

DRAFT

North and East Yorkshire and Northern Lincolnshire
Strategic Health Authority

Continuing Health and Social Care Policy

Date of implementation – to be agreed

Primary Care Trusts	Local Authorities
<ul style="list-style-type: none"> • Craven, Harrogate & Rural District • Eastern Hull • East Yorkshire • Hambleton & Richmondshire • North East Lincolnshire • North Lincolnshire • Scarborough, Whitby & Ryedale • Selby & York • West Hull • Yorkshire Wolds & Coast 	<ul style="list-style-type: none"> • City of York • East Riding of Yorkshire • Hull City • North East Lincolnshire • North Lincolnshire • North Yorkshire

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1. Introduction

1.1 Overview of this document

This document covers the North and East Yorkshire and Northern Lincolnshire Strategic Health Authority and the Primary Care Trusts and Local Authorities within the boundaries of that area. It sets out:

- The framework for accessing continuing NHS health care as required by Health Service Circular HSC 2001/015: Local Authority Circular LAC (2001)18 Continuing Care: NHS and Local Authorities responsibilities;
- Identification of entitlement to fully funded continuing NHS health care, to health and social care service arrangements and to social care;
- Information and current arrangements for the review, complaints and disputes processes; and
- New arrangements to ensure effective implementation of the policy by focusing on consistency and best practice in its comprehensive application.

1.2 Revision of the policy

1.2.1. Local context

This policy document supersedes the policy document for continuing health and social care that was agreed and implemented in November 2002. At that time it was also agreed that the policy would be reviewed but no date was set for review.

Subsequent continuing care development work commissioned by the SHA (NEYNL), which took place between September 2003 and March 2004, highlighted the need to clarify both the policy in order to ensure consistent application of the continuing care criteria across the SHA area and some of the terminology which was open to different interpretation.

This new document therefore clarifies a range of critical issues that have emerged since the previous policy was introduced in November 2002, as well problems of definition and interpretation that were identified through the continuing care development programme.

1.2.2. National context

These issues were consistent with the concerns expressed by the Ombudsman in her report of December 2004¹ in particular:

- Lack of clarity around the interpretation of some key words e.g. intensity, unpredictability;
- Difficulties in distinguishing between NHS fully funded continuing care and Funded Nursing Care;
- Assessment methods – with variable quality of clinical assessments and of decision-making.

The report also highlighted the problems resulting from the lack of a national policy and guidance framework and made the following recommendations:

¹ [NHS funding for long term care: follow up report](#)

- Establishing clear, national, minimum eligibility criteria which are understandable to health professionals and patients and carers alike;
- Developing a set of accredited assessment tools and good practice guidance to support the criteria;
- Supporting training and development to expand local capacity and ensure that new continuing care cases are assessed and decided properly and promptly;
- Clarifying standards for record keeping and documentation both by health care providers and those involved in the review process.

In December 2004 the Minister for Health ordered the commissioning of a new national framework for the assessment for NHS fully funded continuing care to improve consistency and ease of understanding. It will include the development of guidance on national criteria and the basis on which they should be applied, particularly their relationship to Funded Nursing Care.

In discussion with the Department of Health it is clear that the local approach outlined in this document may well inform and/or be consistent with the national approach.

The Health Select Committee has also published a report on NHS continuing care.² Three key messages from the report echo those of the Ombudsman, outlined above, namely:

- The relationship between continuing NHS health care and Funded Nursing Care;
- Clarification of terms; and
- The need for a common assessment tool.

1.2.3. Implementation of the revised policy

This policy has been agreed by all six Local Authorities and the 10 Primary Care Trusts, whose Chief Executives are signatories to this document. (See Appendix 1). This revised policy will be effective from ? 2005 and will be reviewed formally in September 2007. Mechanisms are in place to ensure effective implementation of the policy with two network wide, joint (NHS and Local Authorities) groups to take forward development, policy implementation, monitoring and audit (see paragraph 8.5). This was not the case previously. In advance of its adoption the policy will be formally piloted for a 6 month period from ??? across all PCTs and Local Authorities within the SHA area.

1.3 Who is covered by this policy?

This policy applies to all adults (aged 18 years and over) who are registered with a GP in any of the Primary Care Trusts within the boundary of the Strategic Health Authority including:

- Disabled adults with physical impairments
- Older people
- People with mental ill health
- People with a learning disability

² House of Commons Health Committee. NHS Continuing Care. Sixth Report of Session 2004-2005 Vol 1

- Or combinations of the above

If a person is ordinarily resident within one of the Local Authorities, which is party to this policy, but is registered with a GP outside the SHA boundary then the policy of the PCT with whom the GP is aligned will apply.

This policy will operate within the extant Department of Health guidance in respect of the responsible commissioner.

1.3.1. Children and young people

Continuing care in relation to children and young people is not included in this policy. Work on developing criteria and supporting documentation for children and young people with complex needs who may require fully funded NHS continuing health care is being undertaken at local and national levels. However, each local area will need to ensure that robust transition planning arrangements are in place to enable effective implementation of this policy.

1.4. Background to the implementation of continuing care policies

Appendix 2 sets out the national requirements on the NHS and Councils for developing and implementing continuing care policies.

2. Aims of the revised policy

The policy has been revised with the aims of ensuring that:

- People have an equal right of access to fully funded NHS continuing health care whether they are living in care homes or in their own homes;
- The responsibility for arranging or funding care is based on the needs of the individual;
- People with similar physical, mental and psycho-social needs will receive a consistent response irrespective of where they live within the Strategic Health Authority boundary³.

The policy is driven by need, and evidence of that need, and it is need which will guide both agency and funding responsibility.

3. Principles

3.1. Service users and carers

- The service user will be at the centre of the process when applying the criteria, and will receive integrated care from health and social services through joint assessment, care planning and review.
- Service users' right of choice will be respected through a flexible approach to meeting care needs, within the boundaries of what is reasonably achievable, the resources available and risk identified and each local authority's eligibility criteria.⁴

³ See paragraph x for definition of "resident".

⁴ LAC (2004)20: Guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1992 and National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendment) (England) Regulations 2001.

- The service user and his/her carer and other significant people should be as fully involved as possible in the processes affecting them and, within available resources, enabled to exercise choice.
- Communications, assessments and services should, wherever possible, reflect the diverse needs of the minority ethnic communities and people with special needs within the area.
- Advice should be given on the availability of advocacy services for people in situations where there are disputes, conflicts of interest, and/or there may be no-one else available to provide appropriate support for that person.

3.2. Assessment

- Wherever a person enters the care system there will be equal access to assessment of need regardless of age, ethnicity, religion, disability, personal circumstances or where they live within the Strategic Health Authority area.
- Eligibility criteria will be consistently applied and the assessment and decision making process will be transparent to service users, their relatives, carers and staff.

3.3. Information

- Information about how to access the care system will be readily and widely available to service users, their relatives and carers, and all staff
- Information should be provided at appropriate times on the processes involved, services that may be available, and disputes/complaints procedures.
- The privacy and confidentiality of people must be respected. There may be occasions however when circumstances dictate that disclosure of information is necessary. This may be, for example, where there are serious concerns about an issue regarding the personal health, or safety, or other significant circumstances of a person, or others, where there is a legal obligation on the agency involved to take action to protect the person or others. As a first principle the consent of the person should be sought and in any event all cases concerning the handling of personal data must conform to legal requirements. Employees and service providers should have regard to the confidentiality and personal data handling policies in place in their respective agencies.

3.4. Service provision

- All service provision will be subject to review at appropriate intervals.
- Services should have clear goals and intended outcomes.
- Partnership working will be demonstrated and supported at all levels through the development and implementation of the assessment toolkit and a comprehensive joint training programme for staff.

3.5 Setting

Once it is confirmed that a patient is eligible for fully funded NHS continuing care, clinicians and commissioners should discuss with the patient and their family/carer where this care could be provided, and take these views into account when arranging services. The availability of GP prescribing, community nursing, transport and out of hours services should be considered before discharge from hospital. Fully funded NHS continuing care may be provided in a range of settings: a nursing home, hospice, at home or in hospital subject to clinical advice.

4. What is continuing care?

4.1. 'Continuing Care'

This is a general term that describes the care which people need over an extended period of time, as the result of disability, accident or illness to address both physical and mental health needs. It may require services from the NHS and/or social care. It can be provided in a range of settings, from an NHS hospital to a Registered Care Home (subject to the Care Standards Act), and people's own homes. Continuing care provision typically starts after a multi-disciplinary assessment, which determines that some arrangement of services is necessary to meet the needs of the person.

Continuing care is different from **intermediate and transitional care**: **intermediate care** has specific outcomes for rehabilitation, reablement or recuperation and is provided for a time limited period, normally up to six weeks. **Transitional (or interim) care** is where the care setting is temporary and different from where people are expected to receive any continuing care they need.

5. Categories of continuing care

5.1 Introduction

The criteria set out in this document are intended to determine whether or not a person is eligible for fully funded NHS continuing health care (Category 1). If a person is not considered to be eligible for NHS fully funded continuing health care, consideration will be given as to whether the person's needs require a joint package of continuing care from health and social care (Category 2) which may include an assessment for NHS Funded Nursing Care, or where no health care is required, continuing social care (Category 3).

Regardless of the category of care, people are entitled to access the full range of healthcare services commissioned and/or provided by their PCT (as is the general population) e.g. GP, District Nursing, specialist transport services and equipment. Access to some services will be based upon assessed need.

In order to ensure that the appropriate arrangements of services are put into place for everyone who needs them, and to ensure that no-one falls into gaps between agencies or services the categories of care could be described as a continuum of care.

As people's needs change, they will move freely along the continuum of care, receiving different services from different providers. The continuum is not hierarchical so people can enter and exit it at any point. The time a person may be in receipt of services at any point on the continuum, and movement along the continuum will depend on assessed need.

The needs of some people, who have all their care needs arranged and funded by the NHS, may change to the extent that their needs can be met in ways other than solely through the NHS. In these circumstances, and following a re-assessment, they may be transferred to Local Authority funding (and be liable to contributions depending on financial assessment) or they may fund the whole of their care (excluding nursing care) themselves. An assessment that someone is eligible for NHS fully funded continuing care is not necessarily "NHS funding for life", since their eligibility may change should their care needs diminish.

Transfer of responsibility from NHS fully funded continuing care will be based solely on a change in the health care status of the person. This change must be demonstrable and show a significant improvement of condition and/or a sustained stability. In either situation the person's overall condition will have improved and/or stabilised to a level whereby s/he is no longer eligible for NHS fully funded care.

Equally, if a person's health care needs increase significantly their eligibility for NHS fully funded continuing care should be reassessed. Any changes will be agreed through a multidisciplinary process.

The categories below describe a continuum of care as follows:

5.2 Category 1 - NHS Fully Funded Continuing Care

This is a package of care funded solely by the NHS. It may be provided in a hospital, hospice, care home or in the service user's own home (subject to the necessary clinical skills being available and as long as the person's clinical needs can be met safely in the proposed setting). **Whatever the location, the NHS meets the full cost of the health and personal care provided and it is free of charge. (This is still to be agreed).**

The assessment tool described in section 7 will be used to assist the multidisciplinary team by indicating whether the extent of the person's need is such that they may be entitled to NHS fully funded continuing care. It does not replace the need for professional judgement and clinical reasoning. The decision must be made in line with national guidance⁵ as follows:

A person will be eligible for NHS fully funded continuing care when:

- A person is in the final stages of a terminal illness and the prognosis is that they are likely to die in the near future. Whilst not being prescriptive in terms of timescales, within this policy the "near future" is interpreted as days and weeks not weeks and months. Such people should be able to choose to remain in NHS funded accommodation including a care home with nursing, or to return home with the appropriate support.
- Where legislation or guidance determines an automatic eligibility for NHS fully funded continuing care e.g. some sections of the Mental Health Act 1983.
- The nature or complexity or intensity or unpredictability of the healthcare needs (or any combination of these needs) requires regular supervision by a member of the NHS multidisciplinary team such as the consultant, therapists or community matrons. This includes people with rapidly deteriorating or unstable medical, physical or mental health conditions.

⁵ HSC201/015 : LAC (2001)18 'Continuing Care: NHS and Local Councils' Responsibilities

- A person's assessed needs require the routine use of specialist healthcare equipment under the supervision of NHS staff (see Appendix 3).

The location of care should not be the sole or main determinant of eligibility for fully funded NHS continuing care.

The eligibility criteria set out above, in conjunction with application of guidance in respect of NHS Funded Nursing Care (see Appendix 4), fulfil the requirements of the judgement in the Coughlan case (see 5.3 below).

5.3. Category 2 – Continuing Health and Social Care (Jointly funded and/or provided packages of care)

This term describes a package of care that requires services from both the NHS and social care but where the primary need is for accommodation and personal care rather than for care that is the responsibility of the NHS (Coughlan Test)⁶.

In this circumstance, the healthcare component of the care package must be clearly identifiable and capable of being costed. The jointly agreed arrangements must be supported by a checklist of NHS and social care responsibilities.

The assessed needs of the person may be met by existing commissioned services or may require funding for additional services to be commissioned. Continuing health and social care can be provided in a number of settings which could include the person's own home.

Where the NHS and social services are jointly providing a range of services, the NHS's responsibility is to ensure that the identified health care needs of the person are met in terms of services and equipment. The services may be provided through NHS staff working in the community or in day hospitals for example, or through the commissioning by the NHS of health care provided by the private or voluntary sector. This will include the professional nursing care that an individual receives in a care home. The equipment provided will be that which is associated with the management of the person's health condition as opposed to equipment required for social independence.

Within this category four particular jointly funded circumstances can be identified and are set out below. In each of these circumstances, the multidisciplinary team, through local continuing care processes and decision making must firstly agree that category 1 (NHS fully funded continuing care) is not applicable.

The four circumstances are as follows:

⁶ In a care home, accommodation and social care will either be funded by social services (for which the service user will be financially assessed to determine whether they will be required to make a financial contribution) or funded by the user themselves. Health care services (including registered nursing care) and other nursing care which cannot lawfully be provided by Local Authorities will be provided by the NHS in accordance with service users' assessed needs. Local Authorities may only provide nursing care which is incidental or ancillary to the provision of accommodation and of a nature which it can be expected that a Social Services Department can provide. This test is referred to as "the Coughlan test". HSC 1999/180: LAC 99 (30) *Ex Parte Coughlan*

5.3.1 Care in a Registered Care Home with Nursing where nursing care is met within RNCC banding⁷

In this circumstance health care services include the NHS funding of registered nursing care that is covered by the Registered Nursing Care Contribution (RNCC) bandings of Low, Medium or High. This is called NHS Funded Nursing Care. (See also paragraph 6 which sets out the link between NHS fully funded continuing care and Funded Nursing Care).

In this setting social care will either be funded by social services (for which the person will be financially assessed to determine whether they will be required to make a financial contribution) or funded by the person themselves.

5.3.2 Care in a Care Home with Nursing where the nursing needs are above those that can be met within the RNCC banding

In this circumstance, the person has a high level of need but does not meet the eligibility criteria for NHS fully funded continuing i.e. Category 1. However, their nursing needs are more than can be met by the RNCC High Band of NHS Funded Nursing Care. The person's primary need will still be for accommodation and/or personal care.

5.3.3 In a residential bed within a registered care home

In this circumstance social care will either be funded by social services (for which the person will be financially assessed to determine whether they will be required to make a financial contribution) or funded by the person themselves.

However for those individuals whose assessed care needs are complex and challenging requiring a high level of support, local joint decision making mechanisms will be in place to agree the level of joint funding.

NHS services will usually be provided "through the door" e.g. District Nurse, GP to meet the assessed healthcare needs of the service user.

5.3.4 In a Person's Own Home

In this circumstance social care will either be funded by social services (for which the person will be financially assessed to determine whether they will be required to make a financial contribution) or funded by the person themselves. However for those individuals whose assessed care needs are complex and challenging requiring a high level of support, local joint decision making mechanisms will be in place to agree the level of joint funding.

NHS services will usually be provided "through the door" e.g. District Nurse to meet the assessed healthcare needs of the service user.

5.4. Category 3 – Continuing Social Care

Entitlement to community and personal care services will be determined by each social services department in accordance with its eligibility criteria developed under the Fair Access to Care Services (FACS)⁸ guidance. There are four defined areas of risk in the guidance:

- Critical;

⁷ This may include some categories of independent hospital.

⁸ LAC(2002)13 *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*

- Substantial;
- Moderate; and
- Low.

Each social services department will set its eligibility criteria to prioritise which levels of risk and need it will meet in accordance with its powers, statutory duties and available resources.

6. The relationship between NHS Fully Funded Continuing Care, Funded Nursing Care (FNC) and Fair Access to Care Services (FACS)

The criteria set out in this document are intended to help to determine whether or not a person should receive **NHS fully funded continuing care** (Category 1). The decision about continuing NHS care lies at the start of a process. If a person is not considered to be eligible for NHS fully funded continuing care, consideration will be given to whether the person's needs require service arrangements of continuing health and social care (Category 2), which may include **Funded Nursing Care**, in a care home with nursing or, where no health care is required, **continuing social care** (Category 3).

Regardless of the category of care, people are entitled to access the full range of healthcare services commissioned and/or provided by their PCT (as is the general population) e.g. GP, District Nursing, specialist transport services and equipment. Access to some services will be based upon assessed need.

An assessment of nursing need is an important part of a comprehensive assessment of need. However, an assessed need for nursing care in a care home with nursing does not in itself indicate eligibility for NHS fully funded continuing care at any of the FNC banding levels.

7. The assessment tool

7.1 Background

To achieve fairness and consistency of outcome in determining who would be eligible for NHS fully funded continuing care a new assessment tool (see Appendix 5) has been introduced across the SHA area. It is at the heart of this revised policy and has been developed and agreed by all the partner agencies.⁹

The previous policy (adopted in November 2002), and much of the national guidance on which it was based, is couched in subjective language such as *unpredictable*, *unstable* and *frequent* which can be open to wide interpretation. The example set out in Table 1 below illustrates the level of detail and specificity of the assessment tool, which removes much of the subjective interpretation.

Increasingly there are moves towards having the same assessment tool used across large areas where health and social care agencies work in partnership to ensure consistent practice and to address the differing interpretations of

⁹ We are grateful to Thames Valley SHA and Cumbria and Lancashire SHA for sharing their work, which provided the initial impetus for a common assessment process which has been revised and added to locally.

words and concepts. These are the issues which the national work described in paragraph 1.2.2 will be addressing.

Table 1

Example of a care domain

Care domain – mobility

Level of Need	Relative Weighting
Fully ambulant. Or independently mobile.	0
Needs some assistance and/or requires mobility aids or able to weight bear for transfers only, but may need assistance.	20
Not able to weight bear but able to assist or co-operate or is not able to assist but is manageable with transfers or repositioning which requires the use of manual handling equipment.	40
Not able to consistently weight bear ¹⁰ or completely unable to weight bear and unable to assist or co-operate whilst transferring and/or repositioning which is difficult to manage and requires a specific care plan due to practical complexities of moving the client (e.g. obesity, behaviour, resistive, high anxiety). May require up to 3 carers to assist with transfers. or mobile but at severe risk to self or others when mobilising due to uncontrollable movements/unpredictability/falls.	60
There is an increased risk of physical harm when moving or handling due to the individual's condition e.g. myoconvulsive jerks, severe contractures, risk of choking without careful head positioning, exacerbation of pain.	80
Immobility <i>and/or</i> clinical condition such that upon being moved <i>or</i> transferred there is a high risk of serious physical harm e.g. dysreflexia, brittle bones, where positioning of patient is critical.	100

¹⁰ Acknowledging a potential risk if can't be consistent.

7.2 Coverage

In order to ensure as far as possible consistency of assessment and application of eligibility criteria the tool will be used in all cases where a request or application has been made for NHS fully funded continuing care.

7.3. Assessment process

A range of assessments, including for example a community care assessment, may be required to determine the total health and social care needs of an individual and not just eligibility NHS fully funded continuing care. A comprehensive assessment process will involve a range of different professionals or specialist teams with the relevant skills and knowledge. It will be important for the various in-depth assessments to be coordinated and drawn together and interpreted.

All assessments for health need should involve the clinical professionals with responsibility for the care of the patient.

Information and advice should be offered, and individual assessments of need should be arranged, for carers (by agreement) in situations where they provide or intend to provide regular and substantial care.

Assessments of need should initially be reviewed after 6 – 8 weeks, and then at least annually. Under FACS there is an annual re-assessment which includes the application of any eligibility threshold.

7.4. Using the tool

The tool provides a wholly needs-led approach to assessment. It takes account of a range of factors, described as care domains, which have a bearing on a person's dependence and care needs. There are 11 care domains and within each care domain are six 'levels of need' which escalate in terms of need and risk. A score is attached to each level of need and it is these scores which support and inform the decision about eligibility for NHS fully funded continuing care. In this way, the tool can be used to measure how the needs of individuals change over time. The "scoring" device is called the Threshold Tool. For example, the NHS may be responsible for arranging and funding appropriate services to meet a person's need if three or more of the care domains have a weighting of 100; or if two care domains have a weighting of 100 and one care domain has a weighting of 80.

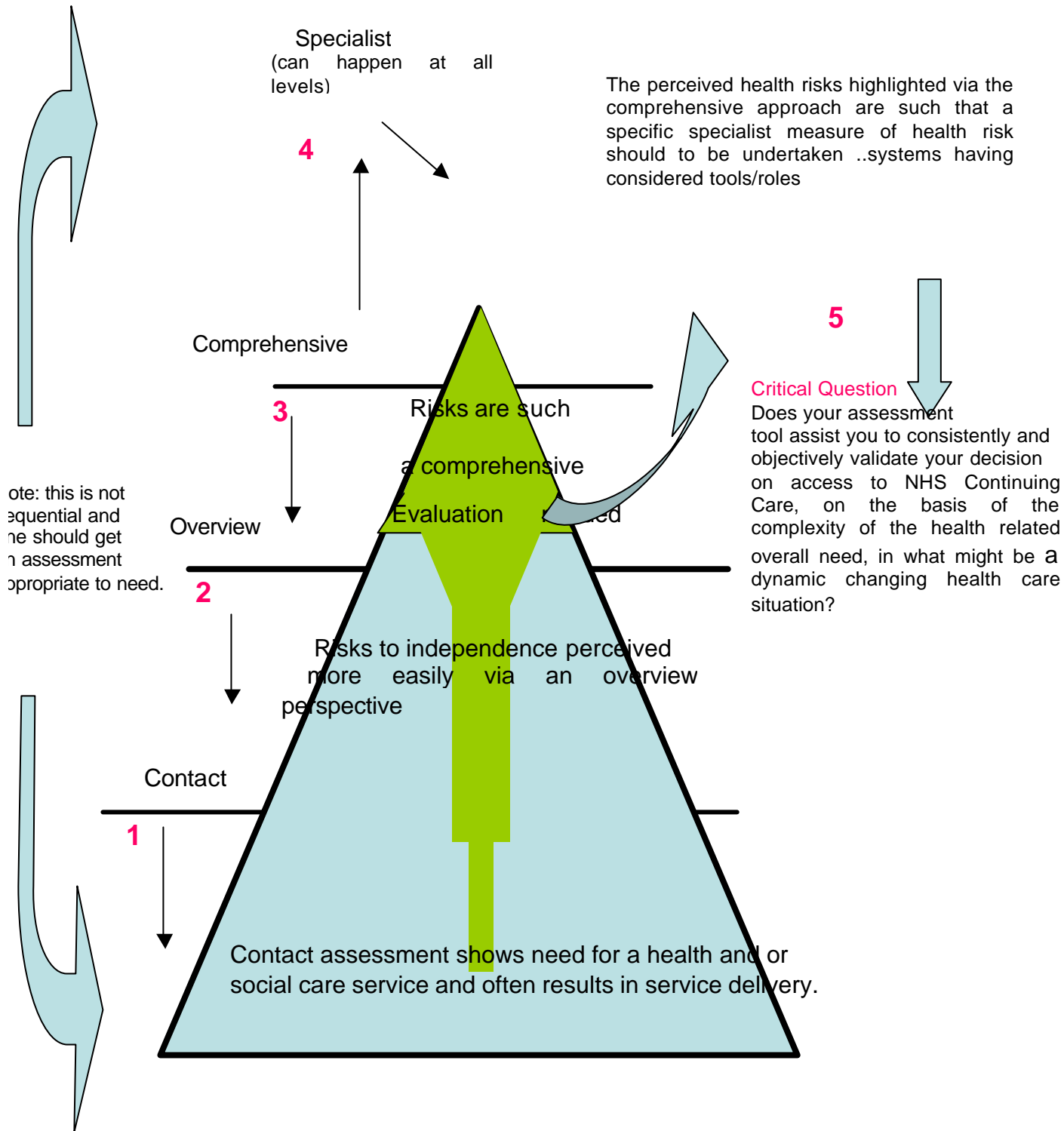
The tool will be completed by the multi-disciplinary team and its completion will be informed by the range of assessments required to determine the full range of a person's health and social care needs.

Once completed the toolkit will inform the decision as to whether a person is eligible for NHS fully funded continuing care. This will be a joint decision agreed by health and social care through locally agreed continuing care processes.

The toolkit will be incorporated into the Single Assessment Process.

The diagram below¹¹ illustrates the links between continuing care and the single assessment process.

¹¹ Developed by the Change Agent Team



The levels of need described within the toolkit domains will not adequately describe every individual circumstance and, therefore, professional judgement and clinical reasoning will be important in ensuring that the scoring reflects the person's needs as accurately as possible.

Free text can be added to explain needs not specifically described by the domain and to justify the scoring.

7.5. Application for funding

The multidisciplinary team will make a recommendation supported by the tool and associated assessment detail through local decision-making processes or,

where budgets are devolved to the level of the multidisciplinary team, the decision will be made at this level in line with local performance management arrangements.

7.6 Benefits of using the tool

The tool:

- Is visible and therefore fair to service users;
- Is client-specific and needs-led;
- Separates out, or grades, the different levels of need;
- Collects the evidence about individuals as the basis for making judgements about needs and eligibility for fully funded NHS continuing health care; and
- Aids understanding of complexity, in the way that the care domains interact.

8. Operation of the policy

8.1 Best practice approach to assessment and decision-making

- The six NEYNL LAs with social services responsibilities and the ten NEYNL PCTs have responded to government guidance on continuing care by setting up joint decision-making processes in local areas. This process deals with situations where the criteria for part or full NHS funding of a placement or package of care/treatment may be met. The joint decision-making process facilitates consistency of decision-making across the area and minimises the need for disputes procedures.
- The criteria for full or part funding of placements and packages of care have been agreed between all the relevant statutory bodies in the NEYNL area and are consistent with the current legislative scheme and with government guidance. Where it appears that an individual situation may meet the criteria for full or part NHS funding a thorough multi-disciplinary assessment will be undertaken, including a comprehensive needs assessment. The results of this assessment will be written up using current agreed documentation. If the Continuing Care operational lead for the relevant PCT is not already involved and not aware of the situation, front-line staff are asked to liaise with this individual to ensure that the process runs smoothly.
- Access to clinical information about a patient should be kept to the minimum number of people and in line with confidentiality policies.

8.2 Continuing care assessment and hospital discharge

In order to allow for the reimbursement policy¹², a screening process is used for people about to be discharged from hospital to determine whether they would be likely to qualify for NHS fully funded continuing care. (See Appendix 6).

The purpose of this screening tool is to avoid, as far as possible, the unnecessary issuing of section 2 notices (assessment notification) to Social Services. To ensure a patient's potential eligibility for NHS fully funded

¹² The Delayed Discharges (Continuing Care) Directions 2004

continuing care a full multidisciplinary assessment process is triggered as early as possible thus preventing delayed transfers of care.

Before a patient has a full assessment for eligibility for fully funded continuing NHS health care, this screening tool should be used as a quick guide to determine whether or not it is likely that the patient will be eligible.

The screening tool uses the levels of need that score 80 in each care domain of the Threshold Tool. Each description should be applied to the patient. Where the patient meets **3** or more descriptions within the screening tool this should trigger a multi-disciplinary assessment for eligibility for NHS fully funded continuing care (once, in the opinion of the multi-disciplinary team, the patient is fit for discharge) and a section 2 notice should **not** be made to Social Services. However if, following that assessment, the patient is not deemed to be eligible, a section 2 notice should be issued at that point.

8.3 Independent review process

A review process is in place to ensure that the eligibility criteria for NHS fully funded continuing care are consistently and fairly applied and provides patients, families and carers with a safeguard at the point of discharge from NHS care. The procedure also exists to review Funded Nursing Care determinations when they are challenged and cannot be resolved informally.

The process includes a panel which has an independent, lay chair.

Details of the review process are attached at Appendix 7.

8.4 Disputes/complaints procedures

8.4.1 Joint solutions, disputes/complaints and appeals

This section covers the formal procedures for dealing with disputes, complaints and appeals in a range of specified situations. However, it is always desirable to avoid the need to invoke such formal processes by:

- Ensuring that clear and accurate information is given to and received from all parties concerned.
- Ensuring that unspoken/unwritten assumptions are checked.
- Conveying clearly and in writing any decisions which are made and the reason for these.
- Ensuring that rules and regulations are explained and applied consistently but also in a way that takes account of the individual circumstances pertaining to the given situation.

In the context of this policy there are eight main areas of formal complaints/disputes to be considered:

- 1) Where the local NHS bodies and the local authority disagree over funding arrangements for a particular placement or package of care.
- 2) Where an NHS patient is in dispute with the local NHS Trust(s) or PCT(s) in relation to discharge from hospital.
- 3) Where local NHS bodies and the local authority disagree over reimbursement for delayed discharges.

- 4) a) Where a patient does not agree with the local NHS Trust(s) or Primary Care Trust(s) decision in relation to funding against the continuing health care criteria for the period between 1st April 1996 and 31st March 2004.
b) Where a patient does not agree with the local NHS Trust(s) or Primary Care Trust(s) decision in relation to funding against the continuing health care criteria for the period after 1st April 2004.
- 5) Where an individual living in or moving to a Registered Care Home (subject to the Care Standards Act) does not agree with the NHS determination of his/her nursing needs in relation to 'NHS Funded Nursing Care'.
- 6) Disputes, appeals, complaints and comments on Community Care Services provided by LAs with social services responsibilities.
- 7) Complaints about NHS services.
- 8) Complaints about independent sector services.

8.4.2 Continuing NHS funding of treatment, placements or packages of care (wherever located) – disputes between LAs with social services responsibilities and NHS regarding funding responsibilities.

The constituent Local Authorities with social services responsibilities and Primary Care Trusts within the NEYNL area have responded to government guidance on continuing care by setting up a joint decision making processes in local areas. This process deals with situations where the criteria for part or full NHS funding of a placement or package of care/treatment may be met. The joint decision making process facilitates consistency of decision making across the area and minimises the need for dispute procedures. **Where disputes do occur this should not delay the discharge or placement of a patient. Local resolution should be implemented.**

The criteria for full/part funding of placements and packages of care have been agreed between all the relevant statutory bodies in the North and East Yorkshire and Northern Lincolnshire area and are consistent with the current legislative scheme and with government guidance. These are set out in section 5 of this policy.

Where it appears that an individual situation may meet the criteria for full or part NHS funding a thorough multi-disciplinary assessment will be undertaken, including a comprehensive needs assessment. The results of this assessment will be written up using current agreed documentation. The Primary Care Trusts named operational lead for continuing care will have overall responsibility for ensuring that the appropriate assessment process is followed. Staff should ensure the notification and engagement of the operational lead who will then co-ordinate the process.

Any disputes between health and Local Authorities with social services responsibilities should be referred upwards within individual organisations for a joint decision at a senior level.

The procedure outlined in this section is not intended for disputes between patient/carers and the individual agencies. Please refer to the sections below which cover such disputes. Where the relevant agencies have agreed about the funding responsibility for a particular placement or care package for hospital discharge, but the patient and/or his/her representative feels that the eligibility criteria have not been correctly applied, reference could be made to the Continuing Health Care Independent Review Panel as outlined in section 8.4.9. Cases cannot be referred to this Panel unless any disputes between the agencies have been resolved.

8.4.3 *Rights to refuse discharge from hospital*

Where patients have been assessed as not requiring NHS continuing (clinically assessed) inpatient care they do not have the right to occupy an NHS bed indefinitely. In all but a very small number of cases where a patient is being placed under Part II of the Mental Health Act 1983, they do however, have the right to refuse to be discharged from NHS care into a Registered Care Home (subject to the Care Standards Act). In such cases Local Authorities with social services responsibilities should work with hospital and community based staff and with the patient, his/her family and any carer to explore alternative options.

8.4.4 *Disputes between NHS bodies and local authorities concerning reimbursement for delayed discharges*

In accordance with paragraph 15 of the National Health Service and Social Services Delayed Discharges (England) Regulations 2003 Strategic Health Authorities are required to establish and maintain a panel to assist in the resolution of disputes arising under the Community Care (Delayed Discharges) Act 2003. A procedure to deal with such disputes has been agreed by the 3 Strategic Health Authorities within the Yorkshire and Humber area. The principle underpinning the dispute resolution procedure is that it is a last resort and therefore should seldom be invoked once all reasonable efforts to resolve matters through local negotiations have been exhausted. This procedure does not involve patients who should be cared for in an appropriate setting though out the process.

8.4.5 *Disputes between patients and statutory authorities over continuing health care and funded nursing care decisions – Independent Review Panel*

The procedure for disputes between patients and statutory authorities over continuing health care decisions for retrospective reviews of continuing care decisions for the period 1st April 1996 to 31st March 2004 is outlined out in the North and East Yorkshire and Northern Lincolnshire Strategic Health Authority Procedure for Retrospective Continuing Care Reviews.

The procedure for disputes between patients and statutory authorities over continuing health care and funded nursing care decisions made after 1st April 2004 is outlined in Appendix 7.

8.4.6 *Complaints about Local Authorities with social services responsibilities*

If an individual wishes to make a complaint about the social services they have received, they should complain in the first instance under Local Authorities with social services responsibilities complaints procedure. In such situations complaints should be addressed to the relevant social services Complaints Officer. Users and carers also have the right to seek legal advice where they think is appropriate and, depending on the nature of the complaint, there are procedures dealing with those situation where even after investigation by the complaints officer the individual remains dissatisfied.

Difference of professional opinion or concerns about the way a service has been provided should usually be handled at an appropriate and local level in the first instance. Official disputes that cannot be resolved in this way should be referred to the relevant Area or Service Manager. Failing a satisfactory resolution at that level, the issue will be considered by the relevant Head of Service and/or members of the service involved as appropriate.

Comments on Local Authorities with social services responsibilities Community Care Services are both invited and welcomed. They will help inform service development and the annual planning processes. Comments should be sent to the relevant Director for your area.

8.4.7 *Complaints about NHS services*

Each NHS organisation has a Patient Advisory and Liaison Service (PALS), who can offer help and advice for any patient or carer concerns and can help to arrange further contact with relevant staff and advice patients / carers of their options. Every trust and Primary Care Trust has a duty to have a named person for addressing complaints, usually the Chief Executive. A leaflet outlining the NHS complaints process should be available from PALS or complaints staff detailing the process and timeframes. Should the patient / carer require support and or advocacy, the Independent Complaints Advisory Service (ICAS) has been established to provide this. Details should be available PALS, NHS staff and through voluntary sector advisory organisations. If local options for resolving the complaint have been exhausted, the patient / carer can ask the Healthcare Commission to review the matter.

Any complaints about the process of the determination of care by a registered nurse under the 'NHS Funded Nursing Care' arrangements should go through the relevant Registered Care Home (subject to the Care Standards Act) co-ordinator in the first instance who will liaise with the PCT complaints manager.

8.4.8 *Complaints about independent sector providers*

If a complaint concerns care that is provided in an independent sector care home, it should be dealt with by the Registered Care Home (subject to the Care Standards Act) itself in the first instance. If the complainant is dissatisfied with the response to their complaint they may refer the matter to the Commission for Social Care Inspection.

Regulations operated by a the Commission for Social Care Inspection regulate care homes and all regulated service providers are required to operate robust and comprehensive complaints procedures.

8.5. Continuous audit and development

New arrangements have been set up to ensure effective implementation of the policy. There are two network wide, joint (NHS and Local Authorities) groups to take forward development, policy implementation, monitoring and audit. The roles and membership of these two groups are attached at Appendix 8.

The Joint Executive Policy Development Group (Continuing Care) is a senior network group comprising PCT and Local Authority representatives which meets quarterly.

The Analysis and Audit Group meets monthly and undertakes both quantitative and qualitative analysis e.g. practice consistency, audit and sampling on key issues.

These two groups:

- Provide leadership, oversight and clarity in policy development across the health and social care economies; and
- Ensure the effective operation of the SHA's Continuing Health and Social Care Policy, particularly in respect of consistency of application of the eligibility criteria for fully funded NHS continuing health care.

Appendices

The PCTs and LAs covered by this policy

Signatories to the document

Background to the implementation of continuing care policies

Assessment tool

Screening process

Equipment

Audit and development

Independent review procedure

(Glossary of terms – to be completed)

Appendix 1 The PCTs and LAs covered by this policy

North and East Yorkshire and Northern Lincolnshire (NEYNL) Continuing Health and Social Care Policy (the policy), adopted by the ten Primary Care Trusts (PCTs) and the six NEYNL Local Authorities (LAs) with social services responsibilities, outlines the framework within which key health and social care services are provided in the NEYNL area. The policy reflects government initiatives on partnerships and the integration and co-ordination of health and social care activities.

The ten NEYNL PCTs have overall responsibility for the planning of services to meet local health needs across the area. They work in partnership with the Local Authorities to commission and purchase services to meet those needs.

The six NEYNL Local Authorities with social services responsibilities have a duty to assess the social care needs of individuals and their carers, to provide or purchase services to meet assessed needs taking into account Fair Access to Care Services, and monitor and review these services to ensure that they continue to be effective and necessary. Other departments of Local Authorities, including Education, Housing and Environmental Protection, have responsibilities which assist in the provision of support to individuals living in the community.

The ten NEYNL PCTs and six NEYNL LAs with social services responsibilities work closely together and in collaboration and partnership with a wide range of other public service agencies, particularly in the health field, and with local voluntary and private sector groups (referred to as the 'independent' sector).

Signed by Date
.....
John Marsden, Chief Executive, North Yorkshire County Council

Signed by Date
.....
David Atkinson, Chief Executive, City of York Council

Signed by Date
.....
Kim Ryley, Chief Executive, Hull City Council

Signed by Date
.....
Darryl Stephenson, Chief Executive, East Riding of Yorkshire
Council

Signed by Date
.....
George Krawiec, Chief Executive, North East Lincolnshire
Council

Signed by Date
.....
Dr Michael Garnett, Chief Executive, North Lincolnshire Council

Signed by Date
.....
Penny Jones, Chief Executive, Craven, Harrogate & Rural
District PCT

Signed by Date
.....
Iain McInnes, Chief Executive, Eastern Hull PCT

Signed by Date
.....
Andrew Williams, Chief Executive, East Yorkshire PCT

Signed by Date
.....
Simon Kirk, Chief Executive, Hambleton & Richmondshire PCT

Signed by Date
.....
Jane Lewington, Chief Executive, North East Lincolnshire PCT

Signed by Date
.....

Cathy Waters, Chief Executive, North Lincolnshire PCT

Signed by Date

.....

Michael Whitworth, Scarborough, Whitby & Ryedale PCT

Signed by Date

.....

Jeremy Clough, Chief Executive, Selby & York PCT

Signed by Date

.....

Christopher Long, Chief Executive, West Hull PCT

Signed by Date

.....

Adrian Smith, Chief Executive, Yorkshire Wolds & Coast PCT

Appendix 2 Background to the implementation and development of continuing care policies

1. Guidance

In February 1995 the government asked Health Authorities to review their responsibilities for the health care of individuals with continuing or long-term care needs. Since that time further guidance has been issued amending and updating the continuing care policies. The most recent of these is HSC 2001/015: LAC (2001)18 Continuing Care: NHS and Local Authorities' Responsibilities.

The purpose of this circular was to consolidate guidance on continuing NHS health care in the light of both the judgement of the Court of Appeal in Rv North East Devon Health Authority ex parte Coughlan (1999) and the role of funded nursing care.

The guidance set the following objectives for former Health Authorities working closely with PCTs and local authorities:

- To agree continuing care criteria with local authorities, using the guidance HSC2001/015: LAC (2001)18 to produce a document which sets out responsibilities for meeting continuing health care needs by 1 March 2002;
- To ensure that review and complaints procedures were in line with that guidance; and
- To implement any necessary changes by 1 March 2002.

Since the guidance was published Strategic Health Authorities (SHAs) have been established and have one set of criteria across their area.

Continuing care policies and practice have also subsequently been informed by reports of the Ombudsman's investigations.

2. Ombudsman reports

February 2003¹³

The Ombudsman reported on four cases where fully funded continuing health care had been wrongly denied. These were indicative of other complaints being investigated and the Ombudsman concluded there was a widespread problem. She therefore recommended that:

Strategic health authorities and primary care trusts should:

- Review the criteria used by their predecessor bodies, and the way those criteria were applied, since 1996. They would need to take into account the Coughlan judgment¹⁴, guidance issued by the Department of Health and the Ombudsman's findings;
- Make efforts to remedy any consequent financial injustice to patients, where the criteria, or the way they were applied, were not clearly appropriate or fair. This was to include attempting to identify any patients in their area who may wrongly have been made to pay for their care in a

¹³ *NHS funding for long term care of older and disabled people*

¹⁴ R. v North and East Devon Health Authority ex parte Coughlan

home and making appropriate recompense to them or their estates (i.e. retrospective reviews).

March 2004¹⁵

- This was a report of a case concerning a man with early onset dementia. The implications of this report were significant in the context of:
- Home as a setting, despite cost;
- The assessment of psychological and mental health needs being adequately reflected in the assessment process/matrix;
- A further erosion of the balance between need/diagnosis;
- The carer view and its impact on outcome;
- A continued increase in public awareness;
- The sustainability of significant 'care arrangements' at home, without addressing the role of mainstream service functions including those of general practice.

December 2004¹⁶

A report, following up the report of February 2003, was published on 16 December. It is based on evidence gathered from almost 4000 complaints received since that first report and shows how, from the patient's point of view, applying for funding for long term care has been a "lengthy hit and miss affair".

The report highlights the problems resulting from the lack of a national policy and guidance framework and makes the following recommendations:

- Establishing clear, national, minimum eligibility criteria which are understandable to health professionals and patients and carers alike;
- Developing a set of accredited assessment tools and good practice guidance to support the criteria;
- Supporting training and development to expand local capacity and ensure that new continuing care cases are assessed and decided properly and promptly;
- Clarifying standards for record keeping and documentation both by health care providers and those involved in the review process.

3. National approach

On 9 December the Health Minister Stephen Ladyman commissioned a new national approach to assessment for fully funded NHS continuing care and announced the publication of an independent report on continuing care¹⁷. Learning from good practice, and using the findings of the independent review, the national approach to assessment for continuing health care should improve consistency, and ease of understanding.

¹⁵ *Mrs Pointon's complaint against the former Cambridgeshire Health Authority and South Cambridgeshire Primary Care Trust*

¹⁶ *NHS funding for long term care: follow up report*

¹⁷ *Continuing Health Care: Review, revision and restitution*

Appendix 3 - Equipment

1. Specialist equipment

Annex C of HSC 2001/15 refers to the need for the routine use of specialist health equipment under the supervision of NHS staff as a “key issue” when considering eligibility for Continuing NHS Health Care, though it does not propose this as a stand - alone criterion. The routine need people have for specialist equipment will be considered as part of the overall assessment for continuing health care.

There is no clear definition of what constitutes a specialist piece of equipment. Much technical equipment used to meet health needs can be used by informal carers or non NHS staff, with suitable training, depending on the circumstances and the patient's health.

Registered care with nursing will be required to supply certain standard items of equipment under the Care Standards Act and regulations. A further range of items will be provided by the NHS (or Social Services) through the integrated Community Equipment Service.

More specialist items, not available on prescription, that are essential for the personal use of a resident to maintain their health status and which are not supplied by the provider as part of the Contract, may be supplied by the NHS to people in the community or in Care Homes (in addition to those items the Care Home is required to supply as part of its Contract). This will be the subject of the multi-disciplinary assessment and endorsed by the relevant NHS budget holder.

The assessment should take into account as the key issues:

- An individual assessment of the need of the patient for the equipment;
- The degree to which the provision of the equipment is essential to produce a significant health gain for the patient;
- The degree to which the provision of the equipment will reduce the NHS professional inputs required to maintain the patient's health status in a stable state.
- The degree to which the provision of the equipment is essential to avoid a significant deterioration in the health of the individual.
- Provision of such equipment will not automatically lead to an entitlement to continuing NHS health care: Nor will the fact that a piece of equipment can only be used by an NHS professional.

2. Equipment in care homes with nursing¹⁸

The list set out below (not exhaustive) includes the type of equipment that should be standard to any care home with a nursing registration, subject to local agreement, to enable them to meet the assessed needs of those people for whom they are providing nursing care:

- a range of seating: to include standard various height /height adjustable armchairs, riser/ recliner chairs, standard orthopaedic chairs which are in regular use and can be used by the majority of clients
- pressure relieving/reduction: to include static replacement mattresses for all clients (e.g.: transfoam, softform) a variety of dynamic mattresses depending on the size of the nursing home
- a variety of static pressure relieving cushions, e.g. transfoam and repose
- all beds should be variable height as standard.
- feeding aids and dressing aids
- bath and shower seats
- fixed items such as grab rails
- a variety of standard hoists, slings, commodes and standing frames
- a minimum of two syringe drivers proportional to number of clients
- a minimum of two suction machines proportional to number of clients
- transit wheelchairs adequate for number of people in home.

The ICES team has produced a document, "Community equipment and care homes" which aims to facilitate the development of local agreements between the statutory agencies and care homes. It has a comprehensive list of equipment, not all of which would be provided by community equipment services, as the basis for local arrangements. An extract from the checklist is set out below.

"The table below is provided to assist community equipment services determine the arrangements for funding, provision and maintenance in the case of examples of equipment for care homes. Not all of the items listed are provided by community equipment services. Some health items may be provided directly by primary care trusts. Care homes will need to meet the minimum standards for provision of equipment for users as well as health and safety for users and staff, etc.

The table can be used for commissioning services, as part of internal protocols for community equipment services or as part of an agreement with a care home or group of care homes.

Type of equipment	Arrangements for funding	Arrangements for provision	Arrangements for maintenance	Comments
For administration of medicine				
For administration of oral medicine e.g., measures, medication boxes				
For administration of rectal medication, e.g., gloves				
For administration of medication by injection				
Specialist syringe drivers, e.g., for epidurals				
Bathing Equipment				
Range of bath seats				
Range of bath boards				
Electric/manual bath lift:				
Range of chairs				

Range of shower stools				
Beds				
General beds under risk management				
PEG feeding equipment (EL (95)5)				
PEG feeding consumables				
For intravenous feeding and transfusion				
Equipment, e.g., plate accessories				
range of feeding equipment				
Environmental Support				
Helping hand				
Trolley				
Perching stool				
Mobility Equipment				
Walking Equipment Provided on basis of assessment				
Wooden walking stick				
Fisher walking stick				
Walking frames				

18. The ICES team has produced a document, "Community equipment and care homes" which aims to facilitate the development of local agreements between the statutory agencies and care homes. It has a comprehensive list of equipment, not all of which would be provided by community equipment services, as the basis for local arrangements. A copy of the checklist is attached for information.

Checklist for community equipment services and commissioners

(Copy/paste and develop your own checklist in a word processor)

Item	Arrangements
1 Identify all care homes where equipment is provided together with types of items currently agreed	
2 Check with commissioners about arrangements for out-of-area placements, responsible commissioner, reference to equipment in contracts etc	
3 Distinguish between items provided as a general loan and items provided for individual end users	
4 Go to list in Appendix C and identify current arrangements	

for funding, provision and maintenance	
5 Identify trends in provision eg intermediate care, pressure relief etc	
6 Assess whether resources are available to meet current needs for coming year	
7 Draft out and develop agreement(s) with care home(s) or local representatives	
8 Finalise local protocols to cover all aspects of provision including recalls etc	

2) Checklist for care homes

(Copy/paste and develop your own checklist in a word processor)

Item	Arrangements
1 Identify what is included in the statement of purpose and care home brochure about provision of equipment and adaptations	
2 Maintain an inventory of equipment in the care home together with maintenance schedules, history etc	
3 Maintain information about staff training for use of equipment	
4 Ensure health and safety requirements are met including risk assessments	
5 Contact local service commissioners, ICES lead officer (if not already in contact) and ensure existing agreements cover equipment and adaptations and who is responsible for provision	
6 Ensure specified individual equipment is not used for other residents	
7 Contact equipment services to arrange return of loaned equipment	
8 Ensure local protocols cover the needs of all residents	

Appendix 4 Funded Nursing Care

Funded Nursing Care (FNC) is applicable only to people who are living in care homes with nursing care provided. It is paid for by the NHS and is free to the individual.¹⁹

People in care homes are assessed by an NHS nurse to determine their need for registered nursing care. An assessment tool called the RNCC Tool (Registered Nursing Care Contribution) is used. It determines whether a person has low, medium or high nursing needs and whether they also have needs for any continence services or related equipment. A nursing home will receive a payment from the NHS to provide the assessed level of nursing care.

The Local Authority remains responsible for the accommodation and social care component of the person's placement in the home, except for people who fund their own placement, and is entitled to charge the person for a financial contribution toward these costs.

¹⁹ HSC 2003/006: LAC (2003)7 *Guidance on NHS Funded Nursing Care.*

Appendix 5

North and East Yorkshire and Northern Lincolnshire
Strategic Health Authority

in conjunction with the Local Authorities and Primary
Care Trusts

**FULLY FUNDED NHS CONTINUING
HEALTH CARE
ASSESSMENT AND THRESHOLD TOOL**

June 2005

1. Introduction

This assessment tool is to be used to **assist** with the determination of eligibility for fully funded NHS continuing health care and takes account of a range of factors, described as care domains, which have a bearing on an individual's dependence and care needs. Following the assessment, the toolkit assigns a weighting "score" to each of the levels of need which helps to indicate which of the continuing care categories, if any, applies to the individual. The "scoring" device is called the Threshold Tool.

2. Decision making

The appropriate professional will score the care domains but the final decision on funding responsibilities will rest with the relevant continuing care panel (or other local decision-making mechanism).

The panel (or other local decision-making mechanism) uses, together with other information which includes the overall risk history (see paragraph 5 below), the threshold tool to decide whether the person meets the criteria for fully funded continuing NHS continuing health care.

An individual's eligibility for fully funded NHS continuing health care will be reviewed at least annually and if there is a change in the service user's condition a re-assessment will be undertaken.

LA – Patients will be reviewed on at least a 3-monthly basis.

3. Care groups

The care domains tool is to be used for all adults (over 18 years) as follows:

- Disabled adults with physical impairments
- Older people
- People with mental ill health
- People with a learning disability
- People who are in the final stages of a terminal illness and who are assessed by an appropriate health professional as likely to die in the near future.

4. Undertaking the assessment

In using this tool, the assessors should not consider it a 'snap shot' in time: they should take a wider view of the person's needs and behaviours rather than just assessing what they see on the day. The assessment of an individual's needs should encompass clinical risk; healthcare needs; social care needs; psychological support (for the patient and the family); and whether the patient is capable of expressing a wish or desire to live in one location or another.

If the patient lacks capacity, although the wishes of the family can and should be taken into consideration, ultimately, the clinical team needs to determine what is in the patient's best interests and where those needs can best be met.

The evidence for assigning a particular 'score' in each care domain must be clearly explained in the summary table (paragraph 7).

The levels of need can not adequately describe every individual circumstance and, therefore, professional judgement will be important in ensuring that the scoring reflects the patient's needs as accurately as possible.

4.1 Accounting for continence problems

Continence problems are common, and figure significantly in care plans for dependent people. All individuals should have access to specialist nurse continence advice and review, wherever they reside. Documentation of bowel or bladder problems is part of normal clinical assessment with a specific care plan to address the problems.

The skills required for effective continence management depend largely on associated problems such as:

- Communication
- Behaviour
- Cognitive impairment
- Mobility
- Skin

Individuals with communication, cognitive or behavioural problems are likely to require the most skilled care and are more likely to require continuous specialist nursing. For each individual, consider the possible impact of continence problems on each of the domains listed (communication, behaviour etc) – and score these accordingly.

5. Overall Risk History

Risks to be considered include self-harming behaviours including restricting fluid/food intake; verbal abuse; physical abuse; disinhibited behaviours; risk of exploitation; risk of falls and tissue viability.

Reference should be made to placement history including periods in hospital, care homes and other institutions such as prison. Admissions to hospital under the Mental Health Act should be recorded.

Risk as determined by Fair Access to Care Services (FACS) for the relevant local social services department should also be noted – i.e. critical, substantial, moderate or low.

6. Threshold Tool

The NHS may be responsible for arranging and funding appropriate services to meet an individual's need if, in the judgement of professionals, the patient meets any of the thresholds indicated below:

3 or more of the care domains have a weighting of 100

or

5 or more of the care domains have a weighting of 60 or more

or

2 care domains have a weighting of 100 and one has a weighting of 80

or

100 for behavioural problems, 0 for mobility

or

100 for seizures

or

100 for behavioural problems and 100 for cognitive impairment

7. Summary of care domains

The following form **MUST** be completed giving as much detail as possible in the “Evidence/justification” column to demonstrate how the weighting is derived from the “level of need” description. Please include references to source material e.g. assessment, consultant report.

Fairness and consistency are derived from an evidence-based and recorded approach of need. An audit trail of decision-making is essential for openness and visibility and therefore this section is critical to informing the judgment,

Name:**DOB:**

Care Domain	Weigh- ting	Evidence i.e. justification
1 Breathing		
2 Functional mental illness		
3 Communication		
4 Cognitive Impairment		
5 Behaviour		
6 Seizures		

Name:**DOB:**

Care Domain	Weigh- -ting	Evidence i.e. justification
7 Mobility		
8 Skin (e.g. pressure area, ulcer care)		
9 Food and Drink		
10 Drug Therapies and Medication		
11 Palliative Care		

Personal information, current status and history.

Name:	DOB:
NHS/Hospital No.	
SSD No.	
Address	
Home GP	
Temporary address (if applicable)	
Social services professional	
Health professional	
Past history incl. placements and brief medical history	
Diagnosis	
General health²⁰	
Personal care	
Night care	
Tissue viability risk score	

²⁰ E.g. recent illnesses, GP visits, hospital admissions

Name:	DOB:
Specialist medical/nursing therapies	
Medication	
RNCC*	
Current care package	
Equipment	
Future potential/prognosis/expected outcomes	
Overall risk history²¹	
Fair Access to Care Services	

* Please indicate banding if patient is currently in receipt of NHS Funded Nursing Care

Additional information/comments:

²¹ Refer to:

- Hospital admissions under MHA 1983
- Placement breakdowns
- Offending history
- FACS risk

Name:**DOB:****Person(s) completing the form – including family member(s) if involved**

Name	Designation	Contact details	Date

Decision/recommendation:**Overall responsibility held by:****Name (please print):****Signature:****Qualifications:****Date:**

Consent to share information

The consent form here is only required if consent has not already been given.

In order for this assessment tool to be used by the NHS and SSD, consent is required from the patient, or their representative, to allow the information to be shared between the NHS and Social Services.

All information will be used in the strictest confidence and shared on a 'need to know' basis and will not be revealed to any other agency without the express permission in writing of the client or their authorised representative.

I consent to the information contained within this assessment being shared between representatives from the NHS and the Local Authority's Social Services Department.

Name of patient.....

Address.....
.....

.....

Telephone No.....

G.P.
.....
...

Signed.....
.....

Date.....
.....

If signed on behalf of the patient

Name of

Representative*
.....

Relationship to the
patient.....

Telephone
No.....

Signed.....
.....

Date.....
.....

1. Breathing

Level of Need	Relative Weighting
<p>Able to breathe totally unaided. Un-supervised use of oxygen nebulisers. Breathing is a problem with or without exertion e.g. in chronic chest conditions.</p>	0
<p>Has chronic breathing difficulties, requiring weekly or less frequent monitoring by a health professional or will, weekly or less, require the supervised use of oxygen, nebulisers and inhalers.</p>	20
<p>Requires supervised use of continuous oxygen therapy and/or requires daily supervised use of inhalers and/or nebulisers and has chronic breathing difficulties requiring risk management by a health professional.</p>	40
<p>Is able to breathe only through a tracheotomy that requires infrequent (not daily) suction.</p>	60
<p>Is able to breathe only through a tracheotomy that requires daily attention and suction Has impaired or absent swallow reflex/unable to clear own secretions/oral suctioning required daily/specialist Speech and Language Therapy and dietetic advice needed. May require cough-assist mechanical intervention or is able to breathe unaided but may be dependent on mechanical ventilation at any time.</p>	80
<p>Unable to breathe independently, requires total ventilation.</p>	100

2. Functional Mental Illness/Dual Diagnosis

This domain is only to be used for individuals with a functional mental illness and who have been formally assessed and diagnosed with a mental illness (e.g. Schizophrenia or Bi-polar Affective Disorder), or personality disorder and who may also have a secondary diagnosis of learning disability.

Level of Need	Relative Weighting
Is stable and medication compliant and can be managed within primary and secondary care services.	0
Is at risk of relapse but is compliant with medication and treatment and can be managed and maintained within primary and secondary care services. Has some insight into difficulties and is fully compliant with care package.	20
There is a risk of relapse and non-compliance. There are periods when there is no insight into difficulties and they may have unrealistic expectations of themselves or others. Is managed and maintained within primary and secondary care services to ensure safety of themselves and others.	40
His/her insight into difficulties varies. Demonstrates non-compliance or treatment resistance, which could lead to risk to self or others. Requires regular (weekly) intervention to be maintained within primary and secondary care services. Staff require specialist training to manage the care required e.g. Assertive Outreach and Crisis Intervention or Community Addiction Teams, or other locally developed enhanced service.	60
Has impaired insight into difficulties. There is high risk of relapse, non-compliance or treatment resistance, which could lead to risk to self or others. Is maintained daily within the community (either within own home, supported housing, care homes registered for residential or nursing care.). Is on Enhanced CPA* and requires enhanced supervision from secondary services e.g. Assertive Outreach (as per department of health guidance) and Crisis Intervention or Community Addiction Teams, or other locally developed enhanced service.	80
Has no insight into difficulties and/or cannot be managed unless 24-hour specialist** staffed (NHS or independent hospital) care is provided. This is usually associated with a high level of risk to self and/or others, which requires interventions needing a regime of close monitoring and supervision, and is on enhanced CPA.	100

*Enhanced CPA - is for individuals with multiple care needs, who need to be in contact with more than one professional or agency. This group will need more intensive help from a range of services and may include those who have more than one clinical condition and/or a drug or alcohol problem. This group would also include those who are hard to engage and/or with whom it is difficult to maintain contact. Some people on enhanced CPA could pose a risk if they lost contact with services. Mental Health services prioritise resources towards this group.

**i.e Registered Mental Health Nurse or Registered Learning Disability Nurse.

DQ: Reverse levels of insight?

3. Communication

Level of Need	Relative Weighting
Able to communicate clearly, verbally or non-verbally, and express basic needs to carers, e.g. hunger, thirst, hot & cold, pain, need to go to the toilet.	0
Able to communicate needs clearly (both basic and fundamental, emotional and psychological), verbally or non-verbally but cannot do so without prompting or facilitation e.g. picture cards or without being in an environment conducive to their communication needs. And/or Ability to comprehend language or process information, is affected to a low degree most of the time And/ or Person's fluctuating condition (e.g. episodic psychiatric breakdowns or someone with learning disability experiencing behavioural distress) is accompanied by inability to comprehend language or process information is affected to a low degree.	20
Able to indicate they have a need to carers, verbally or non-verbally, but require prompting and facilitation and, because they are difficult to understand, need accurate interpretation by carers to understand basic needs.	40
Unable to consistently communicate basic needs due to a person's fluctuating condition including mental disorders (e.g. episodic psychiatric breakdown, depression, or someone with learning disability experiencing behavioural distress), their inability to comprehend language and/or their ability to process information is affected to a high degree, requiring increased support from a Registered Nurse and/or SALT and/or someone with enhanced skills in communication.	60
Unable to consistently communicate basic physical/emotional/psychological needs verbally or non-verbally even when prompted or facilitated, (e.g. Parkinson's/stroke/dementia, severe depression, learning disability), thus placing the individual at significant risk of self-harm, neglect or exploitation, which requires the delivery of care plans requiring specialist professional management* to maintain stability and reduce the risk of harm to the individual or others.	80
Unable to communicate their needs in any way even with prompting or facilitation, thus placing the individual at significant risk of self-harm, neglect or exploitation Or Inability to communicate emotional needs which gives rise to risk of suicide which require both 24 hour 1-1 care and specialist professional management*.	100

***Specialist professional management is the professional management of an agreed care plan designed by e.g. a psychologist, or specialist nurse (e.g. mental health or learning disability).**

4. Cognitive Impairment/Thought Disorder

Level of Need	Relative Weighting
No evidence of impairment, confusion <i>or</i> disorientation	0
Mild confusion, short term memory loss or mental disorder or learning difficulty which, weekly or less, requires supervision and assistance with activities of daily living (including living independently). Able to reason or problem solve. May have occasional difficulty with memory and decisions, requiring support or assistance but has insight into their impairment. Low risk of self-isolation, neglect, harm and relapse.	20
A level of cognitive impairment or mental disorder which requires daily supervision and assistance with activities of daily living and attend to safety needs, e.g. wandering out if unsupervised. Ability to reason is inhibited, but able to make decisions if offered limited options and guidance. Is unable to give informed consent on complex issues because of mental impairment. Moderate risk of self-isolation, neglect, harm and relapse.	40
A level of cognitive impairment or mental disorder which places the individual at substantial risk of harm, self neglect and or exploitation, which requires specialist professional management* or support at least monthly to reduce the risk.	60
A level of cognitive impairment which requires the delivery of care plans requiring specialist professional management* at least weekly to maintain stability and reduce the risk of harm to the individual or others Critical risk of self-isolation, neglect, harm and relapse.	80
A level of cognitive impairment or mental disorder or fluctuating mental state or constant lack of insight, which places the individual at critical and certain risk of self neglect, harm, exploitation or relapse on a regular basis, which requires specialist professional management* and may include 24 hour 1-1 support/care and/or an immediate response from on-site staff throughout a 24 hour period.	100

***Specialist professional management is the professional management of an agreed care plan designed by e.g. a psychologist, specialist health worker²² or specialist nurse (e.g. mental health or learning disability).**

²²A specialist health worker is an individual who has enhanced skills and knowledge in providing specific care and support to individuals requiring specialist ongoing interventions. e.g. Peg feeding, behavioural management support, assistance in communication, support to access main stream services etc.

5. Behaviour that challenges

Level of Need	Relative Weighting
No evidence of behaviour that challenges*, compliant with care.	0
Some incidents of behaviour that challenges* e.g. shouting and screaming, occurring occasionally requiring assessment, support and advice under the direction of a specialist worker**.	20
The person presents with behaviour that challenges e.g. shouting and screaming*, not more than twice a week, requiring specialist assessment, support or advice or would present with such behaviour without that support.	40
Behaviour that challenges occurring on most days which requires specialist assessment, management and support by a specialist worker. The aim of intervention is to manage the level of behaviour to ensure that the individual can continue to participate in activities of daily living and integration. Intervention at night is not required.	60
Erratic or infrequent incidents of behaviour that challenges and of high intensity with a significant risk of self-harm or harm to others. These are expected to occur daily. Has a specialist management plan to reduce or minimise the number or level of incidents. Intervention at night is required and periods of 1:1 intervention and monitoring.	80
High level of behaviour that challenges*** several times over a 24-hour period and on most days, requiring a specialist clinical management plan to reduce the episodes, and additional staff to manage and provide intervention over a 24-hour period.	100

* **Behaviour problems** are those that make it difficult for care to be provided or for the individual to share accommodation with others, but where there is no significant or persistent risk to their own safety or that of others. Such behaviour might include noisiness, resistive to care, anger or frustration, inappropriate physical contact which may cause risk to others or themselves, eating inappropriate matter, inappropriate voiding/defaecation, behavioural distress, restlessness or passive behaviour which puts the individual at risk.

** **Specialist** – e.g. Challenging Behaviour Team, multi-agency support.

*** **Serious behaviour problems** are those that place the individual at risk of significant self-harm, neglect or exploitation, or place others at risk, and which require specialist nursing or medical management to reduce that risk. Such behaviour might include aggression and violence, severe disinhibition; intractable noisiness/restlessness, persistently resistive to necessary care, deliberate and inappropriate voiding and defaecation, severe fluctuations in mental state, severe behavioural distress, extreme frustration associated with communication difficulties, interference with others, or be of a nature that requires the provision of staff to give daytime 1-1 care and/or be available for crisis intervention more than 3 times a night averaged over 7 nights.

6. Seizures and/or Transient Ischaemic Attacks

Level of Need	Relative Weighting
No history of seizures.	0
History of seizures but none within the past three months. Managed with medication. Does not require physical intervention or supervision.	20
Seizures over the last three months that may require the supervision of a carer to minimise the risk of self harm (periods of loss of consciousness) may not require any intervention Would require an epilepsy management plan following assessment by the Epilepsy Specialist Nurse in the use of benzodiazepine (rectal or oral).	40
Seizures which require monitoring at least monthly by a Specialist Epilepsy Nurse and require intervention by a Registered Nurse or Care Worker specifically trained in the care management to minimize the risk of self harm (e.g. administration of rectal medication). Daily seizures (not severe).	60
Has seizures at least weekly which result in severe unpredictable behaviour (e.g. damage to self, others or to property). Is monitored and reviewed at least fortnightly by the Specialist Epilepsy Nurse and requires a management plan which is undertaken by trained carers in epilepsy.	80
Severe uncontrolled seizures (daily or more) that do not respond to treatment and result in a high probability of risk to self or others. Is likely to require Specialist Epilepsy Services including Consultant Neurologist to review on a monthly basis. Requires monitoring and reviewing at least fortnightly by a Specialist Epilepsy Nurse or the responsible medical practitioner.	100

7. Mobility

Level of Need	Relative Weighting
Fully ambulant. Or independently mobile.	0
Needs some assistance and/or requires mobility aids or able to weight bear for transfers only, but may need assistance.	20
Not able to weight bear but able to assist or co-operate or is not able to assist but is manageable with transfers or repositioning which requires the use of manual handling equipment.	40
Not able to consistently weight bear ²³ or completely unable to weight bear and unable to assist or co-operate whilst transferring and/or repositioning which is difficult to manage and requires a specific care plan due to practical complexities of moving the client (e.g. obesity, behaviour, resistive, high anxiety). May require up to 3 carers to assist with transfers. or mobile but at severe risk to self or others when mobilising due to uncontrollable movements/unpredictability/falls.	60
There is an increased risk of physical harm when moving or handling due to the individual's condition e.g. myotonic jerks, severe contractures, risk of choking without careful head positioning, exacerbation of pain.	80
Immobility <i>and/or</i> clinical condition such that upon being moved <i>or</i> transferred there is a high risk of serious physical harm e.g. dysreflexia, brittle bones, where positioning of patient is critical.	100

²³ Acknowledging a potential risk if can't be consistent.

8. Skin Care

Pressure Area Care/Pressure Ulcer Care/Wound Management

Level of Need	Relative Weighting
Skin intact. Patient assessed as not at risk or low risk of pressure/ skin damage and stable.	0
Skin intact. Patient assessed as medium/high or high risk of pressure/skin damage and stable. Patient is independently repositioning and requires ongoing assessment for pressure relieving aids.	20
Skin intact but patient assessed as very high risk of pressure/skin damage or has existing grade 1-2* pressure ulcer. Patient requires assistance with repositioning and requires ongoing assessment for pressure relieving aids Wound(s) assessed by a Registered Nurse as requiring uncomplicated dressings.	40
Existing grade –2-3* pressure ulcer. Patient requires assistance with repositioning and requires ongoing assessment for pressure relieving aids. Wound(s) assessed by a Registered Nurse as of complex aetiology requiring complex nursing care (e.g. leg ulceration, diabetic foot ulceration or wound bed preparation) no more than three times a week.	60
Existing grade –3-4* pressure ulcer(s). Patient requires assistance with repositioning and requires ongoing assessment for pressure relieving aids. Wound(s) assessed by a Registered Nurse as of complex aetiology requiring complex nursing care (e.g. leg ulceration) more than three times a week but not more than daily.	80
Deteriorating multiple pressure ulcers that prevent repositioning the patient off the pressure ulcers, with very high risk of further pressure/skin damage with risk of septicaemia and osteomyelitis. Patient requires hourly assistance with repositioning and requires ongoing assessment for pressure relieving aids. Wound(s) assessed by a Registered Nurse as of complex aetiology requiring complex nursing care (e.g. leg ulceration) more than daily.	100

*European Pressure Ulcer Advisory Panel (2005) *Guide to Pressure Ulcer Grading*. Accessed at <http://www.epuap.org/grading.html>

9. Food and Drink

Level of Need	Relative Weighting
Able to take food and drink by mouth unaided.	0
Some assistance required, e.g. cutting up food, special utensils but thereafter independent or needs supervision, prompting or needs support and advice about diet or needs assisted feeding which takes less than one hour.	20
Able to take food and drink by mouth but needs assisted feeding (including liquidised, modified, artificial means) which takes more than one hour.	40
Able to take food and drink by mouth but risk of choking or aspiration and has difficulty swallowing which may require suction by a Registered Nurse or trained carer. Patient able to take food and drink by mouth but refuses or subsequently vomits. May be unable to take food or drink by mouth, intake via artificial means managed by the individual or trained carer with oversight at least monthly by a health professional.	60
Intake by PEG, total parenteral nutrition or naso-gastric tube requiring oversight at least weekly by a health professional.	80
Unable to take food or drink by mouth and requires intake via intravenous administration which requires monitoring at least daily.	100

10. Drugs/ Therapies/Medication/Therapeutic mechanical intervention²⁴

Level of Need	Relative Weighting
Able to self administer – if setting allows.	0
Requires prompting for medication. Patient self-medicating in a controlled environment.	20
Requires administration of medication or CAPD (continual ambulatory peritoneal dialysis) or controlled and complex liquid medication regime, by an appropriately trained carer, or Registered Nurse. Non complex medication as required e.g. aperients or mild analgesia. And may require oversight by a Registered Nurse.	40
Requires administration by a Registered Nurse, e.g. controlled and complex liquid medication regime, intra-muscular medication, intravenous medication, sub-cutaneous medication and requires at least monthly monitoring by a Registered Nurse.	60
Requires administration by a Registered Nurse, e.g. controlled and complex liquid medication regime, intra-muscular medication, intravenous medication, sub-cutaneous medication, and requires at least daily monitoring by a Registered Nurse.	80
Has a complex regime and fluctuating unstable condition, which require at least daily monitoring by a professional health worker , and requires adjustment by a health professional of medication or regime.	100

²⁴ Excludes respiratory devices – see Breathing

11. Palliative Care

Level of Need	Relative Weighting
Following life limiting diagnosis referred for Palliative Care Assessment, no identified specialist palliative care needs at this time.	0
Symptoms Identified requiring assessment, being managed through Primary Care Team e.g. District Nurse, GP. Able to self administer medication	20
Symptom control requiring clinical review by a Registered Nurse Symptoms causing occasional bad days with some limitation of activity. Requires administration of medication by an appropriately trained carer or Registered Nurse in any setting. May require continual ambulatory pump administered by a Registered Nurse.	40
Symptom control (e.g. pain, dyspnoea, nausea and/or vomiting etc.) such that the care regime requires assessment and evaluation by Specialist Palliative Care Team for an episode of care. Severe symptoms or level of dependency, so that activities and concentration are markedly affected.	60
Symptom control (e.g. pain, dyspnoea, nausea and/or vomiting etc.) such that the care regime requires assessment and evaluation by Specialist Palliative Care Team for more than one episode of care within a month. Severe and continuously deteriorating physical condition resulting in increasing dependency.	80
Symptom control which is difficult to stabilise. (e.g. pain, dyspnoea, nausea and/or vomiting), such that the care regime requires weekly assessment and management by Specialist Palliative Care Team to support the Primary Care Team e.g GP District Nurse. Would require daily intervention by a Registered Nurse	100

N.B. If the client has palliative care needs they should be assessed against this domain, and NOT under the Drugs/ Therapies/Medication/Therapeutic mechanical intervention domain.

Appendix 6 - Continuing health care assessments and hospital discharge – section 2 screening tool

The purpose of this screening tool is to avoid, as far as possible, the unnecessary issuing of section 2 notices (assessment notification) to Social Services at the point of hospital discharge.

Before a patient has a full assessment for eligibility for fully funded NHS continuing health care, this screening tool should be used as a quick guide to determine whether or not it is likely that the patient will be eligible.

The levels of need that score 80 in each care domain of the Standardised Assessment Tool (**DN: Insert agreed title**) are set out below. Each description should be applied to the patient. Where the patient meets **3** or more descriptions this should trigger a multi-disciplinary assessment for eligibility for fully funded NHS continuing health care (if, in the opinion of the multi-disciplinary team, the patient is fit for discharge) and a section 2 notice should **not** be made to Social Services. If, following that assessment, the patient is not deemed to be eligible, a section 2 notice should be made at that point.

Care domains		
Name of patient:	Date of birth:	Please tick
<p><u>Breathing</u></p> <p>Is able to breathe only through a tracheotomy that requires daily attention and suction. Has impaired or absent swallow reflex/unable to clear own secretions/oral suctioning required daily/specialist Speech and Language Therapy and dietetic advice needed. May require cough-assist mechanical intervention or is able to breathe unaided but may be dependent on mechanical ventilation at any time.</p>		
<p><u>Functional Mental Illness/Dual diagnosis</u></p> <p>Has impaired insight into difficulties. There is high risk of relapse, non-compliance or treatment resistance, which could lead to risk to self or others. Is maintained daily within the community (either within own home, supported housing, care homes registered for residential or nursing care.). Is on Enhanced CPA* and requires enhanced supervision from secondary services e.g. Assertive Outreach (as per department of health guidance) and Crisis Intervention or Community</p>		

Care domains		
Name of patient:	Date of birth:	Please tick
Addiction Teams, or other locally developed enhanced service.		
<u>Communication</u> Unable to consistently communicate basic physical/emotional/psychological needs verbally or non-verbally even when prompted or facilitated, (e.g. Parkinson's/stroke/dementia, severe depression, learning disability), thus placing the individual at significant risk of self-harm, neglect or exploitation, which requires the delivery of care plans requiring specialist professional management* to maintain stability and reduce the risk of harm to the individual or others.		
<u>Cognitive impairment</u> A level of cognitive impairment which requires the delivery of care plans requiring specialist professional management to maintain stability and reduce the risk of harm to the individual or others. Critical risk of self-isolation, neglect, harm and relapse.		
<u>Behaviour</u> Erratic or infrequent incidents of behaviour that challenges and of high intensity with a significant risk of self-harm or harm to others. These are expected to occur daily. Has a specialist management plan to reduce or minimise the number or level of incidents. Intervention at night is required and periods of 1:1 intervention and monitoring.		
<u>Seizures</u> Has seizures at least weekly which result in severe unpredictable behaviour (e.g. damage to self, others or to property) Is monitored and reviewed at least fortnightly by the Specialist Epilepsy Nurse and requires a management plan which is undertaken by trained carers in epilepsy.		
<u>Mobility</u> There is an increased risk of physical harm when moving or handling due to the individual's condition e.g. myotonic jerks, severe contractures, risk of choking without careful head positioning, exacerbation of pain.		
<u>Skin</u> Existing grade –3-4* pressure ulcer(s). Patient requires assistance with repositioning and requires ongoing assessment for pressure relieving aids		

Care domains		
Name of patient:	Date of birth:	Please tick
Wound(s) assessed by a Registered Nurse as of complex aetiology requiring complex nursing care (e.g. leg ulceration) more than three times a week but not more than daily.		
<u>Food and drink</u> Intake by PEG, total parenteral nutrition or naso-gastric tube requiring oversight at least weekly by a health professional.		
<u>Drug therapies and medication</u> Requires administration by a Registered Nurse, e.g. controlled and complex liquid medication regime, intra-muscular medication, intravenous medication, sub-cutaneous medication, and requires at least daily monitoring by a Registered Nurse.		
<u>Palliative care</u> Symptom control (e.g. pain, dyspnoea, nausea and/or vomiting etc.) such that the care regime requires assessment and evaluation by Specialist Palliative Care Team for more than one episode of care within a month. Severe and continuously deteriorating physical condition resulting in increasing dependency.		

Appendix 7 - Continuing NHS Health Care and Funded Nursing Care Independent Review Procedure

1. Introduction

The Continuing Care (National Health Service Responsibilities) Directions 2004 require Strategic Health Authorities to make arrangements for the review of decisions in relation to continuing care. The following procedure needs to be read in conjunction with these directions.

The purpose of this document is to set out, in line with the national guidance, local procedures for establishing and managing the process within North and East Yorkshire and Northern Lincolnshire.

A copy of the policy and eligibility criteria for continuing NHS health care is available for information from the Strategic Health Authority's website at www.neynlha.nhs.uk

2. The purpose and scope of the review procedure

The review procedure provides patients, families and carers with a safeguard, at the point of discharge from NHS care, if they believe that the eligibility criteria for fully funded NHS continuing care have not been properly applied.

While the case is being reviewed the patient should remain the responsibility of the NHS. Any existing care package, whether hospital care or community health services, should not be withdrawn under any circumstances until the outcome of the review is known.

The procedure also exists to review Funded Nursing Care determinations when they are challenged and cannot be resolved informally.

The purpose of the review procedure is:

- To check that proper procedures have been followed in reaching decisions about the need for continuing NHS health care and the NHS services contributing to continuing health and social care.
- To ensure that the eligibility criteria for continuing NHS health care are properly and consistently applied.
- To check that proper procedures have been followed in reaching the decision about the level of registered nursing care input to be funded by the NHS.

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 eligibility criteria.
- The type and location of any offer of NHS funded continuing 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 issues should be dealt with through the NHS complaints procedure.

3. Procedure for processing applications

3.1 Requesting a review of the decision on continuing NHS care

All requests for application of the independent review process must be in writing and forwarded to the Review Panel Coordinator at the Strategic Health Authority who will acknowledge receipt of the request within two working days.

3.2 Informal resolution

It is particularly important to ensure that before a Panel is convened, all appropriate steps have been taken, in discussion with the relevant PCT, to resolve the case informally. Each organisation should have a named contact who is the first 'port of call' for queries from partner organisations.

This process should include:

- The relevant continuing care lead meeting with the applicant and/or patient as soon as possible in order to clarify the basis of their request and checking that it does not relate to the conditions set out in paragraph 3;
- Ensuring that the applicant and/or patient has received a copy of the SHA's policy and eligibility criteria;
- Ensuring that a comprehensive, multidisciplinary assessment has been undertaken (if not, the review should not proceed);
- An independent assessment by another PCT.

When meeting with the continuing care lead, (or exceptionally, another person nominated by the Panel, if the case goes to the Panel), a patient may have a representative present to speak on his or her behalf if they choose, or if they are unable to, or have difficulty in presenting their own views. This role may be undertaken by a relative or carer or advocate acting on the patient's behalf.

3.3 Review by the Independent Review Panel

If the case cannot be resolved by informal means, the patient, his or her family or any carer may ask the continuing care lead to arrange for a formal review of the decision that the patient's needs do not meet the eligibility criteria for continuing NHS health care.

The Strategic Health Authority does have 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. In all cases where a decision not to convene a Panel is made, the patient and his or her family or carer should be given a full written explanation of the basis of the decision, together with a reminder of their rights under the NHS complaints procedure.

4. The Independent Review Panel

4.1 Membership of Review Panels

The SHA will maintain a standing Panel, comprising an Independent Panel Chair, a Local Authority Panel member and a PCT Panel member. Panel members can only review cases outside their responsible geographic boundaries. The PCT Panel member must come from outside the area in which the case being reviewed has arisen.

The Panel Chairs have been selected following an open recruitment process. Training is provided for the Lay Chairs and for the Panel members in order to ensure consistency in their decision-making and to ensure they have a clear understanding of the Panel's purpose.

On the basis of the evidence received and the advice given to the Panel, the Chair should be able to determine whether the eligibility criteria have been correctly applied. Chairs should have the capacity to make balanced decisions in sometimes difficult circumstances, whilst taking a sympathetic view of the concerns of patients, their family and any carers.

Those involved in delivering the review process, and in particular the Panel Chair and the continuing care leads and Review Panel Coordinator, should ensure that all requests for review are handled fairly and consistently, that the procedure is implemented properly; its operation monitored, and the procedure reviewed periodically and amended as required to meet changing needs and regulations.

4.2 Support to the Panel

4.2.1 *Independent clinical advice*

The Panel may require access to independent clinical advice which should take account of the range of medical, nursing and therapy needs involved in each case. Such arrangements should avoid any conflicts of interest between the individual clinician(s) giving the advice and the organisation(s) from which the patient has been receiving care.

The role of clinical advisers is to advise the Panel on the original clinical judgements and on how those judgements relate to the eligibility criteria.

It is not the role of the clinical advisers (or the Panel) to provide a second opinion on the clinical diagnosis, management or prognosis of the patient.

4.2.2 *Review Panel Coordinator*

A Review Panel Coordinator has been appointed to support the work of the Panel. The Review Panel Coordinator will maintain the review procedure and coordinate information for the Panel. The Coordinator will aim to ensure that the review procedure is completed within 14 working days of the request being received by him/her. (This period starts once any action to resolve the case informally has been completed, and should be extended only in exceptional circumstances).

4.3 Operation of the Review Panel

4.3.1 Preparation

Where it is decided to convene a Panel, the Review Panel Coordinator will:

- check with the patient and/or the applicant if that is not the patient:
 - that they have received or seen a copy of the eligibility criteria for continuing health care; and
 - that the review process has been explained to them;
- check with the continuing care lead:
 - that the reason for the request for a review has been clarified; and
 - that efforts have been made to resolve the case informally;
- ensure that the need for an advocate has been considered;
- coordinate information for the Panel in collaboration with the responsible PCT. The Panel should have access to any relevant documentation, including the details of the patient's original assessment. They should also have access to the views of key parties involved in the case including the patient, his or her family and any carer, health and social services staff, and any other relevant bodies or individuals.

4.3.2 Review Panel meeting

The members of the Independent Review Panel will meet to consider individual cases. Panel meetings will be attended by Panel members and the Review Panel Coordinator, any invited clinical adviser(s) and the continuing care lead(s) from the responsible PCT.

The patient, and /or their representative (e.g., carer, family member) and/or their advocate (but not legal representative) is welcome to attend the meeting or to make written submission in the event that they do not wish to attend.

The Panel should be satisfied that any person acting on behalf of the patient accurately represents their views and that their own interests or wishes should not conflict with those of the patient.

The process must retain patient confidentiality at all times.

4.3.3 Recommendations of the Review Panel

The Panel will consider all the evidence, make a decision, and make recommendation(s) for consideration to the SHA. The Lay Chair, with guidance from the Panel, will write a report to the SHA setting out the reasoning leading to the recommendation.

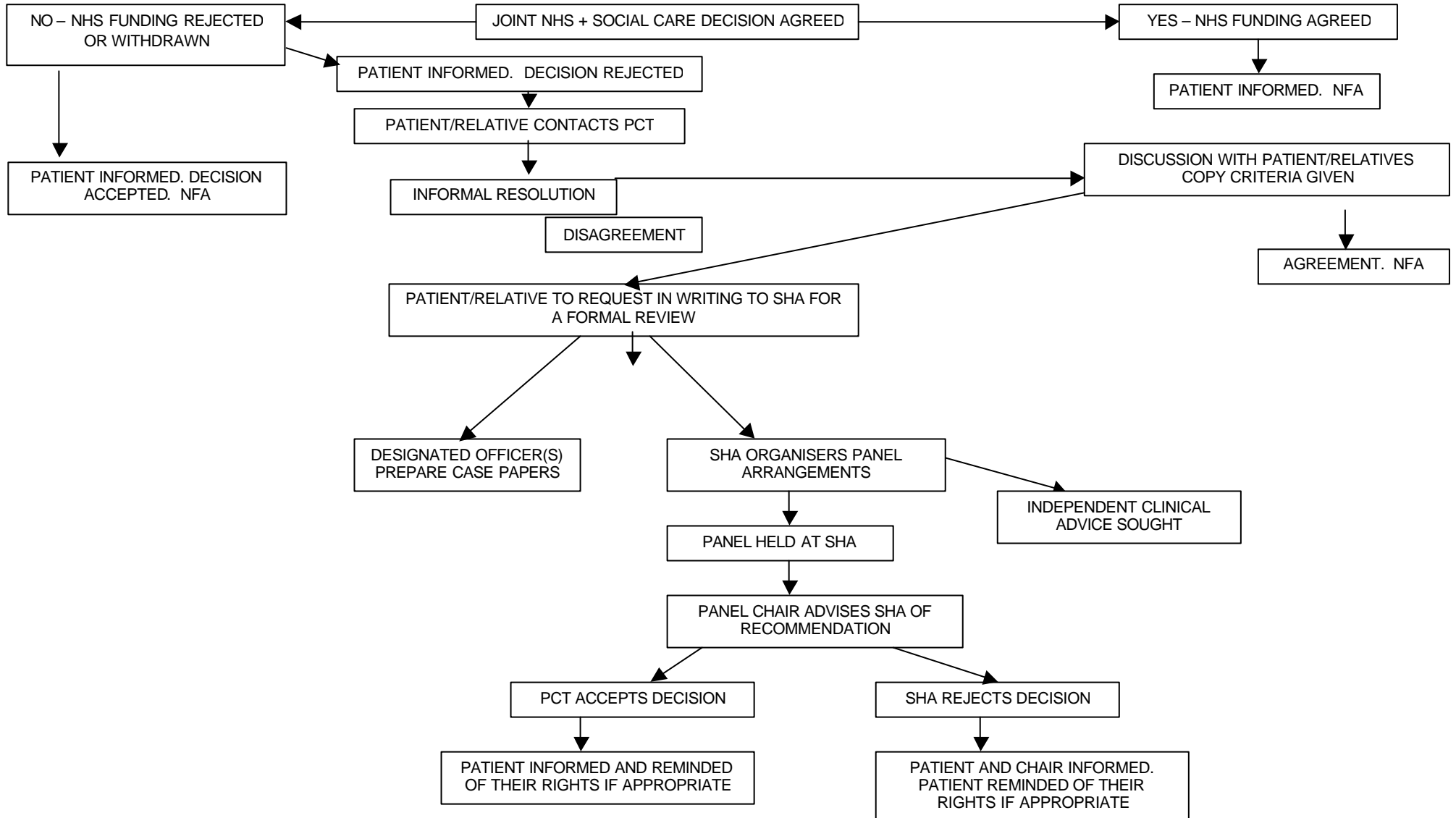
The final report will then be signed by the Panel Chair and submitted to the Strategic Health Authority. The Review Panel Coordinator will ensure that all relevant parties receive this information.

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 in all but very exceptional circumstances. If the SHA rejects a Panel's recommendation in an individual case, it must put its reasons for doing so in writing to the patient and to the Panel Chair.

4.3.4 Complaints

The patient's rights under the complaints procedures remain unaltered by the Panel arrangements. If a patient is dissatisfied with the outcome of the review procedure he or she, or their families or carers may complain to the Healthcare Commission and then the Health Service Ombudsman.

Independent Review Panel Process – Patient / Service User Disagrees with Decision



Appendix 8 – Audit and development

Joint Executive Policy Development Group (Continuing Care)

Terms of reference

- To agree the revised policy document and to determine the process and timescale for implementation.
- To agree the Board/Cabinet report recommending the adoption of the final policy document.
- To identify adjustments to the policy and eligibility criteria in the light of experience, or any national initiatives and guidance, and recommend them to the SHA.
- To receive quarterly reports from the Audit and Analysis Group
- To provide a forum for discussion and resolution of emerging issues in the interpretation and resolution of the policy (including serious disputes) at an SHA wide level. This will not include individual cases.
- To receive exception reports from the peer group reviews particularly where issues of practice and process need to be addressed; and where analysis identifies issues of financial or judicial risk.
- To alert and advise Chief Executives of PCTs and Actue Trusts and Directors of Social Services about significant issues arising from the implementation of the policy, in particular those that carry financial risk or risk of judicial action.
- This group will be directly accountable to the PCT Chief Executive's Forum and the ADSS in fulfilling these terms of reference.
- To provide copies of minutes to the Audit and Analysis Group.

Membership

- Two Joint Chairs – a PCT Chief Executive and a Local Authority Director of Social Services ;
- A PCT Director of Commissioning;
- A PCT Director of Finance;
- A senior Local Authority representative (to be determined by the Local Authorities);
- A senior Local Authority representative (to be determined by the Local Authorities);
- Three continuing care leads from the NHS and three from Local Authorities;
- A representative from the Strategic Health Authority.

Analysis and Audit Group

Terms of Reference

- To be responsible for the administration, collection and interpretation of quarterly returns on uptake and resources for fully funded and jointly funded cases across all client groups (currently excluding children's).
 - To establish joint mechanisms to audit and validate performance across agencies and professional groups. This 'audit' programme will inform practice development, the elimination of differences where appropriate, and the building of understanding in some of the more contentious aspects of interpretation.
- To develop best practice and a sympathetic and consistent data collection, analysis, and forward planning system specifically related to financial risk, and anticipated expenditure.
- To develop and implement a peer review programme based on visiting joint teams from other PCTs/LAs within NEYNL to compare practice on individual cases and outcomes and make recommendations for action.
- To provide quarterly reports to the Joint Executive Policy Group on the application of the continuing care policy, identifying key issues and potential risks and their implications for financial planning and market management. The reports will also recommend action to deal with the problems identified.
- To support local action on the application of the policy through the use of common developmental processes and core training material for staff, Independent Review Panel members and others.
- To develop a market development and market management strategy to address both the lack of some mainstream services and the paucity of some, more specialist services and to advise the Joint Executive Policy Development Group of the implications.