

# **CONTINUING NHS HEALTHCARE**

## **The National Framework for Implementation in Wales**

**Published July 2021**

**Version 2 published February 2022**

**Implemented 1 April 2022**

<b>CONTENTS</b>	<b>Page</b>
<b>SECTION 1: INTRODUCTION TO CHC</b>	
• Introduction	04
• Key Messages	05
• The National Framework	06
• The Legal Framework	10
• Organisational Duties	10
• Governance Arrangements	13
<b>SECTION 2: CHC POLICY</b>	
• CHC Policy	15
• Underpinning Principles	15
• Organisational Responsibilities	22
• Key Roles and Responsibilities throughout the CHC Process	24
• CHC Eligibility Assessment Process Flowchart	32
<b>SECTION 3: BEFORE AN ASSESSMENT FOR CHC</b>	
• Consent	33
• Capacity	37
• Best Interest Decisions	40
• The Fast Track Process	42
• The Use of the Checklist Tool	43
<b>SECTION 4: THE ASSESSMENT OF ELIGIBILITY FOR CHC</b>	
• Identifying an Individual's Needs	46
• Determining a Primary Health Need	47
• Using the Decision Support Tool	49
• Pandemic and Other Emergency Situations	50
• Making the Recommendation on Eligibility	50
• Quality Assurance	52
• Communicating the Decision on Eligibility	53
• Timescales and Commencement of CHC	53
<b>SECTION 5: SERVICE PROVISION AND REVIEWS</b>	
• Care Provision and Monitoring	55
• Responsible Body Guidance for the NHS in Wales	62
• Voice & Control, Direct Payments and CHC	63
• Joint Packages of Health and Social Care	65
• CHC Reviews (3 and 12 months)	67
<b>SECTION 6: LINKS TO OTHER POLICIES &amp; SPECIALIST AREAS OF PRACTICE</b>	
• Mental Health	71
• Deprivation of Liberty Safeguards	72
• Transition from Children and Young People to Adult Provision	73
• Applying the CHC Framework to Adults with a Learning Disability	76
• Entitlement to other NHS Funded Care	77
• Community Equipment	77
<b>SECTION 7: DISPUTES AND APPEALS</b>	
• Disputes between Organisations	78
• Appeals against Eligibility Decisions from Individuals	80

• Promoting Consistency in the Operation of Independent Review Panels	82
• Complaints	84
<b>SECTION 8: RETROSPECTIVE CLAIMS</b>	<b>85</b>
<b>GLOSSARY OF TERMS</b>	<b>91</b>
<b>APPENDICES</b>	<b>99</b>
• ANNEX 1: Legal Judgments	
• ANNEX 2: Simple Process Overview	
• ANNEX 3: Example CHC Process Checklist	
• ANNEX 4: Setting up a Review Panel	
• ANNEX 5: Retrospective Claims Payment Guidance	

# SECTION 1

---

## INTRODUCTION TO CHC

- 1.1 This document sets out the arrangements for the effective and efficient and equitable delivery of Continuing NHS Healthcare (CHC) in Wales.
- 1.2 CHC is a complete package of ongoing care arranged and funded solely by the NHS through local health boards (LHBs), where an individual's primary need has been assessed as health-based.
- 1.3 CHC is one element of a range of services that local authorities (LAs) 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 with complex needs may need as the result of disability, accident or illness to address both physical and mental health needs. Given the nature, intensity, complexity and unpredictability of those needs, these services account for a significant proportion of NHS healthcare overall.
- 1.4 CHC can be provided in any setting outside hospital, such as in a person's own home, in a care home, hospice or in a prison and is part of the continuum of care and support that an individual with complex needs may move in and out of.
- 1.5 CHC is different from 'NHS Funded Nursing Care' (FNC) which is only applicable to individuals requiring nursing care in a care home. The provision of FNC derives from Section 49 of the Health and Social Care Act 2001 (now replaced in relation to Wales, by Section 47(4) and (5) of the Social Services and Well-being (Wales) Act 2014), which excludes nursing care by a registered nurse from the services which can be provided by local authorities. The decision on eligibility for FNC should only be taken when it is considered that the person does not fall within the eligibility criteria for CHC.

**Note: At the time of publication, the [NHS Funded Nursing Care in Care Homes Guidance 2004](#) remains in effect. This will, however be subject to review during the lifetime of this Framework.**

## Key Messages

- K1 For individuals who are eligible to receive it, CHC is an entitlement. It is essential to aim for a decision on eligibility to be right first time. Incorrectly denying someone eligible for CHC access to their entitlement can potentially have a negative impact on the individual's health and incur significant financial costs, leading to distress for them and their families. It may also result in retrospective claims which can be expensive and time consuming.
- K2 The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need.
- K3 This Framework sets out the process for the NHS, working with LA partners, to assess an individual's health needs and to ensure that the appropriate care is provided to meet those needs.
- K4 Individuals may require services from both the NHS and their LA. The NHS is responsible for assessing, funding and providing health services to meet the needs of its population. LAs are responsible for the provision of social services and there may be a charge to the individual for some of these.
- K5 There must be a clear and transparent rationale to support the decision-making process. Professional integrity is vital.
- K6 Individuals and/or their representatives must be fully involved and informed throughout the assessment process, in the language or format of their choice.
- K7 The services provided in response to assessed need must be proportionate to need and effectively co-ordinated, in order to avoid unnecessary disruption to the individual and their family.

## The National Framework

- 1.6 The Welsh Government published *Continuing NHS Healthcare – the National Framework for Implementation in Wales*, in 2014. It set out the Welsh Government’s policy for eligibility for CHC and the responsibilities of NHS organisations and LAs under the Framework and related matters.
- 1.7 The 2021 Framework was published in July 2021 and implemented on 1 April 2022. The 2021 Framework replaces the 2014 publication.
- 1.8 This Framework sets out a process for the NHS, working together with LAs and other partners, to assess health needs, decide on eligibility for CHC and provide appropriate care. LHBs and LAs are required to fully implement the requirements of the National Framework. All LHBs and LAs will be required to participate in joint training, thus ensuring a joint and consistent approach across Wales.
- 1.9 The Framework provides a consistent foundation for assessing, commissioning and providing CHC for adults, over the age of 18, across Wales. This is to ensure that there is a consistent, equitable and appropriate application of the process for determining eligibility.
- 1.10 A summary of the main changes between the 2014 and 2021 Framework is set out in the table below.

Layout and presentation	<p>The revised Framework incorporates a redesigned layout and order/content of the Sections, mirroring the CHC process itself from start to finish. As well as the changes to the layout of the Framework, the following amendments have been made.</p> <p>Removed all reference to the redundant Complex Care Information &amp; Support site.</p> <p>All annexes have been moved to the end of the document and references to policy and legislation have also been updated, notably aligning requirements to the provisions within the Social Services and Well-being (Wales) Act 2014.</p>
Section 1 – Introduction	<ul style="list-style-type: none"> <li>• Includes additional text relating to Welsh Language Requirements</li> </ul>
Section 2 – CHC Policy	<ul style="list-style-type: none"> <li>• Includes additional information on the key roles and responsibilities of each of the organisations involved, the individual and/or their representative, carers and advocates, throughout the CHC Assessment Process</li> <li>• Emphasises the importance of practitioners providing the <i>CHC</i></li> </ul>

	<p><i>Booklet to Individual, Families and Carers</i> as soon as it is considered the individual may have a primary health need</p> <ul style="list-style-type: none"> <li>• Emphasises the importance of appropriate communication</li> <li>• Includes CHC Eligibility Assessment Flowchart</li> </ul>
Section 3 - Before an Assessment for CHC	<ul style="list-style-type: none"> <li>• Additional information relating to Consent, Capacity, and Sharing of Information and Best Interest decisions.</li> <li>• Additional text relating to the Use of the Checklist</li> </ul>
Section 4 - The Assessment of Eligibility For CHC	<p>There is no intention for policy changes made through this process to impact on the eligibility threshold for CHC, which is well-established and based on the consideration of a 'primary health need'.</p> <ul style="list-style-type: none"> <li>• Additional wording ensure screening and assessments of eligibility for CHC should be undertaken at the right time and location, when any ongoing needs are known.</li> <li>• Identifying a person's eligibility for CHC based on the totality of their needs and requiring a clear, reasoned decision which requires LHBs and LAs to consider, regardless of the outcome, whether a multi-disciplinary assessment has identified issues to be addressed.</li> <li>• Decision Support Tool – additional guidance on how, when and by who it can be completed and minor redefinitions in some of the domains of need. Domains reordered more logically into an order in which a person's needs would normally be considered.</li> <li>• Additional information on the role and membership of the Multi-Disciplinary Team</li> <li>• Eligibility – Additional information on the process should engage and involve the individual, how recommendations are reached and recorded, and how any final decision is communicated.</li> <li>• Pandemic and other emergency situations - completing assessments in the event of a pandemic and other emergency situations to ensure individuals continue to receive the care and support they need.</li> </ul>
Section 5 – Service Provision and Reviews	<p>Additional text alignment to arrangements for ongoing monitoring and management of care for adults under part 4 (Meeting Needs) of the Social Services and Well-being (Wales) Act. Also;</p> <ul style="list-style-type: none"> <li>• Reference to the Responsible Body Guidance for the NHS in Wales has been included</li> <li>• Additional text relating to well managed needs, strong emphasis that there should be no gap in the provision of care, and supporting individuals eligible for CHC in their own home</li> <li>• Additional information on the interface between direct payments and CHC and how organisations can provide individuals with voice and control in respect of their health and social care needs.</li> <li>• Clarifying the purpose of the 3 and 12 month reviews and how</li> </ul>

	they should be carried out.
Section 6 – Links to other Policy Areas &	<ul style="list-style-type: none"> <li>• Links to existing provisions have been retained and refreshed</li> <li>• Clarifying and strengthening the wording around aftercare services for mental health services and deprivation of liberty.</li> <li>• Reinforcing provisions around transitional arrangements for a child entering Adult CHC at the age of 18.</li> </ul>
Section 7 - Disputes and Appeals Process	<ul style="list-style-type: none"> <li>• Requirement for LHBs to explain to individuals the arrangements and timescales for dealing with a review of the eligibility decision.</li> <li>• The 2014 Framework does not include timescales for appeals. The 2021 Framework sets out the following <ul style="list-style-type: none"> <li>○ an individual or their representative, should inform the LHB in writing, of their intention to appeal a decision on eligibility for FNC or CHC within 28 days of receipt of the eligibility decision letter. Requests made after this time period will only be considered in exceptional circumstances.</li> <li>○ an individual or their representative, should submit their appeal (in writing) against an eligibility decision for FNC or CHC within 6 months of receipt of the eligibility decision letter. Requests made after this time period will only be considered in exceptional circumstances.</li> </ul> </li> <li>• Added a requirement that where there is an unresolved dispute within the MDT on a recommendation, then this should be escalated within 48 hours to ensure quick consideration of the individual's needs.</li> </ul>
Section 8 - Retrospective reviews	<p>From April 2019, all Retrospective Claims have been managed by individual LHBs. The new 2 Stage Retrospective Claims process has been included into the 2021 Framework to provide effective, timely and correct resolution of these claims.</p> <ul style="list-style-type: none"> <li>○ Stage 1 employs the CHC Checklist Tool to identify triggers for eligibility.</li> <li>○ Stage 2 - Where triggers are found, the information in the chronology will be reviewed and assessed against the 4 primary health need indicators (nature, intensity, complexity and unpredictability)</li> <li>• Analysed information is compiled into a document detailing the recommendation which is peer reviewed by a different clinician to ensure the recommendation and supporting evidence is robust and that the criteria have been consistently applied. To further ensure the timely resolution of claims, cases with no eligibility are peer-reviewed by “<i>at least one different clinician</i>”.</li> <li>• This differs from the 2014 Framework requirement that ‘2 <i>different clinicians</i>’ should review a not eligible decision.</li> </ul>

**Version Control**

Version 2 published February 2022



Minor amendments to address inaccuracies, for example with terminology and paragraph numbering. Also clarifying details in retrospective process and revising the retrospective process flowchart.

1.11 The Framework is supported by:

- A Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers
- A LHB and LA joint e-learning event (delivered virtually) on the implementation of the Framework
- Governance and accountability arrangements
- A National Performance Framework

1.12 The assessment and provision of care for children and young people is addressed in the Welsh Government's [The Children and Young People's Continuing Care \(CYP CC\) Guidance January 2020](#). Details on the transition between CYP CC and adult CHC are set out at **Section 6**.

1.13 This Framework refers to various legislative, regulatory and statutory guidance and some of these will be revised over time. The interpretation of the guidance in this document should therefore take into account future changes.

#### Review of the Framework

1.14 The Welsh Government gives a commitment to review the Framework within five years of implementation and to issue additional or interim guidance where this is required.

1.15 Information on Continuing NHS Healthcare can be found on the Welsh Government's webpages at <https://gov.wales/national-framework-nhs-continuing-healthcare>

Also, by contacting:

Welsh Government  
Cathays Park  
Cardiff  
CF10 3NQ

**Call:** 0300 0604400

**Email:** [customerhelp@gov.wales](mailto:customerhelp@gov.wales)

## The Legal Framework

### Legislation and Case Law

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

- (i) the physical and mental health of the people of Wales; and
- (ii) the prevention, diagnosis and treatment of illness.

1.17 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. This Framework reflects relevant Welsh legislation with particular emphasis on the various provisions contained within the Social Services and Well-Being (Wales) Act 2014 (“The SSWB Act”). These replaced the legislation reported in and court decisions on previous cases, namely:

- (i) The decision of the Court of Appeal in *R v North and East Devon Health Authority ex parte Coughlan [1999]* “The Coughlan Judgment”.
- (ii) The decision of the Court of Appeal in *R v. Bexley NHS Care Trust ex parte Grogan [2001]* “The Grogan Judgment”.

The key points from these judgments are included in **Annex 1**.

- (iii) [Section 47 of the SSWB Act, formerly Section 49 of the Health and Social Care Act 2001](#)

## Organisational Duties

### The Duties of the NHS and Local Authorities

1.18 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” ([National Health Service \(Wales\) Act 2006, Section 3](#)). 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.

- 1.19 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.
- 1.20 Under Part 3 of The SSWB Act, each LA is under a duty to assess the social care needs of an adult where it appears that the adult may have needs for care and support ([Social Services and Well-being \(Wales\) Act 2014, Section 19](#)). An adult's needs may be met by providing or arranging the provision of different types of care and support including accommodation in a care home, as well as in an adults home or in the community or through the provision of information and advice ([Social Services and Well-being \(Wales\) Act 2014, Section 34](#)).
- 1.21 Where, the LA is satisfied, on the basis of the needs assessment, that a person has eligible social care and support needs they must then, in conjunction with the individual, determine how those needs are to be met.
- 1.22 If an NHS body is assessing an individual's needs (whether or not potential eligibility for CHC has been identified) and the assessment indicates a potential need for care and support services that may fall within a LA's responsibilities, it should notify the authority of this and invite it to participate in the assessment process.

#### Extent of Local Authorities' Powers

- 1.23 Section 47(1) of the SSWB Act provides that a LA may not meet an individual's needs for care and support by providing or arranging for a service which is required to be provided under a health enactment, unless doing so would be incidental or ancillary to doing something else to meet those needs. Section 47(1) of the SSWB Act provides that "nursing care" means "a service which involves either the provision of care or the planning, supervision or delegation of the provision of care, but does not include a service which, by its nature and in the circumstances in which it is to be provided, does not need to be provided by a registered nurse".
- 1.24 [Section 47\(4\) of the SSWB Act](#) provides that a LA may not meet an individual's needs for care and support by providing or arranging for the provision of nursing care by a registered nurse.

#### Equality and Human Rights Legislation

- 1.25 [The Equality Act 2010](#) (the Equality 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 Equality 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 Equality Act as 'protected characteristics'.

- 1.26 The Equality and Human Rights Commission also published codes of practice which cover discrimination in services and public functions as set out in Part 3 of the Equality Act, and which became law on 6<sup>th</sup> April 2011.
- 1.27 Part 3 is based on the principle that people with the protected characteristics defined in the Equality Act should not be discriminated against when using any service provided publicly or privately, whether that service is for payment or not.
- 1.28 Under the Human Rights Act 1998 (HRA) it is unlawful for public authorities to act in a way which is incompatible with certain rights under the European Convention for the Protection of Human Rights and Fundamental Freedoms (referred to in the HRA as "the Convention rights"). Public authorities will therefore be in breach of the HRA if they act in a way which is incompatible with the Convention rights in any area of their activity, including service provision or employment and work-related activities.
- 1.29 Human rights issues can arise in relation to the exercise of any public function or the provision of any public service which engages a person's Convention rights, for example rights under Article 8 of the Convention (right to respect for private and family life). If a public authority or any other body discriminates when carrying out a function of a public nature which engages a Convention right, 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.
- 1.30 LHBs and LAs have statutory duties to have due regard to the need to promote equality and human rights and ensure it is integral to the way in which health and social care is prioritised and delivered. This should allow 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 LHBs and LAs 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, individuals 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 LHBs and LAs should work together with individuals to identify and overcome any barriers to economic and social participation within society.

### Welsh Language Requirements

1.31 The Welsh Language (Wales) Measure 2011 (“the Measure”) made the Welsh language an official language in Wales. This means that the Welsh language must not be treated less favourably than the English language. The Measure also created the role of Welsh Language Commissioner and enabled the Welsh Ministers to set standards of conduct relating to the Welsh Language. From March 2016, the Welsh Language Standards replaced the existing system of Welsh language schemes provided for the Welsh Language Act 1993.

1.32 As part of the NHS Delivery Framework for 2018-19, the following measure was included under the domain ‘individual care’:

- *Evidence of implementation of the Welsh language guidance as defined in [More Than Just Words](#)*

1.33 This measure was included in the framework to ensure that NHS organisations are meeting the care needs of Welsh speakers, their families and carers as outlined in the strategic framework ‘More Than Just Words’. To evidence this outcome, all NHS organisations are expected to report on a bi-annual basis the key actions that have been achieved under the six priority areas to ensure that Welsh speakers receive health services in their first language.

1.34 NHS organisations are expected to evidence the implementation of the priority areas in both primary and secondary care sectors.

## **Governance Arrangements**

### Strategic Oversight

1.35 The effective delivery of CHC is a key component of LHB business. Each LHB must identify a named executive, at director level, who is responsible for monitoring performance and maintaining strategic oversight.

1.36 The named director must have access to the data and management information required to enable them to undertake this role effectively.

1.37 Each LA must have a named link with equivalent organisational status. They must liaise closely with their LHB director with responsibility for CHC and be responsible for reporting to their scrutiny committee or equivalent.

1.38 Both LA and LHB Directors should actively engage with local independent and third sector providers, to ensure the views and experiences of providers are included as part of the scrutiny process.

### Performance Framework

1.39 The 2021 Performance Framework forms part of the Governance and Accountability arrangements for CHC in Wales. It provides the Welsh Government with assurance that organisations responsible for the delivery of CHC, are compliant with the CHC Framework. LHBs must comply with the reporting arrangements set out in the 2021 Performance Framework to support continuous service improvement and satisfy the Welsh Government of the consistency of decision-making on CHC eligibility across Wales.

1.40 The 2021 Performance Framework can be accessed on the Welsh Government's website, the contents of the Performance Framework are not repeated in this document.

## SECTION 2

---

### CHC POLICY

- 2.1 The policy of Welsh Ministers on eligibility for CHC is based on whether an individual'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 whether an individual's primary need is a health need.
- 2.2 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. **Figure 1. Sets out the main stages of the eligibility process.** Health and social care practitioners involved are expected to comply with existing Welsh Government practice guidance on assessment and care planning including:
- [Social Services and Well-being \(Wales\) Act 2014 Code of Practice relating to Part 3 - Assessing the Needs of Individuals](#)
  - [Code of Practice relating to Part 4 of the Act - Meeting Needs](#)
  - [Code of Practice to Parts 2 and 3 of the Mental Health \(Wales\) Measure 2010](#)
  - [NAFWC 17/2005 Hospital Discharge Planning Guidance](#)
  - [Passing the Baton: A Practical Guide to Effective Discharge Planning \(2008\)](#)
  - [Hospital discharge service requirements: COVID-19](#)
- 2.3 Practitioners should refer to the guidance above directly. There is no attempt to replicate in this Framework.

### UNDERPINNING PRINCIPLES

- 2.4 No guidance will address all of the potential situations that can present when assessing and meeting an individual's complex needs. There will be occasions when a degree of interpretation is required to apply the guidance in real-life cases. Where this does occur, practitioners must be able to demonstrate that they have applied the underpinning principles detailed below.

#### **Principle 1: People First**

- 2.5 Individuals who turn to health and social care providers when they have complex needs have to know and experience that their best interests and rights are the primary focus of the people assessing, making decisions and supporting them. The focus will be manifested in the dignity and respect shown to them as individuals. Individuals who have a primary health need are entitled to CHC funding. They should therefore feel supported

throughout the process of determination of eligibility and be confident that they will receive the quality of care required to meet their needs.

**Principle 2: Integrity of Decision-making**

- 2.6 Members of the Multi-disciplinary Team are responsible for the integrity of their assessments, expert professional advice and decisions which should be underpinned with a clear rationale. Recommendations on eligibility made by the MDT can only be challenged at the quality assurance stage in exceptional circumstances, and for clearly articulated reasons. This process should not be used as a gate-keeping function or for financial control. A decision not to accept the MDT's recommendation should never be made by one person acting unilaterally. The final eligibility decision should be independent of budgetary constraints, and finance officers should not be part of the decision-making process.

**Principle 3: No decisions about me without me**

- 2.7 Individuals are the experts in their own lives. Including them and/or their representatives as empowered co-producers in the assessment and care planning process is not an optional extra. They must be invited to attend and fully participate in any assessment of their care and support needs. Where the available care options carry financial or emotional consequences, professionals must not avoid honest and mature conversations with the individual and/or their representative. Professionals must be mindful that some individuals or their representatives may need support or advocacy to express their wishes, feelings and aspirations. Individuals or their representatives are entitled to determine themselves who they would like to receive support or advocacy from.

**Principle 4: No delays in meeting an individual's needs due to funding discussions**

- 2.8 The individual must not experience delay in having their needs met because agencies are not working effectively together. Joint funding and pooled budget options must be considered wherever these can promote more agile, and as a consequence, more efficient responses to individual needs and preferences. Commissioners have a responsibility to resolve concerns/disputes at the earliest opportunity by having relevant local protocols in place as set out in the disputes process at **Section 7**.

**Principle 5: Understand diagnosis, focus on need**

- 2.9 Individuals do not define themselves by their medical or clinical diagnosis and nor should the professionals who are supporting them. Health and social care providers must work together to gain a holistic understanding of need and the impact on the individual's daily life. The aim of assessment, treatment and the planning and commissioning of longer-term care should be to deliver quality and tailored support which maximises independence and focuses on what is most important from the perspective of the individual and their carers.



**Principle 6: Co-ordinated care & continuity**

2.10 Fragmented care is distressing, unsafe and costly. It can result in unnecessary change to living arrangements, which in turn creates instability and insecurity. Every effort must be made to avoid disruption to care arrangements wherever possible, or to provide smooth and safe transition where change is required in the best interests of the individual. Where an individual whose care was arranged through Direct Payments becomes eligible for CHC funding, the health board must work with them in a spirit of co-production and make every effort to maintain continuity of the personnel delivering the care, where the individual wishes this to be the case, as set out in **Section 5**.

The individual and/or their representative must have a named contact for advice and support, who can co-ordinate a prompt response to any change in need.

**Principle 7: Communicate**

2.11 The vast majority of complaints, concerns and disputes have poor communication at their core. It is unacceptable for professionals to claim not to have time to communicate – it will take longer to put the situation right later and trust will have been broken. The individual and/or their representative seeking our help, by the nature of the interaction, require clear communication and support.

2.12 Therefore, communication with the individual or their representative must be in the language/format or method of their choice. This includes all verbal and written communication throughout the eligibility process, including the use of the Checklist, DST and Fast Track Processes, and the provision of care and support services.

2.13 Individuals and/or their representatives will be empowered if they are able to speak with staff in their preferred language. It is important to recognise the concept of language as an integral element of an individual's care and their ability to participate in all its aspects as equal partners. Effective communication is a key requirement of assessment and the provision of any support required. In Wales, services must be offered in ways that are compliant with the Welsh Language Standards.

2.14 The same considerations apply to British Sign Language (BSL) users. Evidence suggests that BSL users prefer to communicate directly with professionals who can communicate fluently in BSL when discussing care and support needs. Many LAs employ special social workers who work with deaf people and can communicate in BSL. In cases where professionals cannot communicate directly in BSL, interpreters will have to be used either directly or via video computer link.

2.15 All professionals involved in an assessment of the needs of people with severe speech and communication difficulties will need to establish the preferred means of communication before starting the assessment. Assessment specifically concerned with communication may require the assistance of the National Centre for Electronic Assistive Technology.

- 2.16 There should be no delays to the individual in receiving their assessment or provision of care and support, regardless of the language/format or method of communication used throughout the CHC eligibility process.
- 2.17 Any decision on eligibility must be clearly and professionally explained to the individual or their representative in the language of their choice. See **Communicating the Decision on Eligibility at Section 4**.

### Process

- 2.18 Screening and assessment of eligibility should commence when the individual's ongoing needs are known. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and ongoing needs.
- 2.19 Care must be taken to ensure that no premature presumptions are made regarding the requirements for long-term care whilst the individual is acutely unwell.
- 2.20 Assessments should take place in a person's home or in another suitable community setting; not in an acute hospital bed. 'Home first' and the Discharge to Recover Then Assess (D2RA) pathways should be the default position. Following admission to hospital, there should be a period of rehabilitation / reablement to support independence, prior to assessments for longer term care, except in exceptional circumstances.
- 2.21 It should always be borne in mind that an assessment of eligibility for CHC that takes place in an acute hospital might not accurately reflect an individual's longer-term needs. This could be because, with appropriate support, the individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment.
- 2.22 Where an individual is ready to be safely discharged from acute hospital it is very important that this should happen without delay. Therefore, the assessment process for CHC should not be allowed to delay hospital discharge.
- 2.23 There should be consideration of whether the provision of further NHS-funded services is appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few months. It might also include intermediate care or an interim package of support in an individual's own home or in a care home. In such situations, assessment of eligibility for CHC should usually be deferred until an accurate assessment of future needs can be made. The interim services (or appropriate alternative interim services if needs change) should continue in place until the determination of eligibility for CHC has

taken place. There must be no gap in the provision of appropriate support to meet the individual's needs.

### The use of the Checklist

2.24 The Checklist is the CHC screening tool which can be used in a variety of settings to help practitioners identify individuals who may need a full assessment of eligibility for CHC. Further information on the use of the Checklist is at **Section 3**.

### Fast Track Assessments

2.25 Occasionally, it will be necessary to safeguard an individual's well-being by 'fast tracking' people for immediate provision of CHC. Further information on the Fast Track assessment process is set out at **Section 3**.

### CHC Eligibility Assessment

2.26 When it is considered that longer-term support to meet complex needs is likely to be required on discharge (or in the community if the person is at home), a named care co-ordinator/lead professional must be identified.

2.27 The Care Co-ordinator is the named individual responsible for co-ordinating the whole process of assessment for longer-term care, including gathering evidence to inform the decision on CHC eligibility. Further details on the role of the Care Co-ordinator is set out at **paragraphs 2.67 to 2.72**.

2.28 Discussions about an individual's needs, along with any consideration of eligibility for CHC, including use of the Decision Support Tool (DST), must be undertaken in a formal Multi-disciplinary Team ("MDT") meeting. The individual and/or their representative, (their representative can be their family, carer, advocate or any other representative the individual chooses to support, speak or act on their behalf) must be invited to participate fully in any assessments of their needs as set out at **Principle 3: No decisions about me without me**.

2.29 The assessment process should draw on those who have direct knowledge of the individual and their needs, (further information on the membership of the MDT is at **paragraphs 2.77 to 2.80**) and must include the input of the consultant or GP who has responsibility for the patient, so that the clinical facts and medical needs are considered alongside all other care needs.

2.30 The assessment should, where appropriate, involve other agencies who work with the individual and form part of their existing support mechanisms. This could include for

example, third sector agencies and housing associations.

- 2.31 The Care Co-ordinator must ensure that the assessments undertaken by the MDT are robust and provide the evidence required to enable reasoned decision-making on CHC eligibility. Whilst the benefit of MDT meetings is recognised, they should not result in delay that could negatively impact on outcomes for the person. Co-ordination of assessment can, and should, continue in a timely manner, beyond the confines of a formal meeting. The process of assessment of CHC eligibility, including the completion of the DST, is set out in **Section 4**.
- 2.32 The Care Co-ordinator and/or the MDT may decide that additional information is required to provide robust expert advice to the LHB concerning the individual's eligibility for CHC. If this is the case the information required must be identified together with the most appropriate professional to supplement the assessment. Decision-making should not be delayed because of repeated requests for further information.
- 2.33 As far as is reasonably practicable, the LHB should consult with the relevant LA before making any decision about an individual's eligibility for CHC. In doing so it should cooperate with the relevant local authority to arrange for individuals to participate in an MDT for that purpose. LHBs may use a number of approaches (e.g. face-to-face, video/tele-conferencing etc.) to arrange these MDT assessments in order to ensure active participation of all members as far as is possible.
- 2.34 If an LA is consulted, it is expected to provide advice and assistance to the LHB, as far as is reasonably practicable. It must, if requested by an LHB, co-operate in arranging for persons to participate in an MDT. The involvement of both LA and NHS professionals in the assessment process should streamline the process of care planning and will make decision-making more effective and consistent. As with any assessments that they carry out, LAs should not allow an individual's financial circumstances to affect its participation in a joint assessment.
- 2.35 MDTs should be aware that the DST contains a section at the end of the domain tables for the individual and/or the representative to give their views on the completion of the DST that have not already been recorded elsewhere in the document, including whether they agree with the domain levels selected. It also asks for reasons for any disagreement to be recorded. Therefore, the MDT meeting should be arranged in a way that enables that individual to give their views on the completed domain levels before they leave the meeting.
- 2.36 Once eligibility has been considered and discussed with the individual and/or their representatives, and the DST completed, MDT members will immediately make their recommendation on whether a primary health need is present, based on the four key indicators (**see Section 4**). This recommendation will be made separately from any discussions with the individual and/or their representative but even if they are not present on the day it should be communicated to them as soon as possible.

2.37 A summary overview of the assessment and CHC eligibility decision-making process is provided at **Annex 3**.

### Reviews

2.38 CHC should not necessarily be viewed as a permanent arrangement. Care provision should be needs and outcomes-led and designed to maximise ability and independence. Further information on reviews of care packages is set out in **Section 5**.

2.39 Health and social care professionals involved in arranging the care package must have open conversations with the individual and/or their representative, describing the options to be considered and reflecting the principles and requirements set out in the Sustainable Care Planning Model.

2.40 In keeping with a person-centred approach for the CHC eligibility assessment process, the ongoing assessment and review process should be explained to the individual, and/or their family, carer or any other representative the individual chooses, from the outset. It should be verbally explained to them as well as confirmed in writing, all communication with the individual should be in the language/format chosen by the individual.

2.41 The individual or their representative should be provided with the *Continuing NHS Healthcare Booklet for Individuals, Families and Carers*, as soon as it is considered the individual may have a primary health need and be eligible for CHC.

2.42 For the purposes of this document, where we state the 'individual and/or their representative' this means any representative the individual chooses, this could be a family member, their carer or any other representative they choose to support them, or speak or act on their behalf.

2.43 Also, as set out in the Underpinning Principles of the Framework, individuals are the experts in their own lives. Including them, their families and their carers (be they paid or unpaid) or any other representative, as empowered co-producers in the assessment and care planning process is not an optional extra. Individuals or their representative must be invited to attend and fully participate in all assessment of their care and support needs.

## ORGANISATIONAL RESPONSIBILITIES

- 2.44 The Welsh Government sets the policy approach and strategic direction for CHC. It will scrutinise the delivery of CHC and promote improvement through the 2021 Performance Framework. The Welsh Government will provide a learning event during the implementation period to support LHBs and LAs in their delivery of CHC.
- 2.45 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 physical and/or mental health needs. These services are normally provided free of charge.
- 2.46 LHBs have a role in establishing and maintaining governance arrangements for consideration of CHC eligibility and purchasing and securing care, as they do in other policy areas of health care. They are responsible for:
- ensuring consistency in the application of the Continuing NHS Healthcare National Framework;
  - promoting awareness of CHC;
  - implementing and maintaining good practice, ensuring quality standards are met and sustained;
  - delivering joint, consistent training and development opportunities for all relevant health and social care 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; and,
  - the provision of strategic leadership and organisational and workforce development, and ensuring systems operate effectively and deliver improved performance.
- 2.47 They are responsible for ensuring 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). LHBs are responsible for ensuring that discrimination does not occur and should use effective monitoring to monitor this issue.
- 2.48 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. LHBs 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. LHBs must arrange regular reviews to ensure those services remain fit for purpose.

2.49 During the Framework implementation period, NHS bodies must:

- confirm to the Welsh Government that they adhere to the principles, processes and responsibilities in this Framework
- ensure all relevant staff are fully aware of the procedures for assessing, determining eligibility and providing CHC services, through participation in the Welsh Government's learning event and further joint training as necessary
- ensure the *Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers* is made available in a range of formats to individuals or their representatives, as soon as it becomes apparent the individual may have a primary health need and therefore may be eligible for CHC
- review their current assessment, quality assurance, discharge processes and commissioning arrangements to ensure they comply with this Framework.

2.50 Local authorities (LAs) 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. LAs may charge for care services in accordance with regulations under the Social Services and Well-being (Wales) Act 2014 and the Welsh Government's Code of Practice on Charging and Financial Assessment. It is the responsibility of the LA to ensure that any potential impact on the individual in terms of charging should be explained at the earliest opportunity.

2.51 The fact that someone has health needs which are beyond the powers of a LA to provide for, does not, of itself, mean that the individual is eligible for CHC. If an individual does not meet CHC eligibility they can still access a range of health and social care services. These can be both part of mainstream services, or individually planned to meet specific needs.

2.52 During the Framework implementation period, LAs must consider how their current practice fits with the responsibilities set out in this Framework and make any necessary changes.

2.53 Local health boards (LHBs) and LAs have responsibilities to ensure that the assessment of eligibility for, and provision of, CHC takes place in a consistent manner and the process is actively managed to avoid unnecessary delays. The timing and place of assessment must be carefully considered. If it follows hospital admission, LHBs and LAs should ensure that the individual's potential for recovery and rehabilitation has been maximised, prior to assessment for CHC. This should be at home or another suitable community setting such as step-down/intermediate care

facilities with appropriate support. There should be no delays due to disputes concerning which agency should fund. Partners can use a joint or pooled budget to fund the placement in the short-term, and this fund can be replenished once the funding responsibilities have been determined. NHS bodies and LAs must work in partnership to:

- review 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;
- communicate the requirements of the Framework to service providers across all sectors. This will help them to, for example, identify individuals with continuing health care needs.

## KEY ROLES AND RESPONSIBILITIES IN THE CHC ELIGIBILITY PROCESS

2.54 In implementing the principles detailed above, all of those involved have key roles and responsibilities to play. These include the following:

### The individual whose needs are being assessed

2.55 It is essential that the individual whose needs are being assessed is central to the assessment and care planning process, as set out at **Principle 3** above. They are the expert in their own lives and situation. The assessment will by its nature often be triggered by illness or other life event and every effort must be made by the professionals involved to support the individual to participate in discussions which will impact on their future. This relies on the individual providing honest information, expressing their views and aspirations, and being open if they require further explanation, or there are issues that the team need to understand to effectively meet their needs.

2.56 Throughout the CHC assessment process the individual may choose to have a representative to support them, or speak or act on their behalf, on an informal or formal basis, including at any meetings they attend. The representative could be a family member, their carer or any other representative they choose.

2.57 The individual's representative will have an important role in supporting them and professionals must make every effort to facilitate their involvement. In order to achieve the best possible outcome for the individual, including support for recovery and maintenance of independence, carers/family/representatives will be expected to respond to reasonable requests for information and/or to attend the multi-disciplinary team



meeting in a timely manner. Where there are a number of family members involved, a key contact should be nominated, who will then be responsible for communicating with other family members.

Where the individual does not have capacity, but has an authorised representative

2.58 Where it has been identified that the individual does not have capacity to give their consent or to participate effectively in the decision-making process, as set out at **Section 3**, a representative who has the correct authority, such as a Deputyship Order or registered Lasting Power of Attorney, may make decisions on the individual's behalf. The authorised representative can choose to be supported by an advocate or representative of their choice.

The role of the family/ carer or other representative when a 'Best Interest' decision is made

- 2.59 Where the individual does not have capacity to make decisions, and there is no representative with the authority to make decisions on their behalf, as set out at **Section 3**, the LHB should make a 'best interest' decision on the individual's care and support needs. Where a 'best interests' decision needs to be made, the decision-maker must take into account the views of any relevant third party who has a genuine interest in the individual's welfare (if it is reasonable and practicable to consult them). This will normally include family, friends and advocates. An individual may choose to have a family member or other person, who should operate independently of LHBs and LAs, to act as an advocate on their behalf.
- 2.60 The decision-maker should be mindful of the need to respect confidentiality and should not share personal information with third parties unless it is considered in the best interests of the individual for the purposes of the CHC assessment of eligibility. Where the individual has made an 'advanced statement' to the effect that they do not want personal information shared with specific individuals, this should be taken into account in assessing the individual's best interests.
- 2.61 Although the decision-maker must take account of the views of relevant third parties, those consulted (including family members) do not have the authority to consent to or refuse consent to the actions proposed as a result of the best interests' process. The responsibility for the decision rests with the decision maker, not with those consulted. Where there is a difference of opinion between the decision-maker and those consulted, every effort should be made to resolve this informally. However, this process should not unduly delay timely decisions being made in the person's best interests.
- 2.62 The individual and/or their representatives cannot be members of the MDT. However, they must be given the opportunity to be fully involved in the CHC process and be given every opportunity to attend the MDT meeting where the DST is to be completed so that they are fully able to participate in its completion, as an equal partner.

- 2.63 Therefore, the individual or their representative, must be given reasonable notice of the MDT meeting to enable them to attend, taking into account their personal circumstances. If they do not wish to be present, where consent is given, their views and knowledge should be obtained and actively considered in the completion of the DST.
- 2.64 Completion of the DST should be organised so that the individual or their representative, understands the process and receives information and support to enable them to participate in informed decisions about their future care and support. The reasons for any decisions made should be transparent and clearly documented.
- 2.65 At **Section 1 (2)** of the DST, the MDT should record the individual and/or their representative's views on their care needs, and whether they consider the MDT assessment has accurately reflected their needs.
- 2.66 At **Section 1 (3)** it should be recorded whether and how the individual and/or their representative contributed to the assessment of their needs. If they were not involved, it must be recorded whether or not they were invited or whether they declined to participate.

#### The role of the Care Co-ordinator/Lead Professional

- 2.67 The Care Co-ordinator is the named individual responsible for co-ordinating the whole process of assessment for longer-term care. They are accountable for ensuring that the assessment process is co-produced, robust, and timely. They must ensure that the individual or their representative is kept informed of the process and fully involved in discussions about their care.
- 2.68 The Care Co-ordinator is most likely to be a health professional and it will be important to maintain continuity where for example, the individual has a progressive disease and specialist key professional. This person-centred approach would suggest that it may also be acceptable for a social worker with a long-standing relationship with the individual and the family to act as Care Co-ordinator. This would be subject to inter-agency agreement, with the final decision on who acts as Care Co-ordinator resting with the LHB.
- 2.69 The 'Care Co-ordinator' role can be referred to as the Lead Professional. We use the term 'Care Co-ordinator' in this document but it reads across to the Lead Professional function.
- 2.70 We note that the term 'Care Co-ordinator' has specific meaning in relation to care and treatment planning for people with mental health needs. Whilst the same professional may also co-ordinate the CHC assessment, they are different functions. Where the Care Co-ordinator changes there should be a formal handover of relevant information.

2.71 The Care Co-ordinator's role includes:

- identifying and securing the involvement of all the appropriate MDT members
- ensuring that MDT members understand their role in the comprehensive assessment and their contribution to the decision-making process;
- ensuring that the individual and/or their representative(s) have all the information they need to understand and fully contribute to the assessment and decision-making process. This will include securing access to advocacy support if required.
- ensuring that all assessments are collated in one place and are of sufficient quality to provide the evidence required to support fair and rational decision-making
- ensuring that there is a clear timetable for the decision-making process and that the process complies with the requirements of this Framework
- ensuring that the MDT's expert advice to the LHB on eligibility and the rationale is clearly recorded and communicated to the necessary parties, including the individual or their representative
- liaising with the individual or their representative(s) within 48 hours of the MDT meeting at which CHC eligibility was determined. This is to ensure that the outcome is fully understood and to answer any questions they may have on reflection.
- ensuring compliance with local protocols including quality assurance arrangements and, if required, disputes resolution and appeals processes, prior to escalation to the next level of management

2.72 Specific responsibilities in regard to the individual or their representative include:

- establish consent
- establish the individual has capacity
- establish the individual or their representative's language, format or method of communication as soon as it is considered the individual may have a primary health need and be eligible for CHC;
- provide the *Continuing NHS Healthcare Booklet for Individuals, Families and Carers* as soon as it is considered the individual may have a primary health need and be eligible for CHC;
- explain timescales and key milestones, including timescales for review
- inform them of other individuals likely to be involved in the process
- inform them of any potential delays
- provide a clear channel of communication between the individual or their representative(s) and the MDT

The role of the Multi-disciplinary Team

2.73 Multi-disciplinary Team (MDT) members are responsible for working with the individual and/or their representatives to undertake a thorough and objective assessment of their

needs, for providing expert advice to the LHB regarding eligibility for CHC and for making recommendations as to the setting and skill set required to deliver the co-produced care plan.

- 2.74 The MDT works together to collate and review the relevant information on the individual's health and social care needs. The MDT uses this information to help clarify individual needs, through the completion of the Decision Support Tool (DST) (**Section 4**) and then works collectively to make a professional judgement about the eligibility for CHC, which will be reflected in its recommendation. This process is known as a multi-disciplinary assessment for eligibility for CHC.
- 2.75 Members of the MDT are responsible for the integrity of their assessments, professional advice and decisions which should be underpinned with a clear rationale. They may be challenged on the quality of their assessment, if for example there are gaps in the information required. They must not be subjected to pressure to change their professional views due to financial constraints.
- 2.76 The Chair of the MDT, who must be one of the members detailed below, is responsible for ensuring that the individual and/or their representative, appears to know what to expect during the MDT meeting, are actively included in the discussion and subsequently understand the rationale for the decision made.

#### Members of the MDT

2.77 It is important that those contributing to this process have the relevant skills and knowledge. MDT members must comprise of health and social care staff presently or recently involved in assessing, reviewing, treating or supporting the individual, who can meaningfully contribute to the assessment process, unless in exceptional circumstances. This allows the individual to have confidence that MDTs involved in the recommendation discussions understand their needs. As a minimum, the MDT must include:

- at least two professionals, who have direct knowledge of the individual and their needs, from different healthcare professions, i.e. nurses, GPs or consultants, occupational therapists, other Specialists e.g. Speech and Language / Behavioural Specialists (unless there is only one such professional with the relevant knowledge)
- a social worker

And could also include the following where appropriate:

- Care home staff
- Domiciliary care staff

2.78 It is not appropriate for senior managers or finance managers from either the LHB or LA to be present in the MDT meeting.

- 2.79 Involving LA colleagues as well as health professionals in the assessment process is essential and will make decision-making more effective, informed and consistent.
- 2.80 The MDT meeting is held to determine a primary health need only. Any dispute between the LHB and LA regarding commissioning of services or funding **must not** be discussed at the MDT meeting. This dispute should be resolved following the dispute resolution process set out in the Framework.

### The role of the Commissioning team

- 2.81 LHBs and LAs, for example, should have an integrated approach to the commissioning of residential and nursing home care, to exercise maximum influence over the development of provision. They will also need to work closely with providers to ensure that an appropriate range of services are in place to respond to the needs of their population. Partners may use formal partnerships with pooled funding arrangements to underpin their integrated approach to commissioning.
- 2.82 Each LHB will have a robust mechanism in place for commissioning the services required to meet the individual's needs, as detailed in the assessment and care plan. It must consider and balance the preferences of the individual, the views of their family/representative(s) and the NHS Wales Sustainable Care Planning Policy. It will have the responsibility for identifying and addressing gaps in local service provision. Further details on commissioning are to be found under Service Provision and Review **(Section 5)**.

### Advocacy

- 2.83 The Code of Practice on Advocacy under Part 10 of the SSWB Act sets out the requirements for LAs to ensure that access to advocacy services and support is available to enable individuals to engage and participate when LAs are exercising statutory duties in relation to them; and to arrange an independent professional advocate to facilitate the involvement of individuals in certain circumstances.
- 2.84 The Independent Mental Capacity Advocate (IMCA) has a statutory role to support and provide legal safeguards for vulnerable individuals who lack the mental capacity to make important specific decisions about their care and circumstances. This may include serious medical treatment or change of residence, for example, moving into a care home. LHBs and LAs have a duty under the Mental Capacity Act 2005 (MCA) to instruct and consult an IMCA if those concerned are individuals who lack capacity in relation to the decision being made and who have no family or friends available (or appropriate) to represent them.
- 2.85 The Mental Health (Wales) Measure 2010 expanded the statutory provision of an Independent Mental Health Advocate (IMHA) already given to those detained under the Mental Health Act 1983 to include people receiving inpatient care and treatment on a

voluntary/informal basis. People subject to Community Treatment Orders or Guardianship under the Mental Health Act 1983 are also entitled to the IMHA provision.

- 2.86 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 LAs should ensure individuals are made aware of local advocacy services and 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 LAs, to act as an advocate on their behalf.

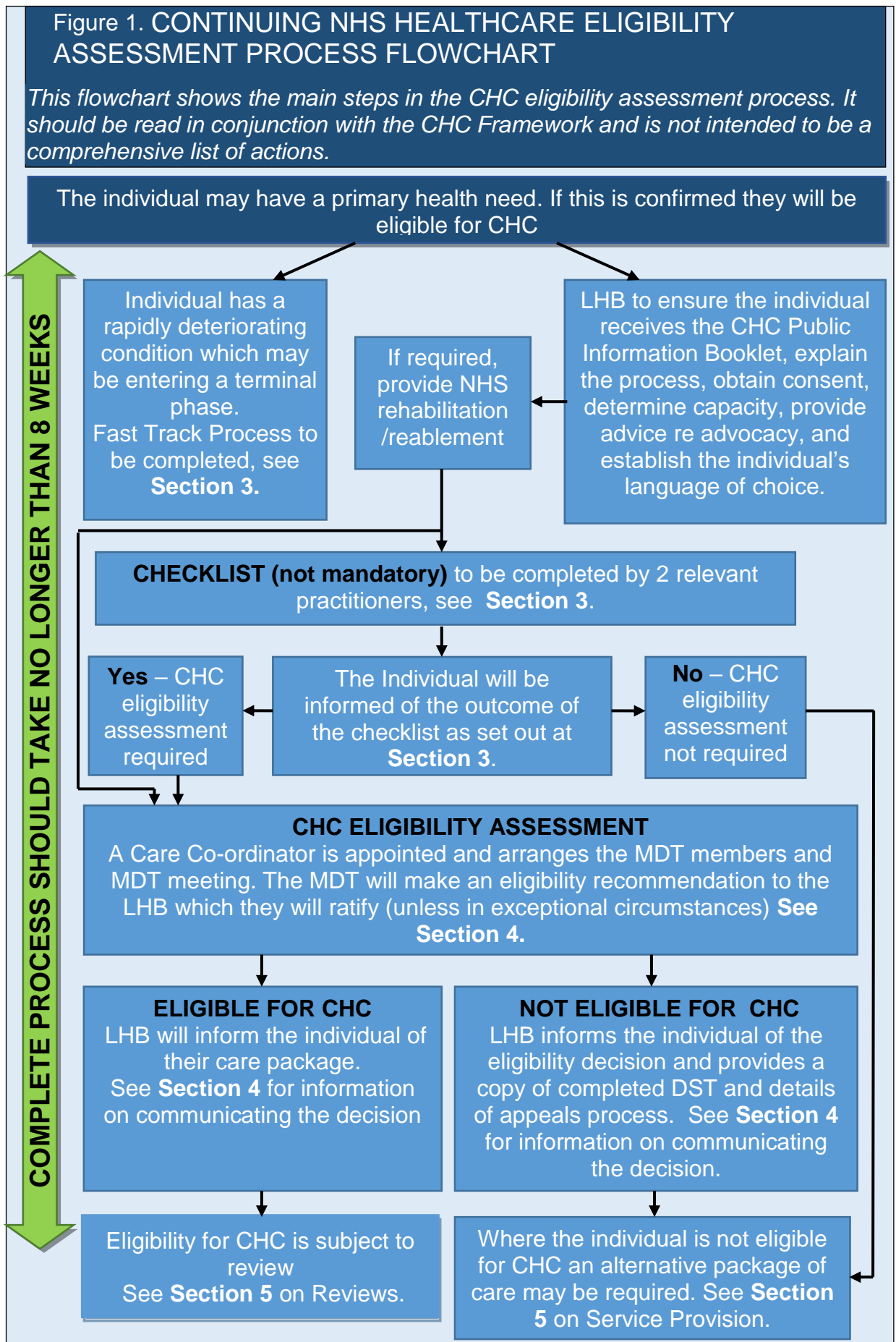
### Unpaid Carers

- 2.87 The Welsh Government has set out the importance of improving the lives of unpaid carers across Wales through setting out three national priorities of: supporting life alongside caring; identifying and recognising carers; and providing information advice and assistance.
- 2.88 The important role played by carers is recognised by both central and local government, irrespective of how the cared-for individual has their care funded. LHBs and LAs have a joint responsibility to identify, and work in partnership with, carers and young carers so that they can be better supported to continue with their caring role, if they are willing and able to do so.
- 2.89 A carer is anyone who, usually unpaid, looks after a friend or family member in need of extra help or support with daily living, for example, because of illness, disability or frailty.
- 2.90 Healthcare professionals and social care practitioners should be proactive in identifying carers and be sensitive to the level of support they need and desire. This empathetic approach should be reflected in any checklist and/or full assessment of eligibility for CHC with carers and family members involved where appropriate.
- 2.91 Where unpaid carers are being asked, or are offering, to provide support, LHBs and LAs have a duty to assess and must offer the carer an assessment for support where it appears to them that the carer may have needs for support. This will include an assessment of the extent to which the carer is able and willing to continue to assume the role. Under the 2014 SSWB Act, carers will:
- have a right to an assessment of their needs for support without the need to formally request an assessment (a local authority's duty to assess is triggered where it appears that the carer may or will have needs as part of their caring role);
  - have a right to support where their need is one that meets with eligibility criteria set out in regulations; and,

- where they have eligible needs, have a statutory support plan which the local authority must review on a regular basis.

2.92 When an LHB is supporting a home-based package where the involvement of a family member or friend is an integral part of the care plan, it should agree with the carer the level of support they will provide. It should also undertake an assessment of the carer's ability to continue to care, satisfying themselves that the responsibilities on the carer are appropriate and sustainable, and establish whether there is an 'appearance of need for support', which would mean that the carer should be referred for a carer's assessment.

2.93 Consideration should also be given to making a referral for a separate carer's assessment by the relevant local authority. Under the SSWB Act, all NHS bodies have a reciprocal duty to cooperate with local authorities in exercise of their respective functions relating to carers. Of particular relevance is the local authority's duty to conduct a carer's assessment 'on the appearance of need for support'. This means that where, on the basis of the steps above the LHB believes that there may be a need for support, a referral should be made. This may be particularly relevant where the carer has needs in relation to education, leisure or work (unrelated to their caring role) as these fall outside the scope of CHC but can be addressed through provisions in the SSWB Act.





## SECTION 3

---

### BEFORE AN ASSESSMENT FOR ELIGIBILITY OF CHC

#### CONSENT

3.1 Where the individual concerned has capacity, their informed consent should be obtained before the start of the process to determine eligibility for CHC. This consent will need to encompass permission to undertake the CHC assessment process and also to the 'sharing and processing of data' (i.e. sharing relevant personal information between professionals in order to undertake the eligibility assessment for CHC and, where appropriate, for audit and monitoring of decisions). For consent to be valid for these purposes it must be:

- **Explicit.** Consent must be expressly confirmed and recorded in writing, in a very clear and specific statement of consent, which is prominent and kept separate from other information.
- **Specific.** It should be made clear to the individual to what they are being asked to consent (e.g. just to having a Checklist completed or to the full assessment of eligibility process as well, if their Checklist is positive) and whether their information will be obtained and shared for a specific aspect of the eligibility consideration process or for the full process. Also, it needs to be explained that, subject to their consent, their personal information will be shared between different organisations involved in their care in order to complete the assessment of eligibility for CHC.
- **Informed.** The individual should be informed about what the CHC eligibility assessment process involves, what information will be obtained, and who it will be shared with before the start of the process to determine eligibility for CHC.
- **Freely given.** This means consent must be given voluntarily by an appropriately informed person who has both the capacity and authority to consent to the intervention in question. It also means giving people genuine ongoing choice and control over how their personal information is used and shared. In the context of CHC this means that the individual must have the capacity to consent freely and voluntarily to the CHC eligibility assessment process as set out in this Framework. The individual should have a choice about whether or not to consent, and consent must not be conditional on the individual agreeing to something that is not related to the CHC eligibility assessment process.

- **Can be withdrawn.** The individual must be made aware that they can withdraw their consent at any time, and made aware of the process for doing so, and that this includes withdrawing consent to share information.

3.2 It should be explained that, depending on the information in question, the decision to withdraw or withhold consent to share information might affect whether it is possible to complete the CHC eligibility assessment.

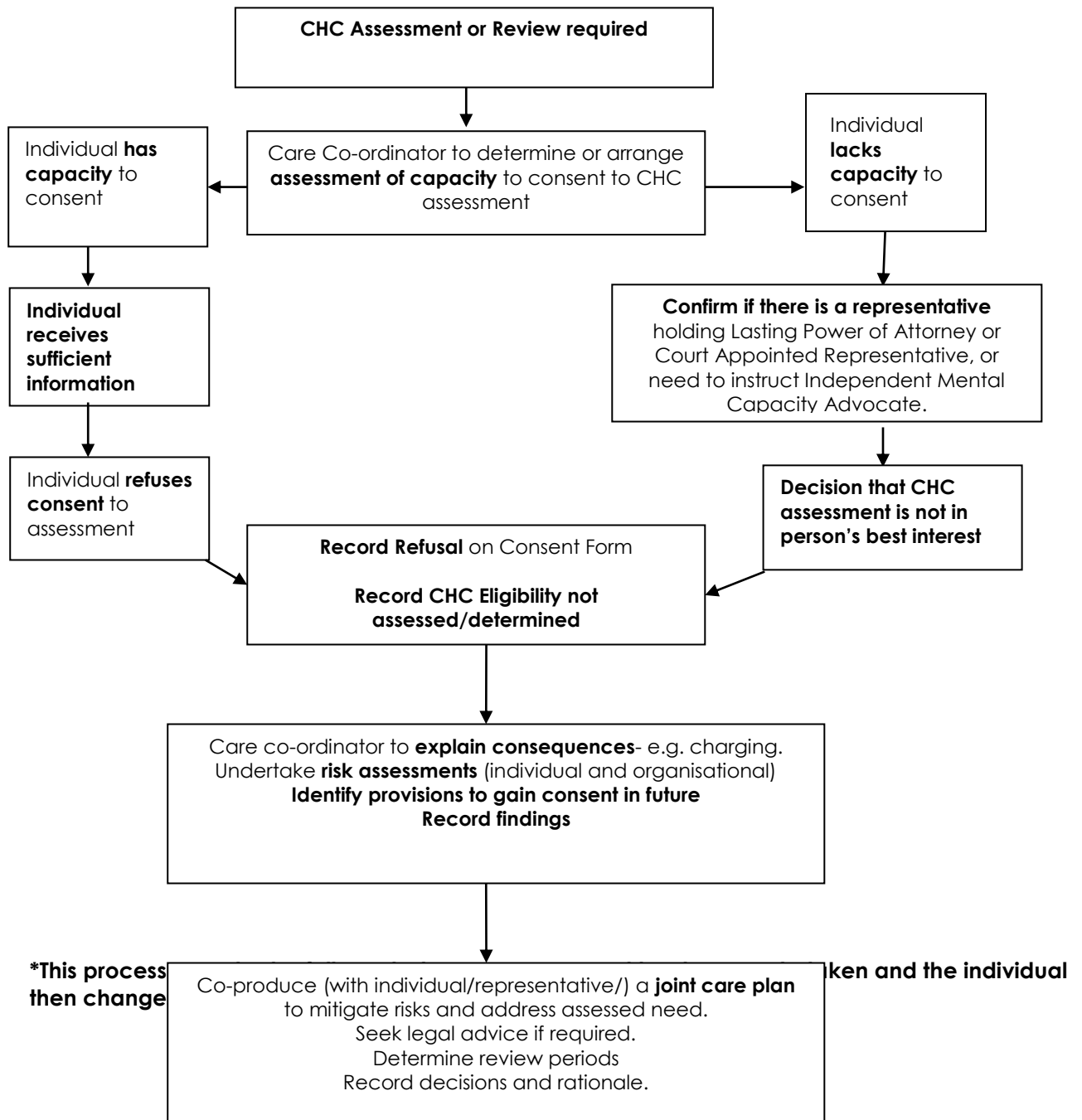
### Refusal to Consent to the CHC Assessment (see Figure 2)

- 3.3 An adult with capacity is entitled to refuse an assessment. If, after providing relevant information and discussing all the options and consequences, an individual refuses an assessment this fact should be documented on the consent form and patient notes. The record should include the stated reasons for the refusal, if given by the person. Although focussed on examination and treatment issues, LHBs should take into account the principles of the guidance [‘Patient Consent to Examination and Treatment’](#) when consenting to an assessment.
- 3.4 If the individual has already signed a consent form, but then changes their mind, this should be noted on the form and preferably signed by them. Professionals should ensure that the individual realises that they are free to change their mind and accept the assessment at a later stage.
- 3.5 If an individual does not consent to an assessment of eligibility for CHC, or changes their mind following an assessment, the individual and/or their representative must be informed of the potential effect this will have on the ability of the LHB or LA to provide appropriate services.
- 3.6 The key consequence of refusing a CHC assessment is that the NHS cannot become responsible for arranging and funding the entire care package and therefore providing care services that are free to the individual. The individual’s long-term care requirements may be met by the NHS and LA sharing responsibility and, as a result, the individual may be charged for a contribution to the local authority arranged services. The individual must be provided with a detailed care plan setting out who will provide which services and what they may be charged.
- 3.7 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 individual following an assessment and if they are found to be eligible. At this point the individual can decline to accept the offer. In these circumstances the LHB cannot become solely responsible for arranging and funding the individual’s future care because they have not agreed to it.
- 3.8 When an individual has the capacity to make a health care decision and has decided to refuse an assessment or care package, follow-up should be arranged with the Care Co-

ordinator, so that they have the opportunity to have a change of mind. The responsible clinician(s) should be told that an assessment or care package was offered and refused.

- 3.9 In the case of individuals lacking capacity, it is important to record whether there is potential for their capacity to make the decision to be restored and when review should take place.
- 3.10 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 LA, taking into account each organisation's statutory legal powers and duties. Where necessary, each organisation should seek legal advice.
- 3.11 Although refusal of consent only occurs in a minority of cases, LHBs and LAs should consider developing jointly agreed protocols on the processes to be followed. These 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.

**Figure 2 Refusing Consent for CHC Assessment\***



## CAPACITY

3.12 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 (**see paragraphs 3.24 to 3.31**).
- **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.

3.13 It is important to be aware that just because an individual may have difficulty in expressing their views or understanding some information, this does not in itself mean that they lack capacity to make the decision in question. Appropriate support and adjustments, for example, using alternative methods of communication, should be made available to the person in compliance with the Mental Capacity Act 2005, and with disability discrimination legislation.

3.14 LHBs and LAs should ensure that all staff involved in CHC assessments are appropriately trained in Mental Capacity Act 2005 principles and responsibilities. Where the assessor is not familiar with Mental Capacity Act 2005 principles and the person appears to lack capacity the assessor should consult their employing organisation and ensure that appropriate actions are identified. Where there is complexity or uncertainty in considering the application of the Mental Capacity Act, all assessors should seek appropriate advice within their organisation.

- 3.15 Language barriers must not be considered a determinant of mental capacity. Consideration must therefore be given to language skill or preference as the medium for undertaking the assessment and appropriate provisions made.

## Sharing of Information

### Individuals without capacity

- 3.16 Under the Data Protection Act 2018, the General Data Protection Regulations 2018 and the Mental Capacity Act 2005, an applicant with an Enduring or Lasting Power of Attorney (EPA or LPA) registered with the Court of Protection may, in general, exercise the patient's rights of access to records on behalf of that patient. However, this is only for information necessary to carry out their duties as an attorney or deputy. There is an important distinction between:

- a) Someone acting as LPA (health and welfare) who will generally be able to exercise the individual's rights of access to health and social care records in order to make informed decisions about their health and welfare. This includes being able to consent (or refuse consent) to the CHC process and to sharing information with relevant professionals involved in the process. The Power of Attorney (POA) has to be registered and this type of POA can only be used if the individual has lost the capacity to make the relevant decision about their health and welfare.
- b) Someone with Enduring Power of Attorney (EPA) or someone acting as LPA (property and finance). The EPA or LPA has to be registered but can be used with the donor's permission to help them make decisions about property and finance even if they still have capacity to make such decisions themselves. More usually, the POA (property and finance) or EPA is used once the individual has lost capacity. Because CHC can have a significant impact on an individual's finances someone with this type of LPA or an EPA may well have legitimate reason for having access to health and social care records but **only** in so far as these are necessary for them to make a particular decision at a particular time regarding property and finance. An obvious example would be for them to have sufficient information to decide whether or not they agree with the eligibility decision made and whether or not to seek a review of that decision. Any health or welfare records which are not directly relevant should not be shared as they may contain sensitive information which the individual would not have wanted shared with the person to whom they gave the right to manage their financial affairs. Generally speaking, the information that they are likely to need should be contained within the Decision Support Tool and the assessments which underlie it.

- 3.17 If someone states that they have such authority the assessor should request sight of a certified copy of the original Deputyship Order or registered LPA and check the wording of the order to confirm that the person does have the relevant authority stated.

3.18 Attorneys and deputies must also act in the person's best interests in accordance with the Mental Capacity Act 2005.

Individuals with capacity

3.19 Where an individual has capacity to make their own decisions, they have the right to be consulted about what information they want shared with relatives/advocates who may be supporting them. The individual can specify they do not want all information shared.

Information from Third Parties

3.20 LHBs often hold information from third parties to inform a comprehensive review (current or retrospective) of an individual's eligibility for CHC. These records typically include care home records, GP notes and records from the local authority (social services).

3.21 The NHS has a duty to protect the privacy of the individuals named in those records but also has a duty as a data controller to consider whether it is reasonable to disclose those records. Any such disclosure will be the minimum information necessary to satisfy the purposes of the disclosure, for example to enable an applicant to contribute usefully to the review process for CHC. Those providing information as part of the CHC process should be reminded of their duties under the Data Protection Act 2018, the General Data Protection Regulations 2018, and Access to Health Records Act 1990 and should be made aware of how the information they provide will be used and shared. In particular, the LHB should ensure that those providing information are asked to confirm that:

- The information provided pertains only to the individual concerned (i.e. it does not include personal/health information about anyone who is not the subject of the CHC assessment and/or review)
- The information provided does not include any information which, if disclosed, would be likely to cause serious harm to any individual, (be that physical or mental harm). The test for serious harm is fairly strict and goes beyond being uncomfortable or unpleasant

3.22 If there is any information in medical records which an individual has provided on the basis that it would not be shared with anyone in any circumstances, it should remain confidential unless disclosure is sanctioned by a Court Order.

3.23 Any information relating to third parties (i.e. information which identifies another individual other than the patient) should be redacted/restricted unless that other individual is a professional, has consented to the disclosure, or, in *all the circumstances*, it is reasonable to disclose that third's party's information without consent.

## BEST INTEREST DECISIONS

3.24 An individual's capacity to make decisions may fluctuate, and there may be circumstances where an individual presents with a temporary loss of decision-making capacity. In these circumstances a decision needs to be made as to whether it would be in the person's best interests whether to proceed with the assessment and sharing of information or to delay seeking consent until capacity is regained. If this is the case, the best interests' decision to be made may also include whether to provide an interim care or support package.

### Making the 'best interests' decision

3.25 Where a 'best interests' decision needs to be made, the decision-maker must take into account the views of any relevant third party who has a genuine interest in the individual's welfare (if it is reasonable and practicable to consult them). This will normally include family, friends and advocates. The decision-maker should be mindful of the need to respect confidentiality and should not share personal information with third parties unless it is considered in the best interests of the individual for the purposes of the CHC assessment of eligibility. Where the individual has made an 'advanced statement' to the effect that they do not want personal information shared with specific individuals, this should be taken into account in assessing the individual's best interests.

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

3.27 In making the 'best interests' decision in such circumstances the decision maker should be mindful of the following factors:

- Whether the individual will regain capacity in the near future? If so, is it possible to delay the CHC process until that patient is able to deal with the process themselves, or provide consent to deal with others?
- What are the relevant circumstances – i.e. would it appear reasonable for example that the particular applicant is acting for the individual?
- What evidence is there of the individual's wishes and feelings? For example, is there any evidence which would suggest that they did not want information shared with the particular applicant?
- Are there any objections or views of others which should be taken into account?



Recording the 'best interests' decision

- 3.28 The 'best interests' decision should be recorded. The person leading the assessment is responsible for making this decision and 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, or for sharing information, on behalf of a person who lacks capacity, unless they have a valid and applicable LPA - Health and Welfare or they have been appointed as a Deputy LPA - Health and Welfare by the Court of Protection.
- 3.29 Where an LA is involved with an individual who lacks mental capacity and an advocate has been appointed, that advocate has a statutory right of access to confidential health and social care information relevant to their advocacy role and function. An advocate would not be appointed solely for the purpose of a CHC assessment. However, where an advocate has already been appointed their role and function legitimately extends, with the individual's consent, to supporting that individual through the CHC assessment process up to the point at which a decision is made that they are eligible for CHC. Where a person has been assessed as eligible for CHC and no other provisions (e.g. safeguarding) apply, the role of the advocate will cease and the LHB will need to consider whether any other advocacy support is required.
- 3.30 Where an Independent Mental Capacity Advocate (IMCA) has been appointed by a LA for an individual who is or subsequently becomes subject to an CHC assessment, the IMCA's role remains limited to the purpose for which they are appointed under the Mental Capacity Act 2005 (e.g. in relation to potential accommodation move or serious medical treatment). The IMCA has a statutory right of access to confidential health and social care information relating to the purpose for which they have been appointed. An IMCA would not be appointed solely for the purposes of a CHC assessment.
- 3.31 Where a person, such as a solicitor or advocate, is acting on behalf of an individual with mental capacity or on behalf of a registered attorney (EPA or LPA) or court appointed deputy for someone who lacks mental capacity then the person may also exercise the rights of access as long as appropriate consent has been given to that person.

## THE FAST TRACK PROCESS

- 3.32 Occasionally, it will be necessary to safeguard an individual's well-being by 'fast tracking' them for immediate provision of CHC. An example of this may be individuals who are rapidly deteriorating. In such circumstances, people can be supported in their preferred place of care without waiting for the full CHC eligibility process to be completed. LHBs must have a robust fast track process in place to complete the assessment process within two days. However, streamlined processes should still ensure that the individual and/or their representative is fully involved.
- 3.33 There will also be cases, other than end-of-life care e.g. a catastrophic event where professional judgement indicates that the individual has evidently developed a primary health need, where LHBs should also consider applying fast track assessment.
- 3.34 Fast track assessments 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.
- 3.35 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 Care Co-ordinator.
- 3.36 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 appropriate clinician to make a decision based on the relevant facts of the case.
- 3.37 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.***
- 3.38 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 **Section 4**. The review should include completion of the DST by the MDT, including a recommendation on future eligibility.

- 3.39 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.
- 3.40 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. An Advance Care Plan should be developed in accordance with Welsh Government policy ([Palliative and End of Life Care Delivery Plan 2017](#)).

## THE USE OF THE CHECKLIST TOOL

- 3.41 LHBs must take reasonable steps to ensure that individuals are assessed for CHC in all cases where it appears that there may be a need for such care. Although not mandatory, if an initial screening process is used to identify where there may be a need for such care, then the Checklist is the *only* screening tool that can be used for this purpose. The Checklist encourages proportionate assessments of eligibility and rationale is provided for all decisions regarding eligibility.
- 3.42 Prior to the Checklist Tool being completed, the practitioner must:
- provide the individual or their representative, a copy of *the Continuing NHS Healthcare Booklet for Individuals, Families and Carers*
  - ensure the appropriate consent is obtained
  - establish the individual's or their representative's language of choice
- 3.43 Completion of the Checklist is intended to be relatively quick and straightforward. It is not necessary to provide detailed evidence along with the completed Checklist. There are two potential outcomes following completion of the Checklist:
- a **Negative Checklist**, meaning the individual does not require a full assessment of eligibility, and they are not eligible for CHC; or
  - a **Positive Checklist** meaning an individual now requires a full assessment of eligibility for CHC. It does not necessarily mean the individual is eligible for CHC.
- 3.44 In order to comply with the ethos of this Framework, the use of the Checklist must not replace professional judgement or dialogue with the individual and/or their representative.

### **When to use a checklist?**

3.45 Screening for CHC should be at the right time and location for the individual and when the individual's needs are known. This will help practitioners to correctly identify individuals who require a full assessment of eligibility for CHC.

### **Who can complete a checklist?**

3.46 The Checklist must be completed by at least 2 practitioners, including a representative of the LA. It can be completed by a variety of health and social care practitioners, who have been trained in its use. This could include, for example: registered nurses employed by the NHS, GPs, other clinicians or LA staff such as social workers, care managers or social care assistants.

3.47 Care homes should contact the relevant CHC team to arrange for a Checklist to be completed for their residents.

### **The role of the individual in the screening process**

3.48 The individual or their representative should be given reasonable notice of the intention to undertake the Checklist and must be given the opportunity to be present on its completion, together with any representative they may have, as set out in **Principle 3: No decisions about me without me.**

3.49 The first page of the Checklist requests the practitioner confirm whether the individual was involved in the completion of the Checklist and whether the individual was offered the opportunity to have a representative such as a family member or other advocate present when the Checklist was completed.

3.50 Before the Checklist is completed, it is necessary to ensure that the individual and / or their representative, understands that the Checklist does not indicate that the individual will be eligible for CHC - only that they are entitled to be assessed for eligibility.

### **How the Checklist should be completed**

3.51 The Checklist requires practitioners to record a brief description of the need and the source of evidence used to support the statements selected in each domain. This could, for example, be by indicating that specific evidence for a given domain was contained within the inpatient nursing notes on a stated date. This will enable evidence to be readily obtained for the purposes of the MDT if the person requires a full assessment of eligibility of CHC.

3.52 The principles of 'well-managed need' (see paragraphs 4.13 to 4.16) apply equally to the completion of the Checklist as they do to the Decision Support Tool.

### **What happens after the Checklist?**

3.53 The outcome must be communicated clearly and in writing to the individual or their representative, in the language/format of their choice, as soon as is reasonably

practicable and should include the rationale for the decision and a copy of the completed Checklist.

### **What happens following a Negative Checklist?**

- 3.54 A Negative Checklist means the individual does not require a full assessment of eligibility and they are not eligible for CHC.
- 3.55 If an individual has been screened out following completion of the Checklist, they may ask the LHB to reconsider the Checklist outcome. The LHB should give this request due consideration, taking account of all the information available, and/or including additional information from the individual and/or their representative, though there is no obligation for the LHB to undertake a further Checklist.
- 3.56 The LHB must provide a written response to the individual or their representative, in response to their request for a re-consideration of the Checklist outcome. This should include information on their rights under the NHS Complaints Procedure if they remain dissatisfied with the position.

### **What happens following a Positive Checklist?**

- 3.57 A Positive Checklist means that the individual requires a full assessment of eligibility for CHC. It does not necessarily mean the individual is eligible for CHC.
- 3.58 An individual should not be left without appropriate support while they await the outcome of the assessment and decision-making process. An individual only becomes eligible for CHC once a decision on eligibility has been made by the LHB. If, at the time of referral for a CHC assessment, the individual is already receiving an ongoing care package (however funded) then those arrangements should continue until the LHB makes its decision on eligibility for CHC, subject to any urgent adjustments needed to meet the changed needs of the individual. In considering such adjustments, LAs and LHBs should have regard to the limitations of their statutory powers.
- 3.59 Where the Checklist has been used as part of the process of discharge from an acute hospital and has indicated a need for full assessment of eligibility, a decision may be made at this stage to provide other services initially and then to carry out a full assessment of eligibility at a later stage. This should be recorded. The relevant LHB should ensure that full assessment of eligibility is carried out once it is possible to make a reasonable judgement about the individual's ongoing needs. This should be completed in the most appropriate setting – whether another NHS setting, the individual's home or some other care setting. In the interim, the relevant LHB retains responsibility for funding appropriate care.
- 3.60 Once an individual has been referred for a full assessment of eligibility for CHC then, irrespective of the individual's setting, the LHB has responsibility for delegating a Care Co-ordinator. See **Section 2** for further information on the role of the Care Co-ordinator.

## SECTION 4

---

### THE ASSESSMENT OF ELIGIBILITY FOR CHC

#### IDENTIFYING AN INDIVIDUAL'S NEEDS

- 4.1 Establishing whether an individual has a primary health need requires a clear, reasoned decision, based on evidence of needs from a comprehensive range of assessments relating to the individual. A good-quality multi-disciplinary assessment of needs that looks at all of the individual's needs 'in the round' – including the ways in which they interact with one another – is crucial both to addressing these needs and to determining eligibility for CHC. The individual and any representative should be enabled to play a central role in the assessment process.
- 4.2 It is important that the individual's own view of their needs, including any supporting evidence, is given appropriate weight alongside professional views. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion naturally progresses, rather than working through an assessment document in a linear fashion.
- 4.3 The multi-disciplinary assessment of an individual's needs informs the process for determining whether or not they are eligible for CHC. However, regardless of whether the individual is determined to be eligible for CHC, LHBs and LAs should always consider whether the multi-disciplinary assessment of needs has identified issues that require action to be taken. For example, if a multi-disciplinary assessment of needs indicates that the individual has significant communication difficulties, referral to a speech and language service should be considered.
- 4.4 If a needs assessment under the Social Services and Well-being (Wales) Act 2014 Act has already been carried out by the LA and is still relevant to an individual's current care and support needs and the outcomes they wish to achieve the local authority may use this assessment as a source of information for the LHB. The LA should provide any other relevant information relating to the individual's up-to-date needs, where appropriate.

- 4.5 Once an individual has been brought to the attention of the LA either through the provision of information advice and assistance or a referral, consideration must be given as to whether an assessment for care and support under the SSWB Act is required. The absence of a needs assessment for care and support should not delay an assessment of eligibility for CHC.
- 4.6 This Framework encourages a joint approach to the assessment of eligibility for CHC and it is important that all agencies respond in a timely manner. Local protocols should set how this is achieved, including in the absence of an existing LA needs assessment under the SSWB Act.

## DETERMINING A PRIMARY HEALTH NEED

- 4.7 The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need. Determining whether an individual has a primary health need involves looking at the totality of the relevant needs. This assessment is undertaken by the MDT (**see the role of the MDT at Section 2**).
- 4.8 Each individual case has to be considered on its own facts in accordance with the principles outlined in this Framework. The following characteristics of need, and their impact on the care required to manage them, will determine whether an individual'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 individual'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.

- 4.9 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.
- 4.10 The diagnosis of a particular disease or condition does not, of itself, determine eligibility. The determination of a primary health need should take into account all the relevant health care needs.
- 4.11 That said there should be no gap in the provision of care. The primary health need test should be applied so ineligibility should only be determined where, taken as a whole, the nursing or other health services required:
- are no more than incidental or ancillary to the provision of accommodation which local authority social services are (or would be but for a person's means) be under a duty to provide; or
  - are not of a nature beyond which a local authority whose primary responsibility it is to provide social services could be expected to provide.
- 4.12 In applying the primary health need test, LHBs should take into account that provisions in the SSWB Act, which requires LAs to apply the incidental and ancillary tests in all situations. LHBs should therefore consider these tests when determining eligibility.

### **Well-managed Needs**

- 4.13 The decision-making rationale should not marginalise a need just because it is successfully managed; well-managed needs are still needs. Only where successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on CHC eligibility. The MDT should therefore give due regard to well-controlled conditions when considering the four characteristics of need and making an eligibility recommendation on primary health need.
- 4.14 Care should be taken when applying this principle. Sometimes needs may appear to be exacerbated because the individual is currently in an inappropriate environment rather than because they require a particular type or level of support. If they move to a different environment and their needs reduce this does not necessarily mean that the need is now 'well-managed'; the need may actually be reduced or no longer exist.
- 4.15 It is also important that deterioration and disease progression are taken into account when considering eligibility. The assessment should anticipate circumstances where deterioration or a material change in condition 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.

- 4.16 The MDT should also advise commissioners of services, such as care homes, if, in their professional opinion, any stabilisation of a progressive condition, and potential withdrawal of CHC funding, is likely to be short-term. In such cases, commissioners should balance the contribution of well-managed need to the current assessment and the benefits to the individual of continuity of care provision, alongside financial considerations.

## **USING THE DECISION SUPPORT TOOL (DST)**

- 4.17 The DST that accompanies this Framework is designed to support the decision-making process. The tool must only be used following a comprehensive assessment of an individual's care needs. It is not an assessment in itself and it does not replace professional judgement in determining eligibility. It is simply a means of recording the rationale and facilitating logical and consistent decision-making.
- 4.18 The MDT should use this tool to support consideration of not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments. Conversely, the DST should not be completed without a multi-disciplinary assessment of needs.
- 4.19 If any assessments relating to the individual's health and wellbeing have recently been completed by practitioners, they may be used to complete the DST. The evidence concerning eligibility and the decision-making process should be accurately and fully recorded. The documentation should be organised e.g. collated into a single folder or section of the patient notes, to ensure the CHC process and the outcomes can be easily identified via a clear audit trail. The focus must be on a rounded and holistic assessment of the individual rather than DST scores.
- 4.20 The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. The tool provides practitioners with a method of bringing together and recording the various needs in 12 'care domains', or generic areas of need. Each domain is broken down into a number of levels. The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided.
- 4.21 The care domains are:
- Breathing
  - Nutrition
  - Continence

- Skin Integrity
- Mobility
- Communication
- Psychological & Emotional Needs
- Cognition
- Behaviour
- Drug Therapies and Medication
- Altered States of Consciousness
- Other Significant Care Needs.

4.22 Completion of the tool should result in a comprehensive picture of the individual's needs that 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. Figure 2 in the Decision Support Tool indicates how the domains in it can illustrate (both individually and through their interaction) the complexity, intensity and/or unpredictability of needs. The overall picture, and the descriptors within the domains themselves, also relate to the nature of needs.

## **PANDEMIC AND OTHER EMERGENCY SITUATIONS**

- 4.23 There is an appreciation that completing a full CHC assessment in hospital during a declared emergency, such as pandemic influenza, would be problematic. As CHC is an assessment of long-term needs, decisions on CHC eligibility should not take priority in these situations. The priority instead should be the safety of the patient, and ensuring they receive the care they need.
- 4.24 In the event of a pandemic or other emergency situation practitioners should refer to the Welsh Government's webpage for up to date information on CHC.

## **MAKING THE RECOMMENDATION ON ELIGIBILITY**

- 4.25 The MDT is required to make a recommendation to the LHB as to whether or not the individual has a primary health need, bearing in mind that where the LHB decides that the individual has a primary health need they are eligible for CHC.
- 4.26 In coming to this recommendation, the MDT should work collectively using professional judgement. All members of the MDT should be present when an eligibility decision is being made.
- 4.27 The written recommendation needs to be clear and concise whilst providing sufficient detail to enable the LHB and the individual to understand the underlying rationale for the recommendation. In doing so, it should;

- provide a summary of the individual's needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs.
- provide statements about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these characteristics provided in **paragraph 4.8**.
- give an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability.
- in the light of the above, give a recommendation as to whether or not the individual has a primary health need. It should be remembered that, whilst the recommendation should make reference to all four characteristics of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

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

4.29 Where an MDT recommends an individual is not eligible for CHC, a clear rationale is needed that considers their circumstances under the four key characteristics of the primary health need test. Care planning for those individuals with ongoing needs, including any consideration for NHS Funded Nursing Care (FNC), will still be necessary.

#### Lack of clear recommendation

4.30 If an MDT is unable to reach agreement on the recommendation this should be clearly recorded.

4.31 The DST advises practitioners to move to the higher level of a domain where agreement cannot be reached but there should be clear reasoned evidence to support this. If practitioners find themselves in this situation they should review the evidence provided around that specific area of need and carefully examine the wording of the relevant DST levels to cross-match the information and see if this provides further clarity. Additional evidence may be sought, although this should not prolong the process unduly. If this does not resolve the situation, the disagreement about the level should be recorded on the DST along with the reasons for choosing each level and by which practitioner. This information should also be summarised within the recommendation so that the LHB can note this when verifying recommendations.

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

## QUALITY ASSURANCE

4.33 It is the responsibility of the MDT to:

- undertake robust needs assessment;
- provide the LHB with consistent expert advice on CHC eligibility;
- develop the care plan to meet the individual's needs, and
- make recommendations regarding the setting and skill set required to most effectively deliver the care plan.

4.34 LHBs and their partners have a responsibility to ensure that MDT members have the knowledge, skills and competency to undertake these functions effectively. LHBs must identify, through their quality assurance system, teams or individuals who fail to follow the CHC process to the expected standard and take the responsive action required to support service improvement.

4.35 Determination of eligibility must be based on assessed need and must be independent of budgetary constraint. LHBs must ensure therefore that there is a clear distinction between the MDT function and confirmation of their conclusions, and the commissioning of the services required to deliver the care plan.

4.36 In the majority of cases, the LHB will accept the MDT's recommendations. In exceptional circumstances, and for clearly articulated reasons, the LHB may request additional evidence to support the MDT's recommendations.

4.37 LHBs must have robust quality assurance (QA) mechanisms in place to ensure consistency of decision-making. This should be in the form of a panel and include peer review by another MDT where consensus has not been achieved. LHBs are also encouraged to incorporate peer review of CHC eligibility decisions into their audit and continuous service improvement programmes.

4.38 Quality assurance processes should not however lead to delay in providing the individual with the support they need and LHBs should consider employing a streamlined process for non-contentious cases.

## COMMUNICATING THE DECISION ON ELIGIBILITY TO THE INDIVIDUAL

4.39 Once the eligibility decision is made by the LHBs following the QA Panel, the decision should be communicated in the individual or their representative's language of choice and should include:

- the decision on primary health need, and therefore whether or not they are eligible for CHC
- the reasons for the decision
- a copy of the completed DST
- details of who to contact if they need further information
- details on how to request an appeal of the eligibility decision if they are dissatisfied with the decision, as set out in **Section 7**.

4.40 Where an individual is not eligible for CHC, the decision letter may also include, where applicable and appropriate, information regarding FNC or a joint package of care.

4.41 Where an individual is eligible for CHC, an indication of the proposed care package, if known, could be included within this communication, or if not known at that stage, information on what the next steps are. Eligibility for CHC is not indefinite, as needs could change. This should be made clear to the individual and/or their representative.

## TIMESCALES AND COMMENCEMENT OF CHC FUNDING

4.42 Care packages must be in place no later than **8 weeks** from the point that it was considered an individual may have a primary health need and be entitled to receive CHC. Extension of the timeframe is only acceptable where further rehabilitation is required. It is not acceptable to extend this period due to the CHC eligibility process.

4.43 In some cases much speedier decisions should be taken in the individual's best interests: for example in terminal illness, or where there has been a catastrophic event from which point it is clear that the individual has a primary health need, further information on Fast Track Assessments are at **Section 3**.

4.44 The care planning process is central to the commissioning and provision of care to meet an individual's needs. Responsibility for this rests with the LHB.

4.45 An individual may require services from the LHB and/or LA. Both have responsibilities, therefore, to ensure assessments of eligibility for CHC takes place in a timely and consistent fashion. The consideration for CHC must always be made first.

4.46 The legal responsibility for the LHB to fund commences at the point at which it confirms the MDT's advice on eligibility. However, the principles of good public

administration dictate that, if an individual has paid for their care in the interim, they should be reimbursed.

- 4.47 As a minimum, reimbursement would normally commence from the date on which the MDT met and made its determination of eligibility. However, the MDT should advise the LHB if they can, in their reasoned professional judgement, identify a date at which the primary health need became evident and the individual should be reimbursed accordingly.

### Planning

- 4.48 In exceptional circumstances timescales may be more protracted, though as an underpinning principle the professionals involved must ensure that the individual is in the most appropriate environment and, wherever possible, re-abled, during this period. The Care Co-ordinator should ensure that timescales, decisions and rationales relating to eligibility are transparent from the outset for individuals, carers, family and staff.

Any exceptions to the 8-week timescale should be monitored locally as part of the performance framework and actioned as appropriate.

- 4.49 Where a person qualifies for CHC, the package to be provided is that which the LHB assesses is appropriate to meet all of the individual's assessed health and associated care and support needs. The LHB has responsibility for ensuring this is the case, and determining what the appropriate package should be. In doing so, the LHB should have due regard to the individual's wishes and preferred outcomes. Although the LHB is not bound by the views of the LA on what services the individual requires, any LA assessment will be important in identifying the individual's needs and in some cases the options for meeting them. Whichever mechanism is used for meeting an individual's assessed needs, the approach taken should be in line with the principles of personalisation.
- 4.50 Care planning for needs to be met under CHC should not be carried out in isolation from care planning to meet other needs, and, wherever possible, a single, integrated and personalised care plan should be developed.

## SECTION 5

---

### SERVICE PROVISION AND REVIEW

#### CARE PROVISION AND MONITORING

- 5.1 The Part 2 Code of Practice of the Social Services and Well-being (Wales) Act 2014 requires local authorities and health boards to conduct a joint Population Needs Assessment (PNA) of care and support services in their region. This means identifying and utilising information about people's well-being, the carers that support them, and the barriers they experience.
- 5.2 The intelligence within these PNAs, combined with corresponding Market Stability Reports around the provision and stability of the services, contribute to strategic Area Plans which will shape the commissioning of care and support at the regional and local level.
- 5.3 The commissioning of services to meet the needs of individuals with continuing care needs cannot be undertaken in isolation to the commissioning of other similar services. LHBs and LAs should have an integrated approach to the commissioning of services, including residential and nursing care homes and domiciliary care to exercise maximum influence over the development of provision. They will also need to work closely with providers to ensure that an appropriate range of services are in place to respond to the needs of their population. The Social Services and Well-being (Wales) Act and the [Partnership Arrangements \(Wales\) Regulations 2015](#) also requires regional partnership boards to establish pooled budgets from April 2018 in relation to the provision of care home accommodation for older people. This should include CHC, FNC and joint packages of care. These pooled budgets will support integrated commissioning allowing local authorities and health boards to focus on improved quality as well as securing better value for money. Regional Partnership Boards are required to promote the use of pooled budgets and to consider them whenever they act jointly. Pooled budget may include funds to cover FNC and CHC commitments and joint packages of care.
- 5.4 The Social Services and Well-being (Wales) Act 2014 Code of Practice relating to Part 4 Meeting Needs, the Unified Assessment Process for other user groups and

Integrated Assessment Framework provide guidance on the arrangements for ongoing monitoring and management of care for adults. In particular, the Code of Practice:

- emphasises the importance of monitoring and reviewing the care and support needs and the personal outcomes the person wishes to achieve, the effectiveness of provision put in place to meet those needs /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.

### **Where a person is eligible for CHC**

5.5 The LHB is responsible to make the necessary arrangements for the individual's care irrespective of their setting. They will work with other organisations to establish an appropriate package of care, accommodation (where appropriate) and support. While the overall responsibility for the care provision 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 social work services
- agreed delegated responsibility, under formal partnership arrangements, for purchasing or providing care
- agreed delegated or shared responsibility for providing ongoing assessment and/or care management
- locally developed joint service provision
- 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
- the provision of equipment via the integrated community equipment services

5.6 The CHC package to be provided is that which the LHB assesses is appropriate for the individual's health and personal care needs. LHBs are encouraged to consider the LAs 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.

5.7 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 health and personal care needs of individuals who are eligible for CHC. Regional partners are expected to develop an integrated approach to the commissioning of care home services, including in relation to negotiating contracts, service specifications, fee negotiations and quality assurance. Partners must establish a pooled fund in relation to care home accommodation functions to support these integrated arrangements.



- 5.8 Unless the function is formally delegated LHBs continue to have responsibility for the case management/care co-ordination 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.
- 5.9 The LHB will have arrangements in place for brokering and commissioning the services required to deliver the detailed care plan. The MDT recommendations and the individual's preferences need to be balanced in accordance with the Sustainable Care Planning Policy.
- 5.10 The LHB must demonstrate a clear rationale for its decision on the CHC package to be commissioned, and should reflect the principles detailed above. This rationale and the care package arrangements must be clearly explained to the individual and/or their representatives and confirmed in writing.
- 5.11 Clear contract arrangements must be established with the service provider. The contract must be outcomes-focussed and include arrangements for regular review.
- 5.12 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. LHBs should ensure that there is clarity on the respective responsibilities of the LHB and providers for CHC.
- 5.13 LHBs will have in place service specifications and contracts for registered settings which cover health and social care and take into account relevant regulations, Standards for Health Services and other relevant guidance and best practice.
- 5.14 Where individuals eligible for CHC are cared for in a care home, escalating concerns will be managed in accordance with the Welsh Government's *'Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults'* Guidance (May 2009). In accordance with this guidance, LHBs and social care agencies should have in place systems and processes which enable registered providers, contract managers, care managers and other professionals to clearly understand what is expected and required from each setting and how such requirements will be delivered and monitored. These systems will frame how agencies contract and work with providers to shape quality services.
- 5.15 LHBs should develop operational procedures to ensure its responsibility for commissioned services are effectively secured and monitored where care is provided by external agencies.
- 5.16 LHBs have a statutory duty under the Health and Safety at Work Act 1974 (HASAWA) to ensure the health and safety of NHS patients is maintained where a provider is providing services on behalf of the NHS. This duty is owed to residents

both by the provider and the NHS commissioning body.

- 5.17 The individual should be advised that welfare benefits available to support the person's living costs may be affected by eligibility for CHC, and should be signposted to appropriate advice. The location of the delivery of the CHC care package will be determined in response to the care plan and in accordance with the [Sustainable Care Planning Policy](#).
- 5.18 The choice of location for those individuals who meet eligibility for CHC will have differing implications for the involvement of other agencies. Where an individual receives their CHC care package in a hospital or care home, the NHS will arrange and fully fund the care, including the accommodation, board costs and personal care. Where an individual 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.
- 5.19 LHBs and LAs should work together to identify gaps in current and future service provision. There is an expectation that partner organisations will share intelligence to inform future workforce planning and to develop market position statements, working with a range of independent and not-for-profit organisations to develop the required provision.

#### **Additional personal contributions from an individual who is eligible for CHC**

- 5.20 The NHS provides a comprehensive service available to all. Access to NHS services is based on clinical need and not on an individual's ability to pay. Public funds for healthcare will be devoted solely to the benefit of people that the NHS serves. As overriding principles, it is essential that: the NHS should never subsidise private care with public money (which would breach core NHS principles) and patients should never be charged for their NHS care, or be allowed to pay towards NHS care (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS. To avoid these risks, there should be as clear a separation as possible between private and NHS care. LHBs should seek to ensure that providers are aware of the above principles.
- 5.21 The care plan should set out the services to be funded and/or provided by the NHS. It may also identify services to be provided by other organisations such as local authorities and third sector providers. Where such non-NHS funded support is provided as part of a total package, the individual and their carers should be signposted by the local authority to clear information on charging arrangements and by the voluntary sector to potential alternative funding sources e.g. benefits and charitable organisations.
- 5.22 In addition to such arrangements, there may be circumstances, as described below, where individuals and/or their representative may choose to access additional services or premium accommodation by making, and paying for, separate arrangements themselves.

5.23 Queries regarding additional personal contributions ('top ups') to CHC packages usually fall into three categories:

- Additional services;
- Higher cost 'premium' accommodation;
- Retaining an existing (more expensive) provider.

#### Additional Services.

5.24 Where a provider receives a request for privately funded additional services from an individual who is funded by CHC, they should refer the matter to the LHB for consideration.

5.25 'Additional services' are defined as those which are over and above those detailed in the care plan developed to address assessed need. Such personal contribution arrangements must never be utilised as a mechanism for subsidising the service provision for which the LHB is responsible.

5.26 Any decision to purchase additional private services must be borne purely through personal choice and not through a lack of appropriate NHS or LA provision to meet assessed need. It is the responsibility of the LHB to engage with the individual and/or their representatives to assure them that this is not the case, and that individuals are not at risk of financial exploitation. If the individual advises that they have concerns that the existing care package is not sufficient or not appropriate to meet their needs, the LHB should offer to review the care package in order to identify whether a different package would more appropriately meet the individual's assessed needs.

5.27 The following examples of where individuals may choose to purchase private services may be helpful:

#### Example 1:

*An individual who is assessed as requiring, and is provided with, one NHS physiotherapy session a week but wishes to purchase an additional session privately. In such circumstances the financial arrangements for the privately funded service will be entirely a matter between the individual and the relevant provider and it should not form part of any service agreement between the LHB and the provider.*

#### Example 2:

*An individual may wish to purchase an additional visit each day from the care provider. The LHB must firstly consider whether it should meet the full costs of the care package. If after review, the LHB is satisfied that the services it has commissioned are appropriate to meet the individual's identified needs, the person may choose to initiate a private arrangement with the care provider. In such a case*

*the LHB will need to liaise with the individual and the care provider to ensure that all parties are clear as to the additional support to be provided in the privately funded visits.*

- 5.28 Although NHS funded services must never be reduced or downgraded to take account of privately-funded care, the LHB and the organisations delivering NHS funded care should, wherever clinically appropriate, liaise with those delivering privately-funded care in order to ensure safe and effective coordination between the services provided. The care plan should detail effective risk management, appropriate sharing of information, continuity of care and co-ordination between NHS funded and privately funded care.

#### Higher Cost 'Premium' Accommodation

- 5.29 As stated above, the funding provided by LHBs in CHC packages should be sufficient to meet the needs identified by the MDT in the care plan. Unless it is possible to separately identify and deliver the NHS funded elements of the service, it will not usually be permissible for individuals to pay for higher-cost accommodation.
- 5.30 There may be exceptional circumstances, to be considered on a case-by-case basis, where a LHB should consider the case for a higher than usual cost, for example, where an individual and/or their representative requests a larger room or a new placement in a care home which charges a rate significantly above that which the LHB would normally pay.
- 5.31 The LHB must liaise with the individual and/or their representative(s) to identify the reasons for the preference. Where the need is for identified clinical reasons (for example, an individual with challenging behaviour who requires a larger room because it is identified that the behaviour is linked to feeling confined, or an individual considers that they would benefit from a care provider with specialist skills rather than a generic care provider), consideration should be given as to whether it would be appropriate for the LHB to meet this.
- 5.32 If no clinical need is established the LHB will need to make a decision which balances the needs and preferences of the individual with the requirement for probity with public funds. See the All Wales Policy for Sustainable Care Planning.
- 5.33 In some circumstances, providers may offer 'extras' such as flower arrangements, daily newspapers etc. as part of their package. In the interests of public probity, it is reasonable to expect individuals and/or their representatives to make separate arrangements to purchase such items directly from the provider as detailed above.

#### Retaining an existing (higher cost) provider.

- 5.34 In some circumstances, individuals become eligible for CHC when they are already resident in care home accommodation for which the fees are higher than the relevant

LHB would usually meet for someone with their needs. This may be where the individual was previously funding their own care or where they were previously funded by a local authority and a third party had 'topped up' the fees payable.

- 5.35 'Topping up' is legally permissible under legislation governing local authority social care but it is not permissible under NHS legislation. In such situations, LHB should consider whether there are reasons why they should meet the full cost of the care package, notwithstanding that it is at a higher rate. Such reasons could include for example the frailty, mental health needs or other relevant needs of the individual which mean that a move to other accommodation could involve significant risk to their health and well-being.
- 5.36 There may also be circumstances where an individual in an existing out of area placement becomes entitled to CHC and where, although the care package is of a higher cost than the responsible LHB would usually meet for the individual's needs, the cost is reasonable taking into account the market rates in the locality of the placement. LHBs should establish this by liaison with the LHB where the placement is located.
- 5.37 LHBs should also consider whether there are particular circumstances that make it reasonable to fund the higher rate. This could be because the location of the placement is close to family members who play an active role in the life of the individual or because the individual has resided in the placement for many years so that they have strong social links with the area and it would be significantly detrimental to the individual to move them.
- 5.38 LHBs should deal with the above situations with sensitivity and in close liaison with the individuals affected and, where appropriate, their families, the existing service provider and the local authority if they have up to this point been funding the care package. Where a local health board determines, following the recommendations from the MDT, that circumstances do not justify their funding an existing higher cost placement or services for which they have inherited responsibility, the LHB does have the authority to move accommodation or change provider. Any decisions should be taken in full consultation with the individual concerned and confirmed in writing with reasons given. Advocacy support should be provided where this is appropriate.
- 5.39 Where an individual becomes entitled to CHC and has an existing high-cost care package, LHBs should consider funding the full cost of the existing higher-cost package until a decision is made on whether to meet the higher cost package on an ongoing basis or to arrange an alternative placement.
- 5.40 Where an individual wishes to dispute a decision not to pay for higher-cost accommodation, they should do so via the NHS Complaints Procedure. The letter from the LHB advising them of the decision should also include details of the complaints process and who to contact if the individual wishes to make a complaint.

- 5.41 In cases of transition, a care plan should be developed by the existing commissioners with the new providers that identifies health and social care needs, and addresses how any specific clinical needs and risks should be addressed. The LHB is responsible for monitoring and reviewing the placement. It should keep in regular liaison with the new provider and with the individual during the initial weeks of the new services to ensure that the transition has proceeded successfully and to ensure that any issues that have arisen are being appropriately addressed.

### **Supporting individuals eligible for CHC in their own home**

- 5.42 Where an individual is eligible for CHC and chooses to live in their own home, the LHB is financially responsible for meeting all assessed health and associated social care needs. This does not include the cost of accommodation, food or general household support. There is a range of everyday household costs that are expected to be covered by personal income or welfare benefits, including food, rent/mortgage interest, fuel and water, clothing and other normal household items.
- 5.43 Whilst LHBs can take comparative costs and value for money into account, they must not set arbitrary limits on care at home packages based purely on the notional costs of caring for an individual in a home.
- 5.44 People who are eligible for CHC and who choose to live in their own home may have additional support needs which it may be appropriate for the local authority to address subject to SSWB Act provisions and eligibility guidance, e.g. assistance and advice regarding property adaptation, support with essential parenting activities, deputyship or appointeeship services, safeguarding concerns, carer support or services required to enable the carer to maintain his/her caring responsibilities.

## **RESPONSIBLE BODY GUIDANCE FOR THE NHS IN WALES**

- 5.45 The [Responsible Body Guidance](#) provides a framework for establishing the body responsible for securing secondary and tertiary health care for an individual within the NHS in Wales. It replaces the Establishment of District of Residence guidance set out in DGM (94) 15 and DGM (93) 133. Whilst policy has changed since then, the guidance had not been formally revised.
- 5.46 The legal basis for the directed functions of LHBs is set out in the [Local Health Boards \(Directed Functions\) \(Wales\) Regulations 2009](#). The Responsible Body Guidance is intended to provide guidance on the application of that legal framework to particular situations.
- 5.47 In general, the responsible body will be the LHB where the person considers himself or herself to be usually resident. This is explained in detail in Section 2 of the

guidance. The subsequent sections provide further clarification regarding the responsible body in particular cases and situations.

- 5.48 In cases where people are assessed as eligible for CHC, and are placed, or have already been placed in a care home outside their home area, the placing LHB will remain responsible for funding the care home placement. The LHBs involved should liaise to ensure that appropriate arrangements are in place before the patient moves.
- 5.49 In identifying responsibility, all parts of the NHS are expected to act in the best interests of the patient at all times, working together in partnership, and to abide by the fundamental principle.

**Fundamental Principle**

**The safety and well-being of patients is paramount. The overriding principle is that no treatment should be refused or delayed due to uncertainty or ambiguity as to which body is responsible for funding an individual's healthcare provision.**

## **VOICE AND CONTROL, DIRECT PAYMENTS AND CHC**

- 5.50 It is currently unlawful for Direct Payments to be used to purchase health care which the NHS is responsible for providing, however it is not unlawful for local authorities and health boards to work together to provide individuals with voice and control in respect of their health and social care needs.
- 5.51 LHBs must have a robust mechanisms in place for commissioning the services required to meet the individual's needs, as detailed in the assessment and care plan. They must consider and balance the preferences of the individual, the views of their family/representative(s) and the '*Sustainable Care Planning in Continuing NHS Healthcare: Operational Policy for Health Boards in Wales.*'
- 5.52 Where an individual whose care was arranged utilising Direct Payments becomes eligible for CHC funding, the LHB must work with them in a spirit of co-production. Although Direct Payments will no longer be applicable where an individual has a primary health need, this should not mean that the individual loses their voice, choice and control over their daily lives.
- 5.53 LHBs should consider a range of options to ensure voice and control for the individual, including the following:
- **Maintaining personnel**  
When a person develops a primary health care need, the health board must work to maintain continuity of personnel delivering care, where the individual wishes this to be the case and it can contribute to meeting their needs. The health board

could employ staff (either directly or via an agency), e.g. personal assistants, previously employed by the individual under direct payments.

➤ Independent User Trusts

Health boards could also consider providing funding to an Independent User Trust, to manage an individual's care. This is where a relative of a patient or other interested party sets up a trust which becomes the provider of care for the individual. The LHB then contracts with the trust to provide specified health care services for the individual.

- 5.54 There may be circumstances where it is possible for an individual to retain some Direct Payment for the elements of their care for which the local authority is still responsible, e.g. opportunities for social inclusion. Partner organisations must work together to explore all the options available to maximise an individual's independence.
- 5.55 Further guidance on these measures will be published on the Welsh Government website.
- 5.56 An individual in receipt of Direct Payments (or any individual) retains the right to refuse to consent to a CHC assessment and /or care package, as detailed in **Section 3**. In such cases, partner agencies must work together with the individual and their family/carers to ensure that the risks are fully understood and mitigated as far as possible. If a person is assessed as eligible for CHC but refuses a care package, there may be an impact on the way their care is delivered. It cannot automatically be assumed that LAs will continue to provide those services, as this may mean that they are acting outside of their legal authority.

**Where a person is not eligible for CHC**

- 5.57 Where it has been determined that a person is not eligible for CHC and an alternative package of care is required (e.g. FNC in a care home, or a joint package of care in the community), the lead role will normally lie with the LA, 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.
- 5.58 This care plan must not require a LA to provide services which are beyond its powers to provide. However, neither the LHB nor the LA can dictate what the other organisation can provide.
- 5.59 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.



- 5.60 A written agreement should also be established with the individual and/or their representative, clearly setting out what is covered by NHS funding, what may be accessed via the local authority subject to its eligibility criteria, and what the individual will be responsible for.

## JOINT PACKAGES OF HEALTH AND SOCIAL CARE

- 5.61 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.
- 5.62 Increasing numbers of people with complex care needs are being supported in the community. If services are to be truly outcome-focussed, person-centred, supporting independence and not diagnosis-led, then it is logical that, where sustainable, individuals will be supported for longer at home with joint packages of care.
- 5.63 If an individual is not entitled to CHC but has some healthcare and social care needs, they should receive a package of health and social care that is tailored to their individual needs. 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 LA to agree their respective responsibilities in joint care packages and ensure seamless provision of care.
- 5.64 As a matter of principle, if an individual has existing Direct Payment arrangements, these should continue wherever and for as long as possible within a tailored joint package of care.

### Joint funding in care home placements.

- 5.65 Where an individual is not eligible for CHC but has health needs which are different from, or additional to, those supported by FNC, 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.
- 5.66 There may be some individuals in care home placements who do not have a primary health need indicating eligibility for CHC but are acknowledged to have nursing needs greater than would normally be expected to be covered by the FNC rate and what can be reasonably expected for an LA to commission. Along with this Framework, [Welsh Health Circular \(2004\) 024 \(NHS Funded Nursing Care in Care Homes\)](#) states that there should be no gap between local authority and NHS provision.

- 5.67 Options available to LHBs to meet their responsibility in providing this additional level of health care include NHS in-reach from core services or additional financial contribution to the total funding package. LHBs and local authorities will need to work together to ensure that neither body is operating outside of its statutory duty. The funding arrangements and the LA contribution for which the individual may be charged must be confirmed in writing by the lead agency and shared with commissioners, providers and the service user and/or representative.
- 5.68 Examples of additional services to funded nursing care, which may also be provided by the NHS if these are agreed as part of an assessment and individual care plan include (but are 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.
  - community mental 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).

Joint funding of packages of care delivered in an individual's own home.

- 5.69 More, and increasingly complex, packages of care are being delivered in an individuals' own homes. Where an individual is not eligible for CHC, a comprehensive joint health and social care package must be developed and agreed co-productively which meets the person's assessed care and support needs and achieve personal outcomes. This must be detailed in a clear inter-agency care plan, with a named care co-ordinator/lead professional, which is jointly owned by commissioners, providers and the individual and/or their representative.
- 5.70 LAs have a responsibility to meet people's needs for care and support in accordance with the Social Services and Well-being (Wales) Act 2014, as set out at paragraph 1.23.
- 5.71 The joint funding arrangements will be determined locally and in accordance with the needs and outcomes of the individual. Options available include the use of a joint funding matrix or formalised pooled budget arrangements. The individual should not experience delay in receiving their care package whilst funding arrangements are negotiated.

5.72 A written agreement should also be established with the individual and/or their representative, clearly setting out what is provided by the LHB, what may be accessed via the local authority subject to its eligibility criteria and charging, and for what the individual will be responsible.

## **REVIEWS (3 AND 12 MONTHS)**

### **Purpose and frequency of reviews**

- 5.73 Any care package, regardless of the funding source, should be regularly reviewed in partnership with the individual and/or their representatives to ensure that it continues to meet their needs.
- 5.74 As a minimum there should be an initial review of the care plan within 3 months of services first being provided, unless this is triggered earlier by the individual or their representative or the provider. Thereafter, reviews should be at least annually. Where an individual's condition is anticipated to deteriorate, more regular review may be necessary.
- 5.75 Reviews should follow the format of an assessment, consider all the services received and be tailored to the individual.
- 5.76 These reviews should primarily focus on whether the care plan or arrangements remain appropriate to meet the individual's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility.
- 5.77 Where an individual's condition is anticipated to deteriorate, more regular review may be necessary. The frequency of such reviews will be determined by professional judgement based on the individual's assessed needs or if there is a change in circumstances. They should be proportionate to the situation in question in order to ensure that time and resources are used effectively. Where there is an obvious deterioration in circumstances, reviews should also be held within 2 weeks and acted upon appropriately.
- 5.78 The individual and/or their representative and the service provider must be provided with the contact details of a named care co-ordinator, so that any changes in the individual's condition or circumstances can be promptly addressed.
- 5.79 Review timescales should be identified and communicated to the individual and their relatives verbally and in writing. For those receiving secondary mental health services there is a legal requirement to review their care at least every 12 months and

in line with the Code of Practice to Part 2 and 3 of the Mental Health (Wales) Measure 2010.

- 5.80 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.
- 5.81 The most recently completed DST should be available at the review and used as a point of reference to identify any potential change in needs. Where there is clear evidence of a change in needs to such an extent that it may impact on the individual's eligibility for CHC, the LHB should arrange a full reassessment of eligibility for CHC.
- 5.82 Where reassessment of eligibility for CHC is required, a new DST must be completed by a properly constituted MDT, as set out in this Framework. The individual and or their representative must be invited to attend the MDT as set out in **Principle 7: No decisions about me without me**. Where appropriate, comparison should be made to the information provided in the previous DST. LHBs are reminded that they must consult with the LA before making an eligibility decision, including any re-assessment of eligibility. This duty is normally discharged by the involvement of the LA in the MDT process, as set out in the Assessment of Eligibility section of this Framework (**Section 4**). LHBs should ensure an individual's needs continue to be met during this reassessment of eligibility process.
- 5.83 If the LA is also responsible for any part of the care, both the LHB and the LA will have a requirement to review care and support needs and ensure that personal outcomes are being met by the provisions in place. 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.
- 5.84 Individuals who are in receipt of FNC in a care home must also be reviewed at least annually. The LHB must ensure that the individual, their family/representative and care home provider have the information and contacts available to enable them to identify changes in need which indicate a timely review is required.
- 5.85 When reviewing the need for FNC, potential eligibility for CHC must always be considered and a full assessment should be carried out, where necessary.
- 5.86 Care providers who monitor their own service effectiveness should contribute this information to the review of the whole plan of care.
- 5.87 The review should be recorded and set out:

- who was involved
- those individuals not involved and reasons why
- the location
- the method of review
- issues that the individual (or carer/advocate) raised.

5.88 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. The individual and the carer or representative should be provided with the Continuing NHS Healthcare Information Booklet at the commencement of their CHC care package.

#### Outcomes of a review

5.89 The review will determine whether:

- the individual's needs are being met appropriately,
- whether eligibility should be reconsidered through a MDT reassessment for CHC.
- whether the individual's needs have changed, which then determines
- whether the package of care needs to be revised or the funding responsibilities altered.

5.90 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.

5.91 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.

5.92 If the individual and/or their representative 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.

5.93 The CHC Independent Review Panel (see **Section 7**) 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.

- 5.94 Services cannot be discontinued without a full re-assessment being carried out at a formal MDT meeting.
- 5.95 Providers must be made aware, within the contract documentation, of their responsibilities to notify the funding body of any marked deterioration or significant improvement and any other issues affecting the delivery of care.
- 5.96 Neither the LHB nor the LA 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. Therefore, in order to ensure continuity of care, if there is a change in eligibility, it is essential that alternative funding arrangements are agreed and put into effect **before** any withdrawal of existing funding. 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 Section 7**) should be invoked and current funding arrangements should remain in place until the dispute has been resolved.
- 5.97 The risks and benefits to the individual of a change of location or support (including funding) should be considered carefully before any move or change is confirmed. Neither the LHB nor the LA should unilaterally withdraw from funding of an existing package until there has been appropriate reassessment and agreement on future funding responsibilities and any alternative funding arrangements have been put into effect. Further details on responsibilities during changes (including approaches to disputes) are set out in **Section 7**.

## SECTION 6

---

### LINKS TO OTHER POLICIES AND SPECIALIST AREAS OF PRACTICE

#### LINKS TO MENTAL HEALTH ACT 1983 - AFTERCARE SERVICES

- 6.1 Under Section 117 of the Mental Health Act 1983 (the 1983 Act), health and social services authorities have a duty to provide or arrange 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. It should be borne in mind, however, that some people may be eligible for care and support under both CHC and Section 117.
- 6.2 Section 117 is a free-standing joint duty. Local health boards (LHBs) and local authorities (LAs) should develop protocols to help determine their respective responsibilities for the delivery of Section 117 aftercare (see for example Mental Health Act 1983 Code of Practice for Wales, chapter 31). This Framework does not therefore attempt to provide additional guidance on this issue, but focusses on the interface between Section 117 and eligibility for Continuing NHS Healthcare.
- 6.3 Responsibility for the provision of Section 117 is shared between LAs and LHBs, although this does not necessarily mean there should be a 50/50 split in all cases. Where a patient is eligible for services under Section 117 these should be provided under Section 117 and not under CHC.
- 6.4 All those subject to Section 117 are considered to be in receipt of secondary mental health services, as defined under the Mental Health (Wales) Measure 2010 (the Measure) and will therefore have a Care Co-ordinator and an outcome-focussed prescribed Care and Treatment Plan (CTP) that is reviewed at least annually. Detailed guidance regarding care and treatment planning is given in the Code of Practice to Parts 2 and 3 of the Measure.
- 6.5 There are no powers to charge for services provided under Section 117 of the 1983 Act, regardless of whether those services are provided by LHBs or LAs. Accordingly, the question of whether services should be 'free' NHS services rather than potentially charged-for 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.

- 6.6 However, an individual in receipt of after-care services under Section 117 may also have additional needs which are not related to their mental disorder. For example, an individual may be receiving services under Section 117 and develop separate physical needs, for example following a stroke, which may then mean they are eligible for CHC or FNC.
- 6.7 In such cases, the general approach set out in this Framework of considering the totality of need in assessing eligibility for CHC still applies. The individual may as a result, have the services required to meet their total care needs funded by the NHS, but this does not necessarily remove the shared *duty* under Section 117. The Section 117 shared duty remains unless a joint assessment and agreement by both the LA and the LHB determines that those arrangements are no longer needed.
- 6.8 Where an individual in receipt of Section 117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase (or a catastrophic health event which clearly requires CHC), consideration should be given to the Fast Track process.
- 6.9 Where an individual is to be discharged from Section 117, eligibility for CHC or FNC will need to be considered where the transition assessment and plan indicates that new or other services may be required.
- 6.10 Information should be provided to the individual or their representative on the effect that discharge from Section 117 may have on their financial circumstances.

## DEPRIVATION OF LIBERTY SAFEGUARDS

- 6.11 The Mental Capacity Act 2005 contains provisions that apply to a person who lacks capacity and where care arrangements amount to a deprivation of their liberty. The fact that a legal authorisation is being sought or is in place in relation to a deprivation of liberty of capacity does not affect the consideration of whether that person is eligible for CHC. The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system in April 2022. LHBs must ensure they are compliant with this new legislation when it is in force
- 6.12 Where an individual is in receipt of CHC, and they lack mental capacity to consent to their accommodation, or care and support arrangements, the LHB must ensure that the arrangements they commission are lawful and compliant with provisions under the Mental Capacity Act.



## TRANSITION FROM CHILD AND YOUNG PERSON'S TO ADULT PROVISION

- 6.13 This Framework should be used to determine eligibility for CHC and what services people aged 18 years or over should receive from the NHS. The Framework should be used in conjunction with the [Welsh Government's Children's and Young People's Continuing Care Guidance](#) (2020) and the Sustainable Care Planning in Continuous NHS Health Care operational policy for local health boards (2012) and the Social Services and Well-being (Wales) Act 2014. Key principles for transition from children's to adult's services for young people using health or social services are outlined in National Institute for Health and Care Excellence ([NICE](#)) [guidance \(2016\)](#) and support best practice which equally applies to young people with continuing care needs.
- 6.14 The legislation and the respective responsibilities of the NHS, social services and other services are different in children and young persons (CYP) and adult services. The term 'continuing care' also has different meanings in CYP and adult services. The Children and Young People's Continuing Care Guidance was issued in January 2020. The guidance applies to children and young people whose health needs cause them to require a bespoke multi-agency package of continuing care that cannot be met by existing universal or specialist services alone. Although the main reason for such a package will derive from the child or young person's health needs, they are likely to require multi-agency service provision involving input from education, social services and sometimes others. CHC for adults refers to a package of care which is arranged and funded solely by the NHS for those individuals who have been assessed as having a primary health need. The LA will retain the responsibility for meeting any ongoing educational needs.
- 6.15 It is important that young people and their families are helped to understand this and its implications right from the start of transition planning.
- 6.16 While service provision and the meaning of the term 'Continuing NHS Healthcare' is different pre- and post-18 years, the needs of the individual will not automatically change because an individual has reached 18 years of age. Individuals with complex needs, regardless of their age, require continuous review and assessment to ensure that their needs are met in the most effective way. The assessment and review process should continue throughout transition.
- 6.17 Transition is an area that can cause anxiety for children, their parents and carers. When some young people move from CYP services to adult services they experience uncertainty about future care provision and support and also the loss of income due to changes in benefits. Each LHB must draw up a robust local transition policy with its partner agencies.

- 6.18 Transitional arrangements with key milestones must be identified in care plans and LHBs must work with their partners and with the young person and their family/carer to agree a process for transition from CYP services into adult services.
- 6.19 All of the partner agencies must ensure that practitioners with the appropriate skills and knowledge are available to contribute to the assessment and care planning process. Appropriateness of practitioners will be indicated by the child or young person's presenting needs.
- 6.20 Initial planning for transition to adult CHC services must commence when the young person is aged 14, where the need is already identified or as soon as possible, if problems emerge that will require ongoing care, after this age. A lead professional must be identified and supported by all the agencies involved. This person will act as the Transition Co-ordinator and key point of communication for the individual and their family. There is an expectation that partners will work together to define and agree the role and responsibilities of the Lead Professional/ Transition Co-ordinator.
- 6.21 Support during transition should be routinely provided up to 19 years of age, though there will be cases where such support may be required up to the age of 25 years, for example, local authorities have the discretion to support a young person in the process of leaving care, who may need ongoing support with support living/emotional support.
- 6.22 Once the young person reaches 16 years of age there should be a formal referral for screening to the appropriate adult CHC team. At the age of 17, eligibility for adult CHC should be determined in principle by the relevant HB, bearing in mind that, in complex cases, needs can change in the course of a year. Local multi-disciplinary teams will need to use their professional judgement regarding the timing of assessment and review to ensure that effective packages of care can be planned and commissioned in time for the individual's 18<sup>th</sup> birthday. If needs are likely to change, it may be appropriate to make a provisional decision and then to recheck it be repeating the process as adulthood approaches.
- 6.23 Even if a young person is not entitled to adult CHC, provision of services for health needs is 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 services to meet these needs are provided. The focus should always be mutually agreed and take into account the individual preferences.
- 6.24 A key aim is to ensure that a consistent package of support, jointly designed and agreed by the young person and their carers, is provided based on assessed need. The nature of the package may change because the young person's needs or circumstances change. However, it should not necessarily change simply because of the move from CYP 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 and their

family. No services or funding should be withdrawn unless a full assessment has been carried out of the need for adult health and social services.

- 6.25 Service provision should be tailored for the individual and may be drawn from a combination of sources, including core (e.g. primary care, district nursing, social services), specialist services (e.g. mental health, learning disability, residential educational placements) as well as individually funded elements of the package. The potential complexity of the package means that effective care co-ordination by the designated lead professional is essential. The individual and their family must be provided with a detailed and co-produced multi-agency care plan which sets out which services will be provided by whom, including funding arrangements.
- 6.26 Financial implications for the young person and their family, including any changes to benefits or other funding sources such as Direct Payments, must be clearly explained at the earliest possible opportunity. Accommodation and independent living choices should be fully explored, and a clear explanation provided of entitlements and options. Support for carers must be included in the care plan, in accordance with the Social Services and Well-Being Act.
- 6.27 The young person and their family/carers should not experience any delay in receiving the services they require whilst funding sources are being negotiated. Partner agencies should consider joint/pooled resource, including budget arrangements to ensure that the right care is provided at the right time.
- 6.28 There is a risk that the tailoring of comprehensive packages of care (be they CHC or joint funded) for children and young people with complex needs can lead to families feeling overwhelmed by the numbers of people involved. Co-ordination of care, active involvement of a designated lead professional, and effective communication will do much to mitigate that risk.
- 6.29 In order to continue to provide effective support to the increasing numbers of young people with complex needs who move to adult service provision, there is an expectation that partner agencies and providers will share intelligence and work together to address any emerging skills and service gaps. Examples may include developing a workforce (registered and unregistered) which has a broad range of skills to support young people and adults with a combination of physical, mental health and learning needs, and developing market position statements to bring residential provision closer to home.
- 6.30 Compliance with the guidance on transition will be assessed via the Performance Management Framework.

## APPLYING THE CHC FRAMEWORK TO ADULTS WITH A LEARNING DISABILITY

- 6.31 [‘The Statement on Policy and Practice for Adults with a Learning Disability’](#), published in 2007, sets out the key principles, aims, responses and outcomes the Welsh Government believes are desirable. This is the Welsh Government’s latest guidance and is still relevant today.
- 6.32 In 2017 a review of learning disability services was undertaken to identify areas where action could potentially be taken to build on good practice in Wales taking a lifespan approach and considering all main service areas. This review resulted in the Learning Disability Improving Lives Programme of work which contains 24 recommendations focusing on improving services in five key areas: Early Years; Housing; Social Care; Health; and Education, Skills and Employment (June 2018)’.
- 6.33 It is expected that partnerships will work in collaboration to ensure that evidenced need is appropriately met. Care packages should be developed in accordance with the Mental Capacity Act 2005 or the Mental Capacity (Amendment) Act 2019 when it is in force, and the following long-established principles, [‘The Origins of Person-Centered Planning’](#):
- a. Community Presence
  - b. Relationships & Partnerships
  - c. Choice
  - d. Competence
  - e. Respect & Status
  - f. Individuality & Continuity
- 6.34 Many individuals with a learning disability already live in supported living environments. In order to maintain continuity and stability for the individual, joint care packages which utilise staff with whom they are familiar, supplemented by flexible health and social care responses, must be the preferred option wherever it is safe to do so from a clinical and social perspective. Funding arrangements will change once an individual has been assessed as having a primary health need (**see Section 4**) but disruption to the individual should be minimised as far as possible.
- 6.35 In all cases, eligibility for CHC should be informed by good quality multi-disciplinary assessment. It will be important to involve all professionals who know and are involved with the individual. The question is not whether learning disability is a health need, but rather whether the individual concerned, whatever client group he or she may come from, has a ‘primary health need’.
- 6.36 NHS and social care service providers have a responsibility to ensure that their staff have the inclusive skills required to assess and support people with a learning

disability. Access to care should not be restricted to specialist learning disability services.

- 6.37 Where an individual is presenting with behaviours that challenge, there is an expectation that the MDT will have undertaken the appropriate assessment to attempt to determine the cause.

## ENTITLEMENT TO OTHER NHS FUNDED CARE

- 6.38 Those in receipt of CHC continue to be entitled to access the full range of primary, community, secondary and other health care services regardless of care setting.
- 6.39 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 (**see Section 5**).

## COMMUNITY EQUIPMENT

- 6.40 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.
- 6.41 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. The care home should normally provide equipment which can or is used by a number of residents i.e. it is not prescribed for an individual. Equipment which is specifically prescribed for an individual and should not be used by other residents should be provided by the LHB.
- 6.42 LHBs have the option to contribute to the existing formal partnership and pooled fund arrangements for community equipment services to purchase and manage CHC equipment to benefit from existing procurement arrangements. Alternatively, where LHBs purchase CHC equipment separately they should consider an agreement with the joint store to manage this equipment to ensure that appropriate servicing and maintenance are in place. Where the LHB maintains completely separate arrangements for CHC equipment it must have in place systems to keep track of equipment, maintain and service it and recall and refurbish when no longer required.
- 6.43 LHBs should ensure that there is clarity about which of the above arrangements is applicable in each individual case.

## SECTION 7

---

### DISPUTES AND APPEALS

#### DISPUTES BETWEEN ORGANISATIONS

##### Principles

- 7.1 It should be remembered that decisions regarding eligibility for CHC are the responsibility of the LHB, who may choose to make their decision before an inter-agency disagreement has been resolved. In such cases it is possible that the formal dispute resolution process will have to be concluded after the individual has been given a decision by the LHB.
- 7.2 The Welsh Government expects LHBs and their partners to work together to deliver the best possible outcomes for the citizens of Wales.
- 7.3 The fundamental principle is for LHBs and LAs to minimise the need to invoke formal inter-agency dispute resolution procedures through effective partnership working, integration and implementation of this Framework.
- 7.4 In the first instance, where the MDT is unable to reach a consensus view on CHC eligibility, they should escalate the dispute to the appropriate managers and access peer review from within, or outside of, their LHB. Normally, this should be within 2 working days.
- 7.5 If mature partnership discussion, including objective managerial/clinical expertise and peer review, has failed to achieve a consensus view, the formal dispute process will need to be initiated.
- 7.6 Where disputes relate to LAs and LHBs in different geographical areas, the dispute resolution process of the responsible LHB should normally be used in order to ensure resolution in a robust and timely manner

##### Protocols

- 7.7 LHBs and LAs should have in place locally agreed procedures/protocols for dealing with any formal disputes about

- eligibility for CHC and/or about the apportionment of funding in jointly funded care packages.
- where an individual is not eligible for CHC:
  - the contribution of either party to a joint package of care
  - the operation of refunds guidance

7.8 These protocols should make clear how the LHB discharges its duty to consult with the local authority and how the LA discharges its duty to co-operate with the LHB. **(See Section 1).**

7.9 LHBs and LAs must maintain a culture of genuine partnership working in all aspects of CHC. They should ensure eligibility decisions are based on thorough, accurate and evidence-based assessments of the individuals' needs. Individuals must never be left without appropriate support while disputes between statutory bodies about funding responsibilities are resolved. They should be kept at the heart of the process and there should be a person-centred approach to decision-making.

7.10 If there is an opportunity to resolve inter-agency disagreements this should be explored and undertaken at the earliest opportunity and preferably at an informal stage. Any genuine disagreements between practitioners must be undertaken in a professional manner, without drawing the individual concerned into the debate, or attempting to gain the individual's support for one professional's position or the other.

7.11 Practitioners in health and social care receive high-quality joint training (i.e. health and social care) which gives consistent messages about the correct application of the Framework.

7.12 Disputes must 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 LAs in different geographical areas, the relevant NHS body and LA 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.

7.13 All stages of disputes procedures will normally be completed within four weeks of raising the dispute. All stages will be appropriately documented.

### **What should a protocol contain?**

7.14 When developing and agreeing local inter-agency disagreement and dispute resolution protocols, LHBs and LAs should both encompass the following elements:

- A brief summary of principles, including a commitment to work in partnership and in a person-centred way.

- The LHB's and the LA's various duties to consult with each other. This should include arrangements for situations where the local authority has not been involved in the MDT and in formulating the recommendation.
- An 'informal' stage at operational level whereby disagreements regarding the correct eligibility recommendation can be resolved – this might, for example, involve consultation with relevant managers immediately following the MDT meeting to see whether agreement can be reached. This stage might include seeking further information/clarification on the facts of the case or on the correct interpretation of this Framework.
- A formal stage of resolving disagreements regarding eligibility recommendations, involving managers and/or practitioners who have delegated authority to attempt resolution of the disagreement and can make eligibility decisions. This stage could involve referral to an inter-agency CHC panel.
- If the dispute remains unresolved, the dispute resolution agreement may provide further stages of escalation to more senior managers within the respective organisations.
- A final stage involving independent arbitration. This stage should only be invoked as a last resort and should rarely, if ever, be required. It can only be triggered by senior managers within the respective organisations who must agree how the independent arbitration is to be sourced, organised and funded.
- Clear timelines for each stage.
- Agreement as to how the placement and/or package for the individual is to be funded, pending the outcome of dispute resolution and arrangements for reimbursement to the agencies involved once the dispute is resolved. Individuals must never be left without appropriate support whilst disputes between statutory bodies about funding responsibility are resolved.
- Arrangements to keep the individual and/or their representative informed throughout the dispute resolution process.
- Arrangements in the event of an individual requesting a review of the eligibility decision made by the LHB.

## **APPEALS AGAINST ELIGIBILITY DECISIONS FROM INDIVIDUALS**

- 7.15 The formal responsibility for informing individuals of the decision about eligibility for CHC and of their right to request an appeal against that decision 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, and explain the arrangements and timescales for dealing with a review of the eligibility decision in the event that the individual or someone acting on their behalf disagrees with it.
- 7.16 If an individual or their representative disagrees with the eligibility decision for either CHC or NHS Funded Nursing Care, and intend to appeal that decision, they must inform the relevant LHB of their intention to appeal within 28 days of receipt of the decision letter.



- 7.17 Written notification of intention to appeal a decision outside of the 28 days period will only be accepted in exceptional circumstances.
- 7.18 The individual must submit their written appeal to the relevant LHB within 6 months of the individual /or their representative being informed of that decision. Requests made after this time period will only be considered in exceptional circumstances.
- 7.19 An individual or their representative may appeal to the relevant LHB if they are dissatisfied with:
- the procedure followed by the LHB in reaching its decision on the individual's eligibility for CHC or FNC, or
  - how the primary health need was considered.
- 7.20 LHBs must give this request due consideration, taking into account all the information available, including any additional information from the individual or their representative.
- 7.21 It is important to note that the appeals process is different to the **Retrospective Claims for Reimbursement** process. The appeals process relates to appeals against an eligibility decision on either CHC or FNC. The Retrospective Claims for Reimbursement process, set out at **Section 8**, relates to claims from individuals or their representatives, where they contributed to the cost of their care but have reason to believe that they may have met the eligibility criteria for CHC due to the nature, intensity, complexity and/or unpredictability of their healthcare needs.

#### Local Resolution

- 7.22 Where the individual and/or their representative disputes the clinical assessment of the MDT, external (from another directorate or LHB) peer review should be offered as a matter of course, as soon as is practicable to do so.
- 7.23 LHBs should deal promptly with an appeal that requests a review of a decision about eligibility. A clear and written response should be given including the individual's rights to complain under the NHS Complaints Procedure.
- 7.24 Each LHB must have local review processes, including timescales, in place. These should be available publicly and set out the stages and timescales of the appeals process.
- 7.25 Once local procedures have been exhausted, referral to the Independent Review Panel should be considered (See below).

- 7.26 If the original decision is upheld by the Independent Review Panel and the individual still wishes to challenge the decision, the individual has access to the Public Services Ombudsman for Wales.
- 7.27 The individual's rights under the existing NHS Complaints Procedure 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 above, the matter should be considered through the appropriate complaints procedure.
- 7.28 LHBs are accountable for ensuring that processes are in place and their staff have the skills and resources required to determine CHC eligibility correctly first time.
- 7.29 LHBs 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, as detailed above. They should ensure that appropriate assessments have been undertaken, applied, recorded and peer reviewed. Where the patient still wishes to contest the decision, the LHB will consider whether it is appropriate to convene the review panel.

## PROMOTING CONSISTENCY IN THE OPERATION OF INDEPENDENT REVIEW PANELS

### Independent Review Panel

- 7.30 The Independent Review Panel (IRP) process (**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 FNC or CHC has not been correctly applied in their case, or that appropriate procedures have not been followed.
- 7.31 If the local review process, including peer review, indicates that there is an element of doubt then recourse to the IRP process should be granted.
- 7.32 There should be recourse to the IRP process if the individual or their representative has significant additional information to present or exceptional circumstances apply.
- 7.33 Before taking a decision, the LHB will seek the advice of the chair of the review panel. In all cases where a decision not to convene a panel is made, a full written explanation of the basis of its decision should be provided to the individual and/or their representative, together with a reminder of their rights under the NHS Complaints Procedure.

- 7.34 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 CHC.
- 7.35 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 FNC.
- 7.36 When reviewing the need for FNC, potential eligibility for CHC should always be considered and a full assessment carried out where necessary.
- 7.37 LHBs must ensure that arrangements are in place for:
- the establishment and operation of independent panels (**see Annex 4**)
  - providing any additional translation or communication services so that individual and/or their representatives may fully engage with the process.
  - access to independent clinical advice where needed, taking into account the range of medical, nursing and therapy needs in each case. Advisers 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.
- 7.38 In order to avoid delay and to maximise available expertise LHBs should implement an Independent Review Panel process as described in **Annex 4**. 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.
- 7.39 LHBs are responsible for ensuring that the Independent Review Panels operate to a consistent standard and must make arrangements for the appropriate training and mentorship of all panel members.
- 7.40 There is an expectation that the partner agencies will allocate sufficient time within normal working hours for panel members to prepare sufficiently for the Panel proceedings. The importance of the role of a member of the Independent Review Panel should be reflected in their employing organisations through their job description and personal objectives.
- 7.41 The Panel's deliberations must be unanimous and properly recorded and communicated, with a clear rationale provided for their decision. This must be in line with the provisions under **Principle 7**.

## COMPLAINTS

- 7.42 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, 'Putting Things Right', which is the appropriate mechanism for lodging such a complaint.
- 7.43 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 LHB. Under the Regulation and Inspection of Social Care (Wales) Act 2016, 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 Inspectorate Wales (CIW) 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 protecting adults at risk.
- 7.44 It is good practice for LHBs and LAs 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.
- 7.45 Information on all relevant complaints procedures should be available in all service provision settings. The need for advocacy should be considered where appropriate.
- 7.46 Individuals who are dissatisfied with the way in which the NHS, an LHB or CIW investigates their complaint may complain to the Public Services Ombudsman for 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.
- 7.47 Further information on the NHS Complaints Procedure is contained in: [Putting Things Right: raising a concern about the NHS \(Welsh Government, 2020\)](#).

## SECTION 8

---

### RETROSPECTIVE CLAIMS FOR REIMBURSEMENT

- 8.1 An individual and/or their representative may request a retrospective review where they contributed to the cost of their care but have reason to believe that they may have met the eligibility for CHC due to the nature, intensity, complexity and/or unpredictability of their healthcare needs. A retrospective review claim is different from an appeal against a current CHC assessment and decision on eligibility. The appeals process is outlined in **Section 7**.
- 8.2 If eligibility is demonstrated for either the full or part period of the claim, the principles of good public administration demand that timely restitution be made.
- 8.3 As with the process of determining CHC eligibility, the retrospective claim process is not a legal process. Consideration of an individual's eligibility for a retrospective claim involves the use of distinct processes such as the All Wales Retrospective CHC Review to analyse the chronology of need over the entire period of the claim, as opposed to the Decision Support Tool, which provides indications of need over a snapshot in time. It is delivered by the LHB and therefore no charge will be made to the individual.
- 8.4 The process for making a claim is set out in **Figure 3**, below. If the individual and /or their representative wish to access support in following the process they may seek advice from the LHB itself, from voluntary sector advocacy or they may choose to engage a solicitor to act on their behalf. If eligibility is found, reimbursement will not cover the costs of any legal fees incurred.
- 8.5 Each LHB should publish a point of contact to which retrospective claims may be submitted.
- 8.6 The claim may be submitted by either:
- the individual who is the subject of the claim.
  - a person authorised by the individual to receive reimbursement on his/her behalf.
  - a person holding a registered Enduring or Lasting Power of Attorney or who is a Court-appointed deputy for an individual who lacks mental capacity.

- in the case of a deceased individual, an executor named in the Grant of Probate in respect of the deceased's estate or an administrator named in the Grant of Letters of Administration of the estate.

8.7 Reimbursement, should eligibility be found, will only be paid to the above.

8.8 The process for considering the claim period for a retrospective review is as follows:

- the end of the claim period to be considered will be **no longer than 12 months** before the date of application.
- if the claim period is after a MDT/Independent Review Panel (IRP) decision of no eligibility, the period to be reviewed may go back to the date of the decision as long as it is no longer than 12 months.
- if the claim period is prior to a MDT/IRP decision, no longer than a 12 month period will be reviewed.
- **within 5 months** of registering the claim, claimants will be required to provide evidence of:
  - proof of fees paid to care home or domiciliary agency (see **Annex 5**)
  - where the claimant is not the patient, their right to make the claim on the individual's behalf (i.e Enduring/Lasting Power of Attorney or Grant of Probate).

8.9 LHBs need to balance their requirement to provide timely restitution with that of demonstrating probity with the public purse. Making an application does not mean that reimbursement is guaranteed; LHBs must satisfy themselves that the application is genuine and that the person was indeed eligible for CHC during the disputed period.

8.10 Applications outside of the stated claim period may be considered in exceptional circumstances where there is justification. Such circumstances can include for example, the claimant suffering critical illness, serving with the armed forces or living abroad. This is not an exhaustive list and other circumstances may apply.

**The process for considering retrospective claims is as follows:**

- i. Evidence of legal authority to make the application and proof of payment of care fees will be provided by the claimant.
- ii. A claim form (including a request for the claimant's views), a consent form and an Information Booklet are sent to the claimant.

- iii. On receipt of the consent form, proof of payment and legal authority to make the claim, requests are made to the appropriate care providers for records. In accordance with the all-Wales protocol for obtaining records, all agencies are allowed a maximum of 3 months to provide the records or to inform LHBs that they have been destroyed, lost or are unavailable for any other reason.
- iv. A comprehensive chronology of need is produced from a range of available records including a claimant statement, care home records (inc. care plans, risk assessments and daily diaries etc, GP, district nurse and any other available and relevant clinical records. If any of these records are unavailable then the records that are available will be used.
- v. The guidance in this Framework must be applied to the claim.
- vi. Stage 1 Review – The All Wales Retrospective CHC Review (AWRCR) document is used to produce the Stage 1 chronology of need. The Checklist is then applied to the information in the Stage 1 AWRCR. If there are no triggers for consideration of eligibility, the case is closed at this point. An IRP Chair must ratify if the recommendation is “no eligibility” or “partial eligibility.” If Chair disagrees with the recommendation of partial or no eligibility, then the case should proceed to Stage 2 on the basis of the highest level of eligibility suggested e.g. full rather than partial; partial rather than no eligibility. If the claimant/their representative is already eligible for FNC or CHC, the case should proceed directly to Stage 2, without the need for a Stage 1 Review.
- vii. In order to comply with the ethos of this Framework, the use of the Checklist must not replace professional judgement. Claimants should be sent a written explanation of the outcome of the application of the Checklist to their claim.
- viii. Stage 2 Review - If triggers are found for all or part of the period, the Stage 1 chronology of need is transferred to a Stage 2 AWRCR, all other records are added and this is the document used by the clinical reviewer to analyse the evidence and make a recommendation on eligibility. This is done by analysing the information in the chronology using the 4 key indicators of Nature, Intensity, Complexity and Unpredictability, applying the primary health need approach for the claim period.
- ix. On completion of the analysis, the document will be peer reviewed by a different clinician to ensure the recommendation is robust, based on the evidence available and that the criteria have been consistently applied. If the clinicians do not agree, the case will be referred to the Independent Review Panel (IRP).
- x. In cases where no eligibility is found, the document will be peer reviewed by at least one further different clinician to ensure that the evidence supports the recommendation made.

xi. The recommendation on eligibility will be made on the evidence available. It can be 1 of 4 possibilities:

- **matching**- the period of eligibility found matches the claim period in totality from the trigger date
- **partial**- eligibility is found for part of the claim period from the trigger date
- **no eligibility** found for any part of the claim period from the trigger date
- **Panel** - the reviewer has been unable to make a decision as the information available is complex or the clinicians are unable to agree on the period of eligibility.

xii. Dependant on the recommendation made, the case will go along 1 of 3 pathways:

- **matched** cases will go directly for ratification
- **partial** and **no eligibility** cases will be forwarded to claimants with the opportunity to discuss the findings
- **Panel** cases- an Independent Review Panel will be convened.

8.11 The claimant and/or their representative will be invited to discuss cases where partial or no eligibility has been found:

- Partial eligibility- the discussion will aim to reach a mutually acceptable period of eligibility based on the evidence available and/or new evidence that has not previously been available. If agreement is reached at this stage, the case will be forwarded for scrutiny and ratification. If no agreement is reached, the case will be forwarded for IRP consideration.
- No eligibility- the discussion will provide opportunity for further explanation of the CHC criteria and to check that the claimant/representative has understood the lack of evidence on eligibility. The case will then be forwarded to an IRP Chair for ratification.

If claimant seeks an IRP, the health board should seek advice from an IRP Chair on whether to hold IRP. The Chair would be required to provide advice to the health board answering the following:

- Whether the health board had followed the appropriate procedures (due process)
- Did the health board apply all available evidence to the domains and the 4 Key Indicators to determine eligibility or otherwise, and
- Was there a robust rationale for the decision?

### Independent Review Panel

8.12 If the peer review indicates that there is an element of doubt then recourse to the IRP process should be granted.

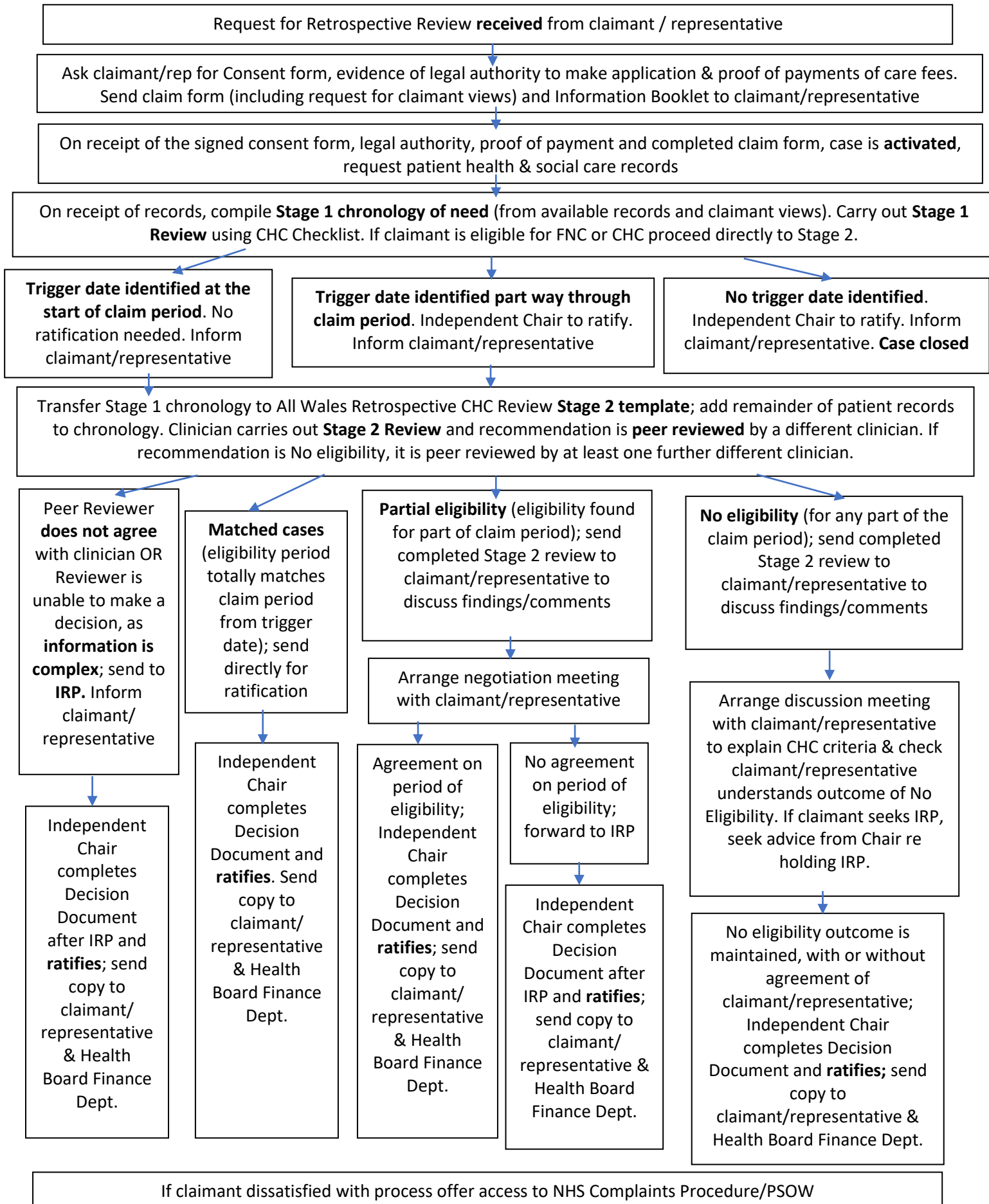


- 8.13 There should be recourse to the IRP process if the individual or their representative has significant additional information to present or exceptional circumstances apply.
- 8.14 Before taking a decision, the LHB will seek the advice of the Chair of the review panel. The Chair provides the lay perspective in the review process. In all cases, where a decision not to convene a panel is made, a full written explanation of the basis of its decision should be provided to the individual and/or their representative, together with a reminder of their rights under the NHS Complaints Procedure and access to the Public Services Ombudsman for Wales.
- 8.15 The following principles and processes should be followed for all IRP cases:
- all decisions of the IRP should be unanimous. (The Panel attempts to reach a unanimous decision but if not possible a majority decision is accepted.)
  - an All-Wales Decision Document will be completed by the person scrutinising and ratifying the recommendation made/Chair of the IRP.
  - a copy of the completed Decision Document is provided to the claimant/representative and the LHB Finance Department.
  - in cases of no eligibility, if a claimant does not wish to attend a meeting in person, the recommendation should be discussed over the telephone or in writing as far as possible.
  - in cases of partial eligibility, a claimant not wishing to attend the negotiation should be able to discuss the recommendation over the phone. An IRP should then be convened.

### **Responsibility for the management of claims**

- 8.16 In July 2015 the Welsh Government issued additional guidance in respect of proof of payment for reimbursement of retrospective claims ([WHC\(2015\)039](#)).
- 8.17 From April 1, 2019 LHBs became responsible for the management of all retrospective claims.
- 8.18 Claimants who are dissatisfied with the review process are able to access the NHS Complaints Procedure and have recourse to the Public Services Ombudsman for Wales, as outlined in **Section 7**.

Figure 3: Process for undertaking a Retrospective Review



## Glossary of Terms

### **All Wales Retrospective CHC Review Document**

There are different arrangements concerning the administration of ongoing or contemporary CHC cases and those of backdated, or retrospective ones. The DST is used in contemporaneous assessments and provides a picture of the needs at one point in time. A retrospective review covers a long period of time and it is necessary to identify changes in need over that period that may indicate eligibility /no eligibility at different times based on identified need. The All Wales Retrospective CHC Review document (formerly the All Wales Needs Assessment document) is based on the DST but facilitates the identification of needs over an extended period of time which may be divided in to a number of periods depending on the length of the whole claim period.

### **Assessment**

Assessment involves a balanced analysis of the individual's needs, resources and capacities and the outcomes they want to achieve, in order to identify how they can best be supported to achieve them.

### **Behaviours that challenge**

Behaviours that challenge are 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.

### **Care Home**

An establishment registered under the Regulation and Inspection of Social Care Act 2016 to provide accommodation, together with nursing or personal care.

### **Care Planning and Review**

Care Planning and Review is a dynamic process, bringing together the individual, their carers and professionals to agree how their needs can best be met, the actions needed and who will do them.

### **Care and Support Package**

A combination of support and services designed to meet individual's assessed health and social care needs, as detailed in the Care and Support Plan.

### **Care and Support Plan**

A Care Plan must contain:

- plans and actions to be undertaken to help achieve the desired outcomes;
- the roles and responsibilities of the individual, carers and family members and practitioners (including for example GP, Nurse), and the frequency of contact with those;
- the resources (including financial resources) required from each party; and

- the review and contingency arrangements and how progress will be measured.

### **Carer**

The Social Services and Well-being (Wales) Act 2014 defines a carer as a person who provides or intends to provide care for an adult or disabled child. The definition excludes those who provide or intend to provide care under, or by virtue of, a contract or as voluntary work.

### **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.

### **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**

Commissioning involves a set of activities by which local health boards and local authorities ensure that services are planned and organised to best meet the health and social care outcomes of people in Wales. It involves understanding the need of their populations, best practice and local resources and using these to plan, implement and review changes in services. It encompasses both planning and procurement.

Commissioning requires a whole systems perspective and applies to services across all sectors. Commissioning services to respond to the needs of people with continuing health care should not be undertaken in isolation to commissioning other closely related services.

Local health boards can delegate the function of commissioning to local authorities and local authorities can delegate the function of commissioning to local health boards whilst still retaining their statutory responsibilities. This facilitates the development of a coherent approach to commissioning services such as, for example, residential and nursing home care or reablement and intermediate care services with one approach to developing contracts, service specifications, fee settings and quality assurance.

### **Continuing NHS Healthcare (CHC)**

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.

### **Decision Support Tool**

The Decision Support Tool (DST) is designed to support the decision-making process. The tool must only be used following a comprehensive assessment of an individual's care needs. It is not an assessment in itself and it does not replace professional judgement in determining eligibility. It is simply a means of recording the rationale and facilitating logical and consistent decision-making.

The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. It provides practitioners with a method of bringing together and recording the various needs in 12 'care domains' (see below), or generic areas of need. Each domain is broken down into a number of levels of severity.

### **Domain**

One of 12 key areas of consideration within the integrated assessment and the Decision Support Tool. These are breathing, nutrition, continence skin integrity, mobility, communication, psychological & emotional needs, cognition, behaviour, drug therapies and medication, altered states of consciousness and other significant care needs.

### **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.

### **Funded Nursing Care – see NHS Funded Nursing Care**

### **General Household Support**

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

### **IRP**

Independent Review Panel

### **Intermediate Care**

A range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living. 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.

### **Lead Professional/Care Co-ordinator**

This is the person who:

- co-ordinates the assessment process, and draws in additional specialists as required;
- acts as a focus for communication for different professionals and the individual to make sure that information is recorded correctly; and,
- ensures that any problems or difficulties in the co-ordination or completion of an assessment are resolved.

For people with mental health needs the Mental Health Measure makes specific requirements regarding who the Care Co-ordinator should be.

### **LA**

Local authority

### **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 in order 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 is distinct from intermediate/transitional/interim care which has specific time limited outcomes for rehabilitation, reablement or recuperation.

### **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 or disability of the mind'.

### **Multi-disciplinary or Multi-agency**

These terms refer 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.

### **National Integrated Assessment Framework**

This is the Welsh Government Framework that applies to promoting wellbeing, assessment, care planning and review arrangements for services for people aged 65+ irrespective of presenting need, disability or condition and supports access to care and support in the community. (**See Annex 1**)

### **NHS**

National Health Service

### **NHS Funded Nursing Care (FNC)**

The provision of NHS Funded Nursing Care derives from Section 49 of the Health and Social Care Act, 2001 (now replaced, in relation to Wales, by Section 47(4) and (5) of the Social Services and Well-being (Wales) Act 2014), which excludes nursing care by a registered nurse from the services which can be provided by local authorities. NHS Funded Nursing Care applies to all those persons currently assessed as requiring care by a registered nurse in care homes. The decision on eligibility for NHS Funded Nursing Care should only be taken when it is considered that the person does not fall within the eligibility criteria for CHC.

### **Palliative Care**

The active holistic care of patients with advanced, progressive illness. This includes the 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, "special category information" (e.g. health information). Those terms have the same meaning as "personal data" and "special category data" in the Data Protection Act 2018.

### **Power of Attorney**

an applicant with an Enduring or Lasting Power of Attorney registered with the Court of Protection may, in general, exercise the patient's rights of access to records on behalf of that patient, but only to the extent that the information is necessary for them to be able to carry out their duties as an attorney or deputy. There is an important distinction between:

- a) Someone acting as Lasting Power of Attorney (health and welfare) who will generally be able to exercise the patient's rights of access to health and social care records in order to make informed decisions about their health and welfare. This includes being able to consent (or refuse consent) to the CHC process and to sharing information with relevant professionals involved in the process. The Power of Attorney (POA) has to be registered and this type of POA can only be used if the individual has lost the capacity to make the relevant decision about their health and welfare.
  
- b) Someone with Enduring Power of Attorney (EPA) or someone acting as Lasting Power of Attorney (property and finance). Again the EPA or LPA has to be registered but can be used with the donor's permission to help them make decisions about property and finance even if they still have capacity to make such decisions themselves. More usually, the POA (property and finance) or EPA is used once the individual has lost capacity. Because CHC can have a significant impact on an individual's finances someone with this type of LPA or an EPA may well have legitimate reason for having access to health and social care records but **only** in so far as these are necessary for them to make a particular decision at a particular time regarding property and finance. An obvious example would be for them to have sufficient information to decide whether or not they agree with the eligibility decision made and whether or not to seek a review of that decision. Any health or welfare records which are not directly relevant should not be shared as they may contain sensitive information which the individual would not have wanted shared with the person to whom they gave the right to manage their financial affairs. Generally speaking the information that they are likely to need should be contained within the Decision Support Tool and the assessments which underlie it.

### **Primary Health Need**

An individual is deemed to be eligible for CHC when their primary need is a health need: 'the primary health need approach'. This is determined by consideration of the four key characteristics of need: nature, intensity, complexity and unpredictability.

### **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. This definition should be viewed in the context of the policy of the Welsh Government to move to a more integrated approach. The Social Services and Well-being (Wales) Act 2014 emphasises the duty of local authorities and local health boards to work together to develop integrated primary, community and well-being services that are focussed on the holistic needs of people.

### **Social services and Wellbeing (Wales) Act 2014**

The Social Services and Well-being (Wales) Act (SSWBA) came into force on 6 April 2016.

The SSWBA 2014 provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales. It transforms the way social services are delivered, promoting people's independence to give them stronger voice and control.

The fundamental principles of the SSWBA 2014 are:

- Voice and control – putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being.
- Prevention and early intervention – increasing preventative services within the community to minimise the escalation of critical need.
- Well-being – supporting people to achieve their own well-being and measuring the success of care and support.
- Co-production – encouraging individuals to become more involved in the design and delivery of services.

### **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.

**Sustainable Care Planning Policy**

This is a policy which has been developed and adopted by all local health boards in Wales for use when considering care planning options appropriate to meet the assessed need for people eligible for CHC. It describes the approach to fair and sustainable care planning within CHC and to the management of a fair allocation of resources within the wider context of care planning considerations.

## APPENDICES

### Annex 1: Legal Judgments

#### The Coughlan judgment

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

A 1.1 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.

A 1.2 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.

A 1.3 The Court examined the language of the relevant sections of the National Assistance Act 1948 (“the Care Act”) and the National Health Service Act 1977 (“the Health Act”) and acknowledged that the Health Act is the dominant act. The Court noted that the Secretary of State’s duty under Section 3 of the Health Act 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.

A 1.4 The Court went on to consider the limits on the provision of nursing care by local authorities (in a broad sense, i.e. not just registered nursing). 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.

A 1.5 This case was decided before the enactment of Section 49 of the Health and Social Care Act 2001. 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.

A 1.6 Eligibility for CHC must always be considered prior to any consideration of eligibility for NHS Funded Nursing Care. The interaction between CHC and NHS funded Nursing Care was further considered by the High Court in R v. Bexley NHS Trust, ex parte Grogan [2006]12. The Court also acknowledged that the extent of the Secretary of State's duties to provide health services is governed by the health legislation and not by the limits of the duties of local authorities.

A1.7 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.

A1.8 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 judgment 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 authority is one of degree which will depend on a careful appraisal of the facts of an 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; 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, they can be provided under Section 21 of the National Assistance Act 1948.

1. 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
2. The services that can appropriately be treated as responsibilities of a local authority under Section 21 may evolve with the changing standards of society
3. Where an individual'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
4. An assessment of whether an individual 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
5. 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)
6. 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)

A1.9 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.

A1.10 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.

A1.11 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.

## Annex 2: Overview of Standard Assessment & CHC Eligibility Decision-Making Process

TIMEFRAME					
<b>PROCESS</b>		<b>Up to 8 weeks</b> (extension of the timeframe is acceptable where further rehabilitation is required. but should not be due to the CHC eligibility process)			
		<b>1 week max.</b>	<b>2 weeks</b>		
<b>PROCESS</b>	Comprehensive assessment for longer-term care needs triggered Identify the Care Co-ordinator/Lead Professional Obtain valid consent to comprehensive assessment. Transfer individual (if required) to the most appropriate environment for assessment.	Deliver rehabilitation/reablement programme (unless clinically contra-indicated)			
		Collate co-produced comprehensive assessment.		Complete the quality assurance process	
		Arrange the MDT meeting at which CHC eligibility will be considered Ensure the individual and/or their representatives have the information and support they need to fully participate.	At the meeting, review the comprehensive assessment and determine whether the individual has a primary health need. Ensure that a clear and agreed rationale is documented and shared with the individual and/or their representatives.	Arrange the care package	
		Contact with individual and/or their representatives within 48 hours to answer queries etc.			

**ANNEX 3:**

**Continuing NHS Healthcare  
Checklist**

**for current and retrospective cases**



# Continuing NHS Healthcare Checklist

Introduction	106
<b>Section 1: Current Cases</b>	<b>107</b>
Introduction	
How to use the Checklist	
Completion of the Checklist	
Checklist record form – Current cases	
<b>Section 2: Retrospective Reviews</b>	<b>112</b>
Introduction	
Explanation of review stages	
Process	
Stage 1 Review	
Stage 2 Review	
Complaints	
Completion of the Checklist	
Checklist record form – Retrospective cases	
<b>Section 3: Continuing NHS Healthcare Checklist</b>	<b>117</b>
<b>Equality monitoring form (<i>current cases only</i>)</b>	<b>129</b>

# CONTINUING NHS HEALTHCARE CHECKLIST

## Introduction

1. This Checklist, although not mandatory, is a tool to help practitioners identify people who need a full assessment for Continuing NHS Healthcare (CHC), either for current or retrospective cases. Please note that referral for assessment for CHC is not an indication of the outcome of the eligibility decision. This fact should also be communicated to the individual and, where appropriate, their representative.
2. The Checklist is based on the Decision Support Tool for Continuing NHS Healthcare (DST). The notes to the DST and *Continuing NHS Healthcare – The National Framework for Implementation in Wales 2021* (the 2021 Framework) will aid understanding of this tool. Practitioners who use this tool should have received suitable training.
3. The Checklist is the same for current or retrospective cases, however, the processes around its use differ. This document sets out separate notes for these different circumstances as follows:
  - **Section 1: Current cases**
  - **Section 2: Retrospective reviews**

## SECTION 1: CURRENT CASES

### Introduction

4. The Checklist should be completed in line with guidance set out in the 2021 Framework. It must be completed by at least 2 practitioners, including a representative of the LA. It can be completed by a variety of health and social care practitioners, who have been trained in its use. This could include, for example: registered nurses employed by the NHS, GPs, other clinicians or LA staff such as social workers, care managers or social care assistants.
5. Care homes should contact the relevant CHC team to arrange for a Checklist to be completed for their residents. The intention is for the Checklist to be completed as part of the wider process of assessing or reviewing an individual's needs. Therefore, it is expected that all staff in roles where they are likely to be involved in assessing or reviewing needs should have completion of Checklists identified as part of their role and receive appropriate training.
6. The Practitioners completing the Checklist must establish the individual, or their representatives, language of choice prior to any assessment taking place. All written and verbal communication must be in the individual or their representatives' choice of language as set out in **Principle 7: Communicate**.
7. Individuals may request an assessment for CHC. In these circumstances, the organisation receiving the request should make the appropriate arrangements for a Checklist to be completed. All staff who apply the Checklist will need to be familiar with the principles of the 2021 Framework and with the DST.

### How to use the Checklist

8. Before applying the Checklist, it is necessary to ensure that the individual and (where appropriate) their representative understand that completing the Checklist is not an indication of the likelihood that the individual will necessarily be determined as being eligible for CHC.
9. The individual should be informed that the Checklist is to be completed and should have the process for completion explained to them. The individual and (where appropriate) their representative should be supported to play a full role in the process and should be given an opportunity to contribute their views about their needs. As set out in **Principle 3: No decisions about me without me**. Decisions and rationales should be transparent from the outset.
10. As with any examination or treatment, the individual's informed consent should be obtained before the process of completing the Checklist commences
11. 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. Anyone who completes a Checklist should be particularly aware of the five principles of the Act:
  - **A presumption of capacity:** A person must be assumed to have capacity unless it is established that they lack capacity.

- **Individuals being supported to make their own decisions:** A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
  - **Unwise decisions:** A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
  - **Best interests:** An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
  - **Least restrictive option:** Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
12. It must also be borne in mind that consideration of capacity is specific to both the decision to be made and the time when it is made – i.e. the fact that a person may be considered to lack capacity to make a particular decision should not be used as a reason to consider that they cannot make any decisions. Equally, the fact that a person was considered to lack capacity to make a specific decision on a given date should not be a reason for assuming that they lack capacity to make a similar decision on another date.
13. If the person lacks the mental capacity to either give or refuse consent to the use of the Checklist, a 'best interests' decision, taking the individual's previously expressed views into account, should be taken (and recorded) as to whether or not to proceed. Those making the decision should bear in mind the expectation that everyone who might meet the Checklist threshold should have this opportunity. 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 (Welfare) or they have been appointed a Welfare Deputy by the Court of Protection. Before making a best interest decision as to whether or not to proceed with the completion of the Checklist the assessor should be mindful of their duty to consult with appropriate third parties. This is particularly important if the decision is not to complete a Checklist.
14. Further information on consent and mental capacity can be found in, **Section 3** of the 2021 Framework.

## Completion of the Checklist

15. In an acute hospital setting, the Checklist should not be completed until the individual's needs on discharge are clear.
16. Please compare the descriptions of need to the needs of the individual and select level A, B or C, as appropriate, for each domain. Consider all the descriptions and select the one that most closely matches the individual. If the needs of the individual are the same or greater than anything in the A column, then 'A' should be selected. For each domain, please also give a brief reference, stating where the evidence that supports the decision can be accessed, if necessary.

17. Where it can reasonably be anticipated that the individual's needs are likely to increase in the next three months (e.g. because of an expected deterioration in their condition), this should be reflected in the columns selected. Where the extent of a need may appear to be less because good care and treatment is reducing the effect of a condition, the need should be recorded in the Checklist as if that care and treatment was not being provided.
18. A full assessment for CHC is required if there are:
  - two or more domains selected in column A;
  - five or more domains selected in column B, or one selected in A and four in B; or
  - one domain selected in column A in one of the boxes marked with an asterisk (i.e. those domains that carry a priority level in the DST), with any number of selections in the other two columns.
19. There may also be circumstances where a full assessment for CHC is considered necessary, even though the individual does not apparently meet the indicated threshold.
20. Whatever the outcome, assessors should record written reasons for the decision and should sign and date the Checklist. Assessors should inform the individual and/or their representative of the decision, providing a clear explanation of the basis for the decision. The individual should be given a copy of the completed Checklist. The rationale contained within the completed Checklist should give enough detail for the individual and their representative to be able to understand why the decision was made.
21. Individuals and their representatives should be advised that, if they disagree with the decision not to proceed to a full assessment for CHC, they may ask the Local Health Board (LHB) to reconsider it. This should include a review of the original Checklist and any new information available, and might include the completion of a second Checklist. If they remain dissatisfied they can pursue the matter through the normal complaints process.
22. Each LHB should have clear local processes that identify where a completed Checklist should be sent, in order for the appropriate next steps to be taken. Completed Checklists should be forwarded in accordance with these local processes.
23. The Equality Monitoring Form should be completed by the individual who is the subject of the Checklist. Where the individual needs support to complete the form, this should be offered by the practitioner completing the Checklist. The practitioner should forward the completed data form to the appropriate location, in accordance with the relevant LHB's processes for processing equality data.

## Checklist Record Form – Current Cases

Date of completion of the Checklist \_\_\_\_\_

Date of birth \_\_\_\_\_

Name \_\_\_\_\_

NHS number \_\_\_\_\_ GP practice \_\_\_\_\_

Permanent address and current location (e.g. telephone number, hospital ward etc.)

Gender \_\_\_\_\_

**Please ensure that the Equality Monitoring Form at the end of the Checklist is completed.**

Was the individual involved in the completion of the Checklist? **Yes/No** (please delete as appropriate)

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

If yes, did the representative attend the completion of the Checklist? **Yes/No**

Please give the contact details of the representative (name, address and telephone number).

Did you explain to the individual how their personal information will be shared with the different organisations involved in their care, and did they consent to this information sharing? **Yes/No**

**Please highlight the outcome indicated by the Checklist:**

- Referral for full assessment for Continuing NHS Healthcare is necessary

or

- No referral for full assessment for Continuing NHS Healthcare is necessary.

*(There may be circumstances where you consider that a full assessment for Continuing NHS Healthcare is necessary, even though the individual does not apparently meet the indicated threshold. If so, a full explanation should be given.)*

**Rationale for decision**

--

**Name(s) and signature(s) of assessor(s)**

**Date**

--	--

**Contact details of assessors (name, role, organisation, telephone number, email address)**

--

## SECTION 2: RETROSPECTIVE REVIEWS

### Introduction

24. An individual and/or their representative may request a retrospective CHC review where they contributed to the cost of their care, but have reason to believe that they may have met the eligibility criteria for CHC which were applicable at that time.
25. Local Health Boards (LHBs) need to balance their requirement to provide timely restitution with that of demonstrating probity with the public purse. Making an application does not mean that reimbursement is guaranteed; LHBs must satisfy themselves that the application is genuine and that the person was indeed eligible for CHC during the disputed period.
26. The data generated from Phases 1, 2 & 3 of the All Wales Retrospective CHC Reviews Project, which operated until April 2019, indicates that eligibility was found for 31% and no eligibility for 69%. This data supports the rationale for applying a Checklist to all applications to identify if there are triggers for CHC consideration and if so, for what period. This will facilitate focus on cases where there are triggers identified and will be a more effective and efficient use of the public purse.
27. The Checklist is based on the DST and is advocated for use in the National Framework.
28. This Checklist should be applied to all retrospective CHC cases in Wales, in line with the guidance set out in the National Framework.

### Explanation of Review Stage

29. Stage 1 Review - A chronology of need comprising of care plans and risk assessments from the care provider, the GP records and the claimant's statement is considered to identify if there are any triggers for retrospective CHC to be considered in a Stage 2 Review.
30. Stage 2 Review - Triggers have been identified and the chronology of need is completed using any other records available. The case is then reviewed through the normal process as detailed in the National Framework.

### Process

#### Stage 1 Review

- i. This Checklist will be utilised as a tool to aid suitable clinicians and/or assessors to decide if cases where a retrospective CHC review has been requested should proceed to full review. (Stage 2)
- ii. A suitable officer nominated by the Health Board will be responsible for co-ordinating this part of the process.
- iii. The suitable clinicians and/or assessors who will be applying the Checklist will be familiar with the principles of the National Framework and with the DST.



- iv. The suitable clinicians and/or assessors will apply this Checklist to a comprehensive chronology of need comprised from a range of available records including a claimant's statement, care home records (inc. care plans, risk assessments and daily diaries etc), GP, district nurse and any other available and relevant clinical records. If any of these records are unavailable then the records that are available will be used.
- v. The suitable clinicians and/or assessors will identify if there are triggers for retrospective CHC to be considered in Stage 2 Review for all, some or none of the claim period requested by the claimant/representative.
- vi. The suitable clinicians and/or assessors will complete as many Checklist documents as necessary to ensure that the whole claim period is considered along with any changes in level of need throughout the claim period or until a trigger date is identified.
- vii. If the suitable clinicians and/or assessors do not find any triggers for retrospective CHC to be considered in Stage 2 Review, then following ratification by an IRP Chair, a completed Checklist will be provided to the claimant/representative to explain why the case will not be forwarded for Stage 2 Review and the case will be closed at this stage.
- viii. If the suitable clinicians and/or assessors do find triggers for retrospective CHC to be considered in Stage 2 Review for part of the claim period, then, following ratification by an IRP Chair, a completed Checklist will be provided to the claimant/representative to explain why the whole of the claim period will not be reviewed and will document the dates that will be reviewed in Stage 2 Review.
- ix. If the suitable clinicians and/or assessors find triggers for retrospective CHC to be considered in Stage 2 Review at the outset of the claim period, then they will inform the claimant/representative that the whole claim period will be reviewed in Stage 2. No requirement for IRP Chair to ratify.

**Notes:**

- Progress to Stage 2 Review is not an indication of the outcome of the eligibility decision in that it is not guaranteed that eligibility for retrospective CHC funding will be evidenced.
- If the claimant is already eligible for FNC or CHC, the case should proceed to Stage 2, for consideration of the full period of eligibility, without the need for a Stage 1 review.

If the Chair disagrees with the recommendation of Partial or No eligibility, then progress to Stage 2 on the basis of highest level of eligibility suggested e.g. Full rather than Partial; Partial rather than No eligibility.

**Stage 2 Review**

- i. If the suitable clinicians and/or assessors have identified triggers for CHC to be considered for all or part of the claim period then any additional evidence from available records will be added to the Chronology of Need.
- ii. The case will then be reviewed by a Clinical Adviser encompassing either the whole of the claim period requested if triggers have been identified at the start of the claim period or part of the claim period requested with the start date being identified by the suitable clinicians and/or assessors using the Checklist to identify the start date based on triggers.
- iii. The case will then go through the review process as detailed in the National Framework.

## Complaints

31. If individuals have a concern regarding the process applied by the suitable clinicians and/or assessors, they may wish to access the NHS complaints procedure and/or raise a concern with the Public Services Ombudsman for Wales.

## Completion of the Checklist

32. Please compare the descriptions of needs of the individual and select level A, B or C, as appropriate, for each domain. Consider all the descriptions and select the one that most closely matches the individual. If the needs of the individual are the same or greater than anything in the A column, then 'A' should be selected. For each domain, please also give a brief reference, stating where the evidence that supports the decision can be accessed, if necessary.
33. A case will be forwarded to Stage 2 Review if there are:
- two or more domains selected in column A;
  - five or more domains selected in column B, or one selected in A and four in B; or
  - one domain selected in column A in one of the boxes marked with an asterisk (i.e. those domains that carry a priority level in the DST), with any number of selections in the other two columns.

## Checklist Record Form – Retrospective Cases

### Stage 1 Review

Date of completion of the Checklist \_\_\_\_\_

Name of subject of the claim \_\_\_\_\_

Health Board \_\_\_\_\_

Case Identifier \_\_\_\_\_

Claim period requested from: \_\_\_\_\_

to: \_\_\_\_\_

**Please highlight the outcome indicated by the Checklist:**

- Referral for Stage 2 Review is necessary from (date) **or**
- No referral for Stage 2 Review is necessary as no triggers have been identified.

**Rationale for decision**

<p><b>Clinical Adviser</b> Levels:  Based on the above levels of need:</p> <ul style="list-style-type: none"><li>• the evidence does not support any trigger for Stage 2 Review <b><i>or</i></b></li><li>• the evidence supports a trigger for Stage 2 Review from <b>(enter date)</b> <b><i>or</i></b></li><li>• the evidence supports the need for Stage 2 Review from the start of the Claim Period.</li></ul> <p>Name:  Signed:  Date:</p>
<p><b>Independent Chair</b>  I agree with the recommendation made by the Clinical Adviser/s.  <b>Or</b>  I disagree with the recommendation made by the Clinical Adviser:</p> <ul style="list-style-type: none"><li>• The evidence supports a trigger for Stage 2 Review from (enter date) <b><i>or</i></b></li><li>• The evidence supports the need for Stage 2 Review from the start of the Claim Period.</li></ul> <p><b>The rationale for this decision is documented below:</b>  Name:  Signed:  Date:</p>

## Section 3: CHC Checklist

Name of patient		Date of completion		
Please circle statement <b>A</b> , <b>B</b> or <b>C</b> in each domain. AN <b>ASTERISK</b> placed against each category indicates a <b>PRIORITY</b> domain				
LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	Recorded evidence to support level
<b>1. Breathing *</b>	<p>Normal breathing, no issues with shortness of breath.</p> <p><b>OR</b></p> <p>Shortness of breath, which may require the use of inhalers or a nebuliser and has no impact on daily living activities.</p> <p><b>OR</b></p> <p>Episodes of breathlessness that readily respond to management and have no impact on daily living activities.</p>	<p>Shortness of breath, which may require the use of inhalers or a nebuliser and limit some daily living activities.</p> <p><b>OR</b></p> <p>Episodes of breathlessness that do not respond to management and limit some daily activities.</p> <p><b>OR</b></p> <p>Requires any of the following:</p> <ul style="list-style-type: none"> <li>• low level oxygen therapy (24%);</li> <li>• room air ventilators via a facial or nasal mask;</li> <li>• other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.</li> </ul>	<p>Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers.</p> <p><b>OR</b></p> <p>Breathlessness due to a condition which is not responding to therapeutic treatment and limits all daily living activities.</p> <p><b>OR</b></p> <p>A condition that requires management by a non-invasive device to both stimulate and maintain breathing (non-invasive positive airway pressure, or non-invasive ventilation)</p>	

### Section 3: CHC Checklist

LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	Recorded evidence to support level
2. Nutrition, food and drink	<p>Able to take adequate food and drink by mouth to meet all nutritional requirements.</p> <p><b>OR</b></p> <p>Needs supervision, prompting with meals, or may need feeding and/or a special diet.</p> <p><b>OR</b></p> <p>Able to take food and drink by mouth but requires additional/supplementary feeding.</p>	<p>Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed.</p> <p><b>OR</b></p> <p>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.</p>	<p>Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway.</p> <p><b>OR</b></p> <p>Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. <b>OR</b></p> <p>Nutritional status 'at risk' and may be associated with unintended, significant weight loss.</p> <p><b>OR</b></p> <p>Significant weight loss or gain due to an identified eating disorder.</p> <p><b>OR</b></p> <p>Problems relating to a feeding device (e.g. PEG) that require skilled assessment and review.</p>	

**Section 3: CHC Checklist**

LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	<b>Recorded evidence to support level</b>
<b>3. Continence</b>	<p>Continent of urine and faeces.</p> <p><b>OR</b></p> <p>Continence care is routine on a day-to-day basis.</p> <p><b>OR</b></p> <p>Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc.</p> <p><b>AND</b></p> <p>Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.</p>	<p>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.</p>	<p>Continence care is problematic and requires timely and skilled intervention, beyond routine care. (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).</p>	

### Section 3: CHC Checklist

LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	Recorded evidence to support level
4. Skin and Tissue Viability	<p>No risk of pressure damage or skin condition.</p> <p><b>OR</b></p> <p>Risk of skin breakdown which requires preventative intervention once a day or less than daily, without which skin integrity would break down.</p> <p><b>OR</b></p> <p>Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound.</p> <p><b>OR</b></p> <p>A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.</p>	<p>Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down.</p> <p><b>OR</b></p> <p>Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment.</p> <p><b>OR</b></p> <p>A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.</p>	<p>Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment.</p> <p><b>OR</b></p> <p>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 responding to treatment.</p> <p><b>OR</b></p> <p>Specialist dressing regime in place which is responding to treatment.</p>	



**Section 3: CHC Checklist**

LEVEL→ CATEGORY↓	C	B	A	Recorded evidence to support level
5. Mobility	<p>Independently mobile.</p> <p><b>OR</b></p> <p>Able to bear weight but needs some assistance and/or requires mobility equipment for daily living.</p>	<p>Not able to consistently bear weight.</p> <p><b>OR</b></p> <p>Completely unable to bear weight but is able to assist or cooperate with transfers and/or repositioning.</p> <p><b>OR</b></p> <p>In one position (bed or chair) for majority of the time but is able to cooperate and assist carers or care workers.</p> <p><b>OR</b></p> <p>At moderate risk of falls (as evidenced in a falls history or risk assessment)</p>	<p>Completely unable to bear weight and is unable to assist or cooperate with transfers and/or repositioning.</p> <p><b>OR</b></p> <p>Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate.</p> <p><b>OR</b></p> <p>At a high risk of falls (as evidenced in a falls history and risk assessment).</p> <p><b>OR</b></p> <p>Involuntary spasms or contractures placing the individual or others at risk.</p>	

**Section 3: CHC Checklist**

LEVEL→ CATEGORY ↓	<b>C</b>	<b>B</b>	<b>A</b>	Recorded evidence to support level
<div style="background-color: black; color: white; text-align: center; padding: 20px; font-size: 2em; font-weight: bold; writing-mode: vertical-rl; transform: rotate(180deg);">                         6. Communication                     </div>	<p>Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.</p> <p><b>OR</b></p> <p>Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.</p>	<p>Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through nonverbal signs due to familiarity with the individual.</p>	<p>Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.</p>	

**Section 3: CHC Checklist**

LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	<b>Recorded evidence to support level</b>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>7. Psychological and Emotional Needs</b></p>	<p>Psychological and emotional needs are not having an impact on their health and well-being.</p> <p><b>OR</b></p> <p>Mood disturbance or anxiety or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance.</p> <p><b>OR</b></p> <p>Requires prompts to motivate self towards activity and to engage in care planning, support and/or daily activities.</p>	<p>Mood disturbance or anxiety symptoms or periods of distress which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or wellbeing.</p> <p><b>OR</b></p> <p>Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in support, care planning and/or daily activities.</p>	<p>Mood disturbance or anxiety symptoms or periods of distress that have a severe impact on the individual's health and/or well-being.</p> <p><b>OR</b></p> <p>Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and daily activities.</p>	

**Section 3: CHC Checklist**

LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	<b>Recorded evidence to support level</b>
8. Cognition	<p>No evidence of impairment, confusion or disorientation.</p> <p><b>OR</b></p> <p>Cognitive impairment 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.</p> <p><b>OR</b></p> <p>Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.</p>	<p>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.</p> <p>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.</p>	<p>Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some 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.</p> <p>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.</p>	

**Section 3: CHC Checklist**

LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	<b>Recorded evidence to support level</b>
<p><b>9. Behaviour *</b></p>	<p>No evidence of 'challenging' behaviour.</p> <p><b>OR</b></p> <p>Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care.</p>	<p>'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care.</p>	<p>'Challenging' behaviour that poses a predictable risk to self, others or property. 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.</p>	

**Section 3: CHC Checklist**

LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	<b>Recorded evidence to support level</b>
<b>10. Drug therapies and medication symptom control *</b>	<p>Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.</p> <p><b>OR</b></p> <p>Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime.</p> <p><b>OR</b></p> <p>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.</p>	<p>Requires the administration of medication (by a registered nurse, carer or care worker) due to:</p> <ul style="list-style-type: none"> <li>• non-concordance or noncompliance, or</li> <li>• type of medication (for example insulin); or</li> <li>• route of medication (for example PEG).</li> </ul> <p><b>OR</b></p> <p>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.</p>	<p>Requires administration and monitoring of medication regime by a registered nurse, carer or care worker 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. However, with such monitoring the condition is usually non-problematic to manage.</p> <p><b>OR</b></p> <p>Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.</p>	

**Section 3: CHC Checklist**

LEVEL→ CATEGORY↓	<b>C</b>	<b>B</b>	<b>A</b>	<b>Recorded evidence to support level</b>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>11. Altered states of consciousness *</b></p>	<p>No evidence of altered states of consciousness (ASC).</p> <p><b>OR</b></p> <p>History of ASC but effectively managed and there is a low risk of harm.</p>	<p>Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.</p>	<p>Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.</p> <p><b>OR</b></p> <p>Occasional ASCs that require skilled intervention to reduce the risk of harm.</p>	

**Section 3: CHC Checklist**

<b>Name of patient</b>		<b>Date of completion</b>		
<b>TOTAL FROM ALL PAGES</b>	<b>C</b>	<b>B</b>	<b>A</b>	
ADDITIONAL COMMENTS				
SIGNED AND POSITION OF SIGNATORY				



## EQUALITY MONITORING FORM

### For use with current cases only

Please provide us with some information about yourself. This will help us to understand whether everyone is receiving fair and equal access to CHC. All the information you provide will be kept completely confidential by the NHS. No identifiable information about you will be passed on to any other bodies, members of the public or press.

*Please tick only one box in each category.*

1. SEX	
Male	
Female	
Transgender	

2. SEXUAL ORIENTATION					
Only answer this question if you are aged <b>16 years</b> or over. Which applies to you? (*If 'Other', please highlight and write in box provided)					
Heterosexual / Straight	Lesbian / Gay Woman	Gay Man	Bisexual	Prefer not to say	*Other

\* Any other, write here

3. AGE GROUP –								
Which applies to you?								
0-15	16-24	25-34	35-44	45-54	55-64	65-74	75-84	85+

4. DISABILITY	
Do you have a disability, as defined by the <i>Equality Act 2010</i> ?	The Equality Act defines a person with a disability as someone who 'A physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities. <a href="https://www.gov.uk/definition-of-disability-under-equality-act-2010">https://www.gov.uk/definition-of-disability-under-equality-act-2010</a>

Yes	
No	

**5. ETHNIC GROUP –**

Which applies to you? (\*If 'Other', please highlight and write in box provided)

White		Mixed		Asian or Asian British		Black or Black British		Chinese or other group	
British		White and Black Caribbean		Indian		Caribbean		Chinese	
Irish		White and Black African		Pakistani		African		Other*	
Other*		White and Asian		Bangladeshi		Other*			
		Other*		Other*					

\* Any other, write here

**6. RELIGION**

Which applies to you? (\*If 'Other', please highlight and write in box provided)

*Christian includes Church of Wales, Catholic, Protestant and all other Christian denominations*

Christian	Buddhist	Hindu	Jewish	Muslim	Sikh

\* Any other, write here

## **ANNEX 4: Setting up an Independent 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, a representative of a LHB and a representative of a local authority. It will also have access to expert opinion. In order to avoid delays in the process and to maximise the available expertise, health boards must make use, wherever possible of Independent Review Panel chairs. In using them they should also not rely on any one figure for convenience or consistency and should make use of all operating in their area.
- A.5.2 Independent chairs are appointed via the Public Appointments process and their services can be accessed via the CHC Lead in each LHB.
- A.5.3 The appointment of representatives of the LHB(s) and LAs 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 LHB 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 LHB should aim to ensure that the review procedure is completed within four 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. The review procedure must not delay the provision of care and the local protocol should make clear how funding will be provided pending the resolution.
- 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 is 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

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 LHB should seek the advice of the chair of the review panel. In all cases where a decision not to convene a panel is made, the LHB should give the patient and their 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 LHB 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, their 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 LHB officer. This will normally be managed by the production of written statements prepared by the LHB'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 LHB 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 LHB 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 LHB must communicate in writing to the patient the outcome of the review, with reasons. All relevant parties (NHS, consultant, GP and other clinician(s), LA 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 5: Retrospective Claim Proof of Payment

WELSH HEALTH CIRCULAR



Llywodraeth Cymru  
Welsh Government

Issue Date: 1 February

STATUS: COMPLIANCE  
CATEGORY: POLICY

**Title:**  
Additional Guidance on Proof of Payment for Reimbursement of Retrospective Claims WHC/2016/003

**Date of Expiry / Review**  
n/a

**For Action by:**  
Health boards  
NHS Trusts  
Chief Executives  
Directors of Primary Care

**Action required by:**  
Immediate

**Sender:** Neil Jones

**DHSS Welsh Government Contact(s) :**  
Neil Jones [jones.neil@wales.gsi.gov.uk](mailto:jones.neil@wales.gsi.gov.uk)

Integration Policy and Delivery Division, Health and Social  
Services Group,

4<sup>th</sup> Floor Cathays Park 2, Cardiff. CF10 3NQ.

**Enclosure(s):** Annex 1

**ANNEX 1                      WELSH HEALTH CIRCULAR    WHC/2016/003**  
**Continuing NHS Healthcare (CHC) in Wales**  
**Additional Guidance on Proof of Payment for Reimbursement of**  
**Retrospective Claims.**

**Background**

1. On 16 December 2013, Welsh Government issued MD/ML/001/13. Supplementary Guidance (Proof of Payment) to Welsh Health Circular 015/2010. This guidance related specifically to cases reviewed by the Powys Project where further proof of payment had been requested by health boards (HBs) at the end of the process.
2. Additional guidance followed in WHC/2015/039 which extended the principles of the previous supplementary guidance and addressed the recommendations of the Continuing NHS Healthcare Follow up Report, published by the Wales Audit Office in January 2015. It related to:
  - those claims submitted to HBs since August 2010 but may relate to periods prior to that date;
  - those claims submitted in response to the 31 July 2014 cut off date, which may relate to any period between 1 April 2003 and 31 July 2013.
3. This guidance supersedes WHC/2015/039. It retains the same arrangements albeit no longer referring to the use of the County Court Rate (CCR) in calculating reimbursement in exceptional circumstances for claims still to be processed.
4. Redress is about placing individuals in the position they would have been in had CHC been awarded at the appropriate time and not about the NHS or the public profiting from public funds. The use of retail price index (RPI), without the deduction of historical benefits and allowances already received by the claimant, is considered to be the appropriate method of calculating a fair level of interest payable in addition to the claim settlement amount. It is also considered to be a relatively straight forward method of interest calculation.
5. A calculation using the CCR rate, with a deduction of benefits and allowances received, has proven to be impractical to determine in most cases and, therefore, is not considered an appropriate level of interest to be used in this scenario.

Claimants who have already requested that their settlement be considered using a CCR calculation may continue to pursue this with their Health Board, but all relevant information and evidence would need to be in place for that CCR calculation to be made and if this is not the case then RPI method should be applied as the default.

These arrangements have been agreed with the Public Service Ombudsman for Wales.

6. The new arrangements now relate to:
  - those claim periods set out above;
  - those claims submitted as a result of the 31 October 2015 cut-off date which may relate to any period between 1 August 2013 and 30 September 2014; and,
  - those claims submitted thereafter.

### **Principles of Good Public Administration**

7. Health boards should ensure their undertakings are compliant with the Public Service Ombudsman's Principles of Good Public Administration. The full guidance of which is available via the following link:

[http://www.ombudsman-wales.org.uk/en/public-body-information/~media/Files/Documents\\_en/Principles\\_of\\_Good\\_Administration.ashx](http://www.ombudsman-wales.org.uk/en/public-body-information/~media/Files/Documents_en/Principles_of_Good_Administration.ashx)

### **Implications for redress in CHC retrospective claims**

8. HBs in Wales are independent decision-making bodies, and have agreed the arrangements for dealing with retrospective claims as set out in **Section 6** of Continuing NHS Healthcare: The National Framework for Implementation in Wales (2014).
9. The arrangements for dealing with retrospective claims, as set out in the 2014 Framework, are clear that proof of payment of care fees is required at the outset of the process. The claim will not be progressed if such evidence cannot be provided. The Framework also states that HBs need to balance their requirement to provide timely restitution with that of demonstrating probity with the public purse (para 6.10).

### **Prompt request for Proof of Payment and fair prioritisation of claims**

10. It is the responsibility of the HB to request proof of payment and legal authority to submit a claim promptly on receipt of an application or of intent to claim (e.g. letter to the HB). The written request for Proof of Payment should be posted within 10 working days and recorded on the LHB database.
11. No claimant should be disadvantaged because the LHB has failed to request proof of payment in a timely manner. If the HB has not complied with the timescale as set out above, it should adjust the timescale for review accordingly.
12. As set out in the Framework, it is reasonable to expect the claimant to provide the required proof within 5 months, unless exceptional circumstances apply. The LHB should evidence that:
  - it has monitored progress with the claimant;
  - delays due to other agencies are evidenced; and
  - any exceptional circumstances have been considered.



13. The HB should provide feedback to the claimant and validate or reject the claim within 6 weeks (30 working days) of receipt of the proof of payment.  
**Reasoned and reasonable decisions on acceptable proof of payment.**
14. HBs must make reasoned and reasonable decisions regarding acceptance of evidence of proof of payment, taking into account all available and relevant information. HBs should bear in mind that, owing to the passage of time, evidence may not be complete.
15. In order to demonstrate reasonableness, HBs will need to apply a degree of discretion to the level of evidence they deem acceptable, dependent on the period to which the claim relates. For cases relating to the claim period end date of 5 years or less, all evidence that is accessible, including bank statements, care home statements and invoices, must be provided. This will show there is no outstanding debt to the care provider if the subject of the claim is deceased unless there are extenuating circumstances.
16. As a minimum, HBs should satisfy themselves that:
- The individual was resident in a care home for the period(s) of eligibility;
  - There is no evidence that any public body or agency paid all or part of the fees; and
  - There are no outstanding debts, e.g. unpaid fees to the care home.

#### **Fair and transparent calculation of reimbursement**

17. In arriving at the value for reimbursement, the HB should use a transparent rationale and clear calculations.
18. If evidence exists of proof of payment for part of the claim period, and is deemed robust, then this should be used as a basis for further calculations covering the whole claim period.
19. Where evidence of financial outlay by the claimant is not robust enough, LHBs may calculate reimbursement offers based on a different and well reasoned cost indicator; for example, the high dependency residential care home rate in operation by the Local Authority in the area during the period of eligibility.
20. If there is evidence that a public authority has paid a proportion of the claimants nursing home fees directly to the nursing home, an abatement of the reimbursement may be appropriate to abate that proportion.
21. It is deemed reasonable for HBs to continue to apply the Retail Prices Index (RPI) for the calculation of interest when considering recompense in continuing care reviews. Where RPI is used to calculate interest there will be no deduction for benefits received by the claimant during the claim period

(and the Department for Work and Pensions has agreed that there will be no reclaim of those benefits).

22. On conclusion of the decision of eligibility, HBs should normally take no longer than 1 month (20 working days) to calculate reimbursement and send the indemnity letter to the claimant.

### **Ex-gratia payments**

23. In addition to the reimbursement principles stated above, there may be occasions where HBs also wish to consider making ex-gratia payments in line with the existing guidance on Losses and Special Payments in the IFRS NHS Wales Manual for Accounts. HBs are encouraged to seek legal advice about individual cases where necessary, and make ex-gratia payments if appropriate.

### **Disputes**

24. If the claimant is dissatisfied with the approach taken they may raise a concern with the relevant HB. Their concern will be handled in accordance with the NHS (Concerns, Complaints & Redress Arrangements) (Wales) Regulations 2011. Claimants may also contact the Public Service Ombudsman for Wales.