively considered in the completion of the DST. Those completing the DST are asked to note within it whether the individual was present and/or represented and, if not, the reasons for this.

14. Even where an individual has not elected for a family member to advocate for them, the views and knowledge of family members may be taken into account, where consent has been given to seek these views.

15. Completion of the DST should be organised so that the person understands the process, and receives advice and information to enable them to participate in informed decisions about their future care. Decisions and rationales should be transparent from the outset.

16. If there is a concern that the individual may not have capacity to give their consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice.

17. Robust data-sharing protocols, both within an organisation and between organisations, will help to ensure that confidentiality is respected but that all necessary information is available to complete the DST.

18. A copy of the completed DST should be made available to the individual together with an explanation as to the process and the MDT’s responsibilities in determining eligibility. Although LHBs will have additional processes in place to quality assure the processes and assessment, these panels cannot determine eligibility. Only in exceptional circumstances and for clearly articulated reasons should the LHB not accept the multidisciplinary team’s recommendations. A decision not to accept the recommendation should not be made by one person acting unilaterally.

19. The DST provides practitioners with a needs-led approach by portraying need based on 11 ‘care domains’ with an open domain (domain 12) for needs that do not readily fit into the other 11. The tool is in three sections:

   **Section 1** – Personal Information.

   **Section 2** – Care Domains.

   **Section 3** – Recommendations.

All sections need to be filled in. The care domains should also all be completed, but in the order most appropriate to the individual’s needs. It is best practice to complete the DST on a single date but if this is not practicable each section should state the date of completion.
20. Each domain is subdivided into statements of need representing no needs ('N' in the table below); low (L), moderate (M), high (H), severe (S) or priority (P) levels of need, depending on the domain.

21. The descriptions in the DST are examples of the types of need that may be observed. The MDT should first determine and record the extent and type of need in the space provided. The descriptions may not always exactly describe the individual's needs so if there is difficulty in placing their needs in one or other of the levels, the MDT should use professional judgement based on consideration of all the evidence to decide the most appropriate level. If, after considering all the relevant evidence, it proves difficult to decide or agree on the level, the MDT should choose the higher of the levels under consideration and record the evidence in relation to both the decision and any significant differences of opinion. Please do not identify an individual as being between levels. It is important that differences of opinion on the appropriate level are based on the evidence available and not on presuppositions about a person's need or generalised assumptions about the effects of a particular condition.

22. It is important that the wording of domain levels is carefully considered and assumptions are not made. The fact that an individual has a condition that is described as 'severe' does not necessarily mean that they should be placed on the 'severe' level of the relevant domain. It is the domain level whose description most closely fits their needs that should be selected (for example, the fact that a person is described as having 'severe' learning disabilities does not automatically mean that they should be placed on the 'severe' level of the Cognition domain).

23. Assessors need to consider how different but interrelated needs across more than one domain can complicate the individual's overall care needs. Examples of different needs that should be considered separately in different domains but which may interact across domains are those in the skin and continence domains.

24. A fast-track process should always be considered for any individual with a rapidly deteriorating condition that may be entering a terminal phase. For other individuals who have a more slowly deteriorating condition and for whom it can reasonably be anticipated that their needs are therefore likely to increase in the near future, the domain levels selected should be based on current needs but the likely change in needs should be recorded in the evidence box for that domain and taken into account in the recommendation made. This could mean that a decision is made that they should be eligible for continuing NHS healthcare immediately (i.e. before the deterioration has actually taken place) or, if not, that a date is given for an early review of their needs and possible eligibility. Professional judgement based on knowledge of the likely progression of the condition should determine which option is followed.

25. Where a particular effect of a condition could be reflected in more than one domain it can be recorded in both domains unless specified otherwise. The fact that it is the same need being acknowledged in two or more domains should be recorded both in the space given in that domain and in the recommendation at the end of the DST. Care should be taken in reaching conclusions on eligibility. The question is whether the needs are such that the primary need is a health need, not the number of domains that a single need can be recorded in.
26. The levels are relative to each other and to the other domains: some domains include needs that are so great that they could reach the ‘priority’ level, but others do not. This is because the needs in some care domains are considered never to reach a level at which they, on their own, should trigger eligibility; rather they would form part of a range of needs which, together, could define a primary health need.

27. Within each domain there is space to justify why a particular level is appropriate, based on the available evidence about the assessed needs. It is important that needs are described in measurable terms, using clinical expertise, and supported with the results from appropriate and validated assessment tools where relevant. We know that, around the country, particular types of needs are assessed using different tools: in order to avoid practitioners having to change from tools they know well, we do not prescribe the best assessments to use. However, regard should be given to other existing and emerging policies in each area, for example guidance from the National Institute for Clinical Excellence.

28. The CHC assessment should provide as full a picture of a person’s needs as possible. Needs should not be ignored because they are currently well managed. The domains in the DST explain how to consider interventions in assessing the level of need within each domain.

29. Where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain.

30. There may be circumstances, on a case-by-case basis, where an individual may have particular needs that are not covered by the 11 defined care domains within the DST. In this situation, it is the responsibility of the assessors to determine and record the extent and type of the needs in the “additional” twelfth domain entitled ‘Other Significant Care Needs’ and take this into account when deciding whether a person has a primary health need. The severity of the need should be weighted in a similar way (i.e. from ‘Low’ to ‘Severe’) to the other domains, using professional judgement and then taken into account when deciding whether a person has a primary health need. It is very important that the agreed level is compatible with the levels set out in the other domains. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility.

Establishing a Primary Health Need

31. At the end of the DST, there is a summary sheet to provide an overview of the levels chosen and a summary of the person’s needs, along with the MDT’s recommendation about eligibility or ineligibility. A clear recommendation of eligibility for continuing NHS healthcare would be expected in each of the following cases:

- A level of **priority** needs in any one of the three domains that carry this level.
- A total of two or more incidences of identified **severe** needs across all care domains.
If there is:

- One domain recorded as severe, together with needs in a number of other domains.
- A number of domains with high and/or moderate needs.

This may indicate a primary health need. In these cases, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments should be taken into account in deciding whether a recommendation of eligibility for continuing NHS healthcare should be made. It is not possible to equate a number of incidences of one level with a number of incidences of another level, as in, for example ‘two moderates equal one high’. The judgement as to whether someone has a primary health need must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of the individual’s needs.

32. If needs in all domains are recorded as ‘no need’, this would indicate ineligibility. Where all domains are recorded as ‘low need’, this would be unlikely to indicate eligibility. However, because low needs can add to the overall picture, influence the continuity of care necessary, and alter the impact that other needs have on the individual, all domains should be completed.

33. The coordinator should ensure that all parts of the DST have been completed, including the MDT’s recommendation on eligibility, and forward it to the LHB for decision making. The coordinator should also advise the individual of the timescales for decision making. In doing this, they should also check whether there is a need for urgent and/or interim support and liaise with the LHB and local authority to ensure that this is put in place where appropriate. The National Framework guidance gives further details on the actions to be taken.
### Decision Support Tool for Continuing NHS Healthcare

#### Section 1 – Personal Details

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Completion</td>
<td></td>
</tr>
<tr>
<td>Patient Name (print)</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Permanent Address</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td><strong>Current Residence</strong> (if not permanent address)</td>
<td></td>
</tr>
</tbody>
</table>

*Was the individual involved in the completion of the DST? Yes/No (Delete as appropriate)*

*Was the individual offered the opportunity to have a representative such as a family member or other advocate present when the DST was completed? Yes/No (Delete as appropriate)*

*If yes, did the representative attend the completion of the DST? Yes/No (Delete as appropriate)*

**Contact details of the representative (name, address and telephone number)**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Details:</th>
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<tr>
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</table>
Decision Support Tool for Continuing NHS Healthcare

Section 1 – Personal Details

Summary pen portrait of the individual’s situation, relevant history and current needs, including clinical summary and identified significant risks, drawn from the multidisciplinary assessment.

Summary of individual’s view of their care needs and whether they consider that the multidisciplinary assessment accurately reflects these:

Summary of carer’s view of care needs and support they need as carer and whether they consider that the multidisciplinary assessment accurately reflects these.
Decision Support Tool for Continuing NHS Healthcare

Section 1 – Personal Details

Note below whether and how the individual (or their representative) contributed to the assessment of their needs. If they were not involved, record whether they were not invited or whether they declined to participate.

List the assessments and other key evidence that were taken into account in completing the DST, including the dates of the assessments:
### Decision Support Tool for Continuing NHS Healthcare

#### Section 1 – Personal Details

MDT member’s name/address/contact details noting lead coordinator:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession/Designation</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Contact details of GP and other key professionals involved in the care of the individual:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession/Designation</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>


Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

1. **Behaviour:** Human behaviour is complex, hard to categorise, and may be difficult to manage. To avoid double weighting, if the individual presents with behavioural concerns that are primarily to do with their emotional or mental health, this should be reflected in domain 3 rather than domain 1.

Challenging behaviour in this domain includes but is not limited to:

- Aggression and violence.
- Self Injury or self harm.
- Destructiveness.
- Severe disinhibition.
- Resistance to necessary care and treatment (this may therefore include non-concordance and non compliance, but see note below.
- Inappropriate interactions with others which puts themselves or others at risk.

The assessment of needs of an individual with serious behavioural issues will usually have included a specialist assessment which includes an overall consideration of the risk(s) to themselves, others or property with specific attention to aggression and self-harm and any other behaviour(s).

1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed-specify what health interventions are *currently* in place to meet health needs and what *additional* interventions could be implemented to help achieve this outcome.
4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the behaviour is likely to be performed across a range of typical daily routines and the frequency, duration and impact of the behaviour. Include the frequency and intensity of need, unpredictability, deterioration and any instability.

5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?

6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

1. Behaviour

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>No evidence of ‘challenging’ behaviour.</td>
<td>No needs</td>
</tr>
<tr>
<td>Some incidents of ‘challenging’ behaviour. However the person is generally compliant with all aspects of care. A risk assessment indicates that the behaviour does not pose a risk to self or others or a barrier to intervention.</td>
<td>Low</td>
</tr>
<tr>
<td>‘Challenging’ behaviour that poses a predictable risk that can be managed through planned interventions. The risk assessment indicates a pattern of behaviour that can be anticipated and managed by skilled carers or care workers to maintain a level of behaviour that does not pose a risk to self or others. The person is nearly always compliant with care.</td>
<td>Moderate</td>
</tr>
<tr>
<td>‘Challenging’ behaviour that poses a predictable risk to self or others that may require timely responses to planned intervention by an appropriately trained practitioner. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.</td>
<td>High</td>
</tr>
<tr>
<td>‘Challenging’ behaviour of severity, intensity and/or frequency that poses a significant risk to self and/or others. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.</td>
<td>Severe</td>
</tr>
<tr>
<td>‘Challenging’ behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self and/or others. The risks are so serious that they require intervention from and access to an immediate specialist response at all times for safe care.</td>
<td>Priority</td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

Cognition: Individuals with a learning disability or degenerative disorder will inevitably have cognition difficulties. Therefore, although this domain applies to all individuals, for those individuals with a learning disability or degenerative disorder there must be a summary of their known cognitive functioning and evidence of a significant change in the individual’s cognitive functioning to support increased healthcare needs. Where changes in cognitive impairment are identified in the assessment of need, active consideration should be given to referral to an appropriate specialist if one is not already involved.

Please refer to the National Framework guidance about the need to apply the principles of the Mental Capacity Act in every case where there is a question about a person’s capacity. The principles of the Act should also be applied to all considerations of the individual's ability to make decisions and choices.

1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed- specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the behaviour is likely to be performed across a range of typical daily routines and the frequency, duration and impact of the behaviour. Include the frequency and intensity of need, unpredictability, deterioration and any instability.
5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?

6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
**Decision Support Tool for Continuing NHS Healthcare**

**Section 2 – Care Domains**

Refer to the user notes

2. **Cognition**

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>No evidence of impairment, confusion or disorientation.</td>
<td>No needs</td>
</tr>
<tr>
<td>Cognitive impairment (for example difficulties in retrieving short-term memory) which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident.</td>
<td>Low</td>
</tr>
<tr>
<td>OR Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.</td>
<td></td>
</tr>
<tr>
<td>Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Cognitive impairment that may include marked short-term/long term memory issues and maybe disorientation in time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make choices appropriate to need on a limited range of issues they are unable to do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.</td>
<td>High</td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

3. Mental Health (psychological and emotional needs): Use this domain to record the individual’s psychological and emotional needs and how they contribute to the overall care needs, noting the underlying causes. There should be evidence of whether or not an individual has already got a diagnosed psychiatric disorder, and whether there have been recent changes in psychological needs and their impact on the individual's health and well being. To avoid double weighting, difficulties in behaviour that are not clearly related to underlying mental health difficulties should be considered under Domain 1 and not this domain. Where the individual is unable to express their psychological/emotional needs (even with appropriate support) due to the nature of their overall needs, this should be recorded and a professional judgement made based on the overall evidence and knowledge of the individual.
1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed—specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the behaviour is likely to be performed across a range of typical daily routines and the frequency, duration and impact of the behaviour. Include the frequency and intensity of need, unpredictability, deterioration and any instability.

5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?

6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological and emotional needs are not having an impact on their health and well-being.</td>
<td>No needs</td>
</tr>
<tr>
<td>Psychological and emotional needs which are having an impact on their health and/or well-being but respond to prompts and reassurance.</td>
<td>Low</td>
</tr>
<tr>
<td>OR Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.</td>
<td></td>
</tr>
<tr>
<td>Psychological and emotional needs which do not readily respond to prompts and reassurance and have an increasing impact on the individual’s health and/or well-being.</td>
<td>Moderate</td>
</tr>
<tr>
<td>OR Withdrawn from social situations but with support can engage in care planning, support and/or daily activities.</td>
<td></td>
</tr>
<tr>
<td>Psychological and emotional needs that has a severe impact on the individual’s health and/or well-being.</td>
<td>High</td>
</tr>
<tr>
<td>OR Withdrawn from any attempts to engage them in care planning, support and/or daily activities putting them at significant risk of harm.</td>
<td></td>
</tr>
<tr>
<td>Significant changes in mental health which manifests in extremely challenging unstable, unpredictable and repetitive behaviour over 24 hours on a prolonged basis. Requires the continual intervention of specialist healthcare professionals over and above what can be provided by core NHS services. High risk of suicide.</td>
<td>Severe</td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

4. **Communication:** Some individuals will have long term communication difficulties which can be anticipated and managed through familiarity with the individual. This domain should clearly identify how the individual usually communicates and any changes in communication. If individuals have communication needs these should be reflected in the MDT assessment. This section relates to difficulties with expression and understanding, not with the interpretation of language.

1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed- specify what health interventions are *currently* in place to meet health needs and what *additional* interventions could be implemented to help achieve this outcome.
4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the communication and associated behaviour is likely to be performed across a range of typical daily routines and the frequency, duration and impact of the communication and associated behaviour. Include the frequency and intensity of need, unpredictability, deterioration and any instability.

5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?

6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
## Decision Support Tool for Continuing NHS Healthcare

### Section 2 – Care Domains

Refer to the user notes

### 4. Communication

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to communicate clearly, verbally or non-verbally. May require translation if English is not their first language to improve access to services.</td>
<td>No needs</td>
</tr>
<tr>
<td>Needs assistance to communicate their needs.</td>
<td>Low</td>
</tr>
<tr>
<td>Skill may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.</td>
<td></td>
</tr>
<tr>
<td>Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Carers or care workers are able to anticipate needs through non-verbal signs due to familiarity with the individual and planned care.</td>
<td></td>
</tr>
<tr>
<td>Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to do so have been taken.</td>
<td>High</td>
</tr>
<tr>
<td>The person has to have most of their needs anticipated because of their inability to communicate them.</td>
<td></td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

5. **Mobility**: This section considers individuals with impaired mobility. Please take other mobility issues such as wandering into account in the behaviour domain where relevant. Where mobility problems are indicated, an up-to-date Moving and Handling and Falls Risk Assessment should exist or have been undertaken as part of the current assessment process and the impact and likelihood of any risk factors considered.

1. Identify what has changed in this individual’s life that affects this domain for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual

3. Identify how this can be changed and what can be managed- specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, with reference to moving, handling and falls risks assessments. Describe the frequency and intensity of need, unpredictability, deterioration and any instability. Indicate the times and situations when the intervention is likely to be performed across a range of typical daily routines and the frequency and duration of the intervention.

5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term? Consider the environmental constraints/risks and the type of equipment required.
6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

5. Mobility

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independently mobile</td>
<td>No needs</td>
</tr>
<tr>
<td>Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.</td>
<td>Low</td>
</tr>
<tr>
<td>Able to mobilise but needs some assistance and/or requires mobility equipment for daily living.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Not able to consistently weight bear.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers.</td>
<td></td>
</tr>
<tr>
<td>Not able to mobilise independently.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Completely unable to mobilise but is able to assist or co-operate with transfers</td>
<td></td>
</tr>
<tr>
<td>Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning.</td>
<td>High</td>
</tr>
<tr>
<td><strong>OR</strong> Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Due to risk of physical harm or loss of muscle tone or pain on movement needs assistance to mobilise and is unable to co-operate.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> At a high risk of falls (as evidenced in a falls risk assessment).</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Involuntary spasms or contractures placing themselves and carers or care workers at risk.</td>
<td>Severe</td>
</tr>
<tr>
<td>Completely immobile and the clinical condition is such that on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.</td>
<td></td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

6. Nutrition – Food and Drink: Individuals at risk of malnutrition, dehydration and/or aspiration should either have an existing assessment of these needs or have had one carried out as part of the assessment process with any management and risk factors supported by a management plan. Such assessments must be evidence based and used in conjunction with clinical judgement.

1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed- specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the intervention is likely to be performed across a range of typical daily routines and the frequency and duration. Include the frequency and intensity of need, unpredictability, deterioration and any instability.

5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?
6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
### Decision Support Tool for Continuing NHS Healthcare

**Section 2 – Care Domains**

Refer to the user notes

**6. Nutrition – Food and Drink**

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to take adequate food and drink by mouth to meet all nutritional requirements.</td>
<td>No needs</td>
</tr>
<tr>
<td>Needs supervision, prompting with meals.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> May need assistance with feeding and/or a specific diet e.g. low fat, diabetic diet etc.</td>
<td>Low</td>
</tr>
<tr>
<td><strong>OR</strong> Able to take food and drink by mouth but requires additional/supplementary feeding to maintain appropriate nutritional status.</td>
<td></td>
</tr>
<tr>
<td>History of choking. Needs assistance with feeding/drinking to prevent risks and ensure adequate intake of food/fluids. Takes a long time (half an hour or more) to take meals, including liquidised feed. Nutritional status may be at risk</td>
<td>Moderate</td>
</tr>
<tr>
<td><strong>OR</strong> Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG, etc.</td>
<td></td>
</tr>
<tr>
<td>History of choking with recent occurrences. Evidence of Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway.</td>
<td>High</td>
</tr>
<tr>
<td><strong>OR</strong> Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers on a regular/sustained basis. There is a clinical need to monitor intake/output over a 24 hour period.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Nutritional status “at high risk” and may be associated with unintended, significant weight loss.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Significant weight loss or gain due to identified clinical condition / eating disorder which significantly compromises physical health e.g. pressure area development</td>
<td></td>
</tr>
</tbody>
</table>
OR Problems relating to a feeding device (for example unable to tolerate PEG.) that requires skilled intervention, assessment and review.

Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled professional intervention or monitoring over a 24 hour period due to complexities and to ensure nutrition/hydration, for example I.V. fluids, peritoneal feeding. There is a need for expert and skilled intervention (usually as an inpatient).

| Severe |
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

7. **Continence**: Where continence problems are identified, a full evidence based continence assessment exists or has been undertaken as part of the assessment process, any underlying conditions identified, and the impact and likelihood of any risk factors evaluated.

1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual continence needs of the individual.

3. Identify how this can be changed and what can be managed- specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when intervention is likely to be performed across a range of typical daily routines and the frequency, duration and impact of the condition. Include the frequency and intensity of need, unpredictability, deterioration and any instability.

5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?
6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
### 7. Continence

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continent of urine and faeces.</td>
<td>No needs</td>
</tr>
<tr>
<td>Continence care is managed through a non complex regime on a day-to-day basis; Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. AND is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence.</td>
<td>Low</td>
</tr>
<tr>
<td>Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation. Predictable intervention e.g. management of constipation, bladder washout, re catheterisation, stoma care etc can be managed by a Registered Nurse</td>
<td>Moderate</td>
</tr>
<tr>
<td>Continence care is problematic and requires timely, skilled and frequent intervention from qualified staff/ specialists (e.g. Stoma Nurses), beyond routine care.</td>
<td>High</td>
</tr>
<tr>
<td>Bowel management and skilled intervention is required on at least a daily basis to prevent life threatening/emergency situations.</td>
<td>Severe</td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

8. **Skin (including tissue viability):** Evidence of wounds should derive from an evidence based wound assessment or tissue viability assessment completed by an appropriate professional. Here, a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin. Wound management should be supported by a care plan identifying the wound with a regular evaluation of the treatment given, documented on a wound assessment chart. This chart should clearly state the wound dimensions and appearance. A rationale for the type of dressing should also be provided. This domain should consider the relationship with other domains including mobility and nutrition. Practitioners may wish to consider the European Pressure Ulcer Advisory Panel Classification of ulcers when assessing ulcer grading.

1. Identify what has changed in this individual’s life that affects this domain for example, do the changes reported reflect any changes in the support services received? Look at intrinsic and extrinsic factors that has led to the change eg pressure shear, friction, moisture or medical/neuropathy/medication etc.

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed- specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when intervention is likely to be performed across a range of typical daily routines and the frequency and duration of the intervention .Include the frequency and intensity of need, unpredictability, deterioration and any instability.
5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?

6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
## Section 2 – Care Domains

Refer to the user notes

### 8. Skin (including tissue viability)

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk of pressure damage or skin condition.</td>
<td>No needs</td>
</tr>
<tr>
<td>Risk of skin breakdown which requires preventative intervention <strong>once a day</strong> or less than daily without which skin integrity would break down.</td>
<td>Low</td>
</tr>
<tr>
<td><strong>OR</strong> Evidence of pressure damage and/or pressure ulcer(s) either with ‘discolouration of intact skin’ or a minor wound.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.</td>
<td></td>
</tr>
<tr>
<td>Risk of skin breakdown which requires preventative intervention <strong>several times</strong> each day, without which skin integrity would break down.</td>
<td>Moderate</td>
</tr>
<tr>
<td><strong>OR</strong> Pressure damage or open wound(s), pressure ulcer(s) with ‘partial thickness skin loss involving epidermis and/or dermis’, which is responding to treatment.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.</td>
<td></td>
</tr>
<tr>
<td>Pressure damage or open wound(s), pressure ulcer(s) with ‘partial thickness skin loss involving epidermis and/or dermis’, which <strong>is not</strong> responding to treatment requiring regular assessment and treatment by an appropriately skilled professional (e.g. tissue viability nurse).</td>
<td>High</td>
</tr>
<tr>
<td><strong>OR</strong> Pressure damage or open wound(s), pressure ulcer(s) with ‘full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule’, which is/are responding to treatment requiring regular assessment and treatment by an appropriately skilled professional.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Specialist dressing regime in place; responding to treatment.</td>
<td></td>
</tr>
<tr>
<td>Open wound(s), pressure ulcer(s) with ‘full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not</td>
<td>Severe</td>
</tr>
</tbody>
</table>
extending to underlying bone, tendon or joint capsule’ which is not responding to treatment and requires a minimum of daily monitoring/reassessment by an appropriately skilled professional i.e. Tissue Viability Nurse.

**OR** Open wound(s), pressure ulcer(s) with ‘full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule’ or above requiring a minimum of daily monitoring/reassessment by an appropriately skilled professional i.e. Tissue Viability Nurse.

**OR** Multiple wounds which are not responding to treatment.
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

9. **Breathing** – evidence of breathing difficulties should derive from a clinical assessment by the appropriate professional e.g. COPD/Respiratory nurse. Here a breathing condition is taken to mean any condition which affects respiration and the impact that that this may have on an individual’s ability to independently undertake activities of daily living. In determining the level of need, it is the knowledge and skill required to manage the clinical need that is the determining factor

1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed- specify what health interventions are *currently* in place to meet health needs and what *additional* interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when intervention is likely to be performed across a range of typical daily routines and the frequency and duration of the intervention. Include the frequency and intensity of need, unpredictability, deterioration and any instability.
5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?

6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
### Decision Support Tool for Continuing NHS Healthcare

**Section 2 – Care Domains**

Refer to the user notes

#### 9. Breathing

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal breathing, no issues with shortness of breath.</td>
<td>No needs</td>
</tr>
</tbody>
</table>
| Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities.  
**OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities. | Low |
| Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities.  
**OR** Episodes of breathlessness that do not respond to management and limit some daily living activities. | Moderate |
| **OR** Requires any of the following: low level oxygen therapy (24%).  
• room air purifiers, oxygen via a facial or nasal mask or other therapeutic appliances to maintain airflow.  
**OR** CPAP (Continuous Positive Airways Pressure)  
Is able to breathe independently through a tracheotomy that may require occasional suctioning that they can manage themselves, with the support of registered nurses or skilled carers or care workers  
**OR** Breathlessness due to a condition which is not responding to treatment and limits all daily living activities.  
OR Frequent conditions e.g. chest infections, pneumonia, etc that increases breathlessness and limits all activities of daily living | High |
| Difficulty in breathing, even through a tracheotomy, which requires regular suction by a qualified nurse to maintain airway.  
**OR** Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy. | Severe |
| Unable to breathe independently, requires invasive mechanical ventilation. | Priority |
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

10. Drug Therapies and Medication: Symptom Control: The individual’s experience of how their symptoms are managed and the intensity of those symptoms is an important factor in determining the level of need in this area. Where this affects other aspects of their life, please refer to the other domains, especially the psychological and emotional domain. The location of care will influence who gives the medication. In determining the level of need, it is the knowledge and skill required to manage the clinical need and the interaction of the medication in relation to the need that is the determining factor. In some situations, an individual or their carer will be managing their own medication and this can require a high level of skill. References below to medication being required to be administered by a registered nurse do not include where such administration is purely a registration or practice requirement of the care setting (such as a care home requiring all medication to be administered by a registered nurse).

1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed- specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when intervention is likely to be performed across a range of typical daily routines and the frequency and duration of the intervention. Include the frequency and intensity of need, unpredictability, deterioration and any instability.

5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?
6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
## Decision Support Tool for Continuing NHS Healthcare

### Section 2 – Care Domains

Refer to the user notes

10. **Drug Therapies and Medication: Symptom Control**

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.</td>
<td>No needs</td>
</tr>
<tr>
<td>Requires supervision/administration of and/or prompting with medication or may have a physical, mental state or cognitive impairment requiring support to take medication, but shows compliance with medication regime.</td>
<td>Low</td>
</tr>
<tr>
<td><strong>OR</strong> Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.</td>
<td></td>
</tr>
<tr>
<td>Requires the administration of medication due to: non-compliance, type of medication (for example insulin), or route of medication (for example PEG, intra muscular medication).</td>
<td>Moderate</td>
</tr>
<tr>
<td><strong>OR</strong> Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care. However, with monitoring the condition is usually non-problematic to manage.</td>
<td></td>
</tr>
<tr>
<td>Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Requires increased monitoring and intervention to ensure the condition is managed.</td>
<td>High</td>
</tr>
<tr>
<td><strong>OR</strong> Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> High risk of non-compliance with medication, placing them at risk of relapse.</td>
<td></td>
</tr>
</tbody>
</table>
Requires administration and monitoring of medication regime by a registered nurse specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is **usually problematic** to manage.

**OR** Severe recurrent or constant pain which is not responding to treatment.

**OR** Non compliance with medication with the need for registered nurses or skilled care staff to actively manage risks over a 24 hour period

<table>
<thead>
<tr>
<th></th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition.</strong></td>
<td>Priority</td>
</tr>
</tbody>
</table>

**OR** Unremitting and overwhelming pain despite all efforts to control pain effectively.
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

11. Altered States of Consciousness (ASC): ASCs can include a range of conditions that affect consciousness including Transient Ischemic Attacks (TIAs), temporal lobe epilepsy and Vasovagal Syncope. An altered state of consciousness can come about accidentally through, for example, fever, infections such as meningitis, sleep deprivation, fasting, oxygen deprivation, nitrogen narcosis (deep diving), psychosis, or a traumatic accident.

1. Identify what has changed in this individual’s life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual, outlining the ASCs.

3. Identify how this can be changed and what can be managed - specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when intervention is likely to be performed across a range of typical daily routines and the frequency and duration of the intervention. Include the frequency and intensity of need, unpredictability, deterioration and any instability.
5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?

6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
### Altered States of Consciousness (ASC)

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>No evidence of altered states of consciousness (ASC).</td>
<td>No needs</td>
</tr>
<tr>
<td>History of ASC but it is effectively managed and there is a low risk of harm.</td>
<td>Low</td>
</tr>
<tr>
<td>Occasional episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.</td>
<td>Moderate</td>
</tr>
<tr>
<td><strong>OR</strong> Occasional ASCs that require skilled intervention to reduce the risk of harm.</td>
<td></td>
</tr>
<tr>
<td>Frequent episodes of ASC that require the monitoring and intervention of a registered nurse to minimise the risk of harm. Generally responds to preventative treatment.</td>
<td>High</td>
</tr>
<tr>
<td>Coma.</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.</td>
<td>Severe</td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

12. Other significant care needs to be taken into consideration: There may be circumstances, on a case-by-case basis, where an individual may have particular needs which do not fall into the care domains described above. If the boxes within each domain that give space for explanatory notes are not sufficient to document all needs, it is the responsibility of the assessors to determine and record the extent and type of these needs here. The severity of this need and its impact on the individual need to be weighted, using the professional judgement of the assessors, in a similar way to the other domains. This weighting also needs to be used in the final decision.

1. Identify what has changed in this individual's life that affects this domain, for example, do the changes reported reflect any changes in the support services received?

2. Describe the actual needs of the individual.

3. Identify how this can be changed and what can be managed- specify what health interventions are currently in place to meet health needs and what additional interventions could be implemented to help achieve this outcome.

4. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when intervention is likely to be performed across a range of typical daily routines and the frequency and duration of the intervention. Include the frequency and intensity of need, unpredictability, deterioration and any instability.
5. Are the person’s support needs episodic (for example, requiring additional inputs for time limited periods) or long term?

6. Note any overlap with other domains.

7. Circle the assessed level overleaf.
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

12: Other significant care needs to be taken into consideration

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of Need</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

Assessed Levels of Need

<table>
<thead>
<tr>
<th>Care Domain</th>
<th>P</th>
<th>S</th>
<th>H</th>
<th>M</th>
<th>L</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cognition</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health (psychological and Emotional Needs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition- Food and Drink</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continence</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin (including Tissue Viability)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathing</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Therapies and Medication</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altered States of Consciousness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other significant care needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Decision Support Tool for Continuing NHS Healthcare

Section 2 – Care Domains

Refer to the user notes

Note below any views of the individual on the completion of the DST that have not been recorded above, including whether they agree with the domain levels selected. Where they disagree, this should be recorded below, including the reasons for their disagreement. Where the individual is represented or supported by a carer or advocate, their understanding of the individual's views should be recorded.
Decision Support Tool for Continuing NHS Healthcare

Section 3 – Recommendation

Recommendation of the multidisciplinary team filling in the DST

Give a recommendation on the next page as to whether or not the individual is eligible for CHC. This should take into account the range and levels of need recorded in the Decision Support Tool and what this tells you about whether there has been a change in the individual’s condition and whether the individual’s primary need is for healthcare. Any disagreement on levels used or areas where needs have been counted against more than one domain should be highlighted here. Reaching a recommendation on whether the individual’s primary needs are health needs should include consideration of:

**Nature:** This describes the particular characteristics of an individual’s needs (which can include physical, mental health, or psychological needs), and the type of those needs. This also describes the overall effect of those needs on the individual, including the type (‘quality’) of interventions required to manage them.

**Intensity:** This relates to both the extent (‘quantity’) and severity (degree) of the needs and the support required to meet them, including the need for sustained/ongoing care (‘continuity’).

**Complexity:** This is concerned with how the needs present and interact to increase the skill needed to monitor the symptoms, treat the condition(s) and/or manage the care. This can arise with a single condition or can also include the presence of multiple conditions or the interactions between two or more conditions.

**Unpredictability:** This describes the degree to which needs fluctuate, creating challenges in managing them. It also relates to the level of risk to the person’s health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, or unstable or rapidly deteriorating condition.

Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual’s needs. Also please indicate whether needs are expected to change (in terms of deterioration or improvement) before the case is next reviewed. If so, please state why and what needs you think will be different and therefore whether you are recommending that eligibility should be agreed now or that an early review date should be set. Where there is no eligibility for continuing NHS healthcare and the assessment and care plan, as agreed with the individual, indicates the need for support in a care home setting, the team should indicate whether there is the need for registered nursing care in the care home, giving a clear rationale based on the evidence above.
Decision Support Tool for Continuing NHS Healthcare

Section 3 – Recommendation

Refer to the user notes

Recommendations on eligibility for continuing NHS healthcare detailing the conclusions on the issues outlined on the previous page:

Names of the multi-disciplinary team      Signature      Date

1.

2.

3.

4.

5.

6.
Decision Support Tool for Continuing NHS Healthcare

Glossary

**Altered state of consciousness**

An altered state of consciousness can come about accidentally through, for example, fever, infections such as meningitis, sleep deprivation, fasting, oxygen deprivation, nitrogen narcosis (deep diving), psychosis, temporal lobe epilepsy or a traumatic accident.

**Compliance**

The extent to which a patient takes, or does not take, medicines as prescribed.

**Concordance**

An agreement between a patient and a health professional regarding the provision of care. Concordance and compliance are frequently used interchangeably.

**Contracture**

Abnormal, usually permanent condition of joint flexion and fixation caused by atrophy and shortening of muscle fibres or loss of normal elasticity of skin causing muscle contraction.

**Diagnosis**

This is another term for assessment most usually associated with health care. It often implies a cause and/or prognosis.

**Near future**

Refers to needs that are reasonably considered by the MDT to be likely to arise before the next planned review of the individual.

**Pressure-related injury**

Area of damage to the skin or underlying tissue which has occurred as a result of prolonged pressure to that area.

**Pressure ulcer**

Also known as decubitus ulcer or bed sore. It is an area of local damage to the skin and underlying tissue due to a combination of pressure and friction.
Reviews

This refers to re-assessment of people’s needs and issues, and consideration of the extent to which services are meeting the stated objectives and helping to achieve the desirable outcomes.

Spasm

A sudden, involuntary contraction of a muscle, a group of muscles, or a hollow organ, or a similarly sudden contraction of an orifice. A spasm is usually accompanied by a sudden burst of pain.

Transient Ischemic Attacks (TIAs)

A risk factor for stroke, TIAs are caused by temporary interruptions to the blood supply of the brain. TIA symptoms are similar to stroke symptoms but disappear within a few minutes.

Vasovagal Syncope

A vasovagal episode or vasovagal response or vasovagal attack (also called neurocardiogenic syncope) is a malaise mediated by the vagus nerve. When it leads to syncope or “fainting”, it is called a vasovagal syncope, which is the most common type of fainting. There are a number of different syncope syndromes which all fall under the umbrella of vasovagal syncope. The common element among these conditions is the central mechanism leading to loss of consciousness.