National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England

Core Values and Principles

Contents

Core values and principles

Introduction

1. This document sets out the core values, principles and best practice which underpin the proposals for the new integrated National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England. The values and principles herein have been developed in consultation with representatives from health and social care and voluntary organisations as well as users and carers.

2. This document is intended to support and clarify the main Consultation document which details the proposed National Framework, by describing operational aspects not included in the principal document and the principles which frame the proposals.

3. This document does not form part of the formal Consultation itself, though contributions are welcomed in relation to points which require additional clarity, or where certain aspects have not been covered by this document.

National Policy on Assessment

4. The assessment for, and delivery of, NHS Continuing Healthcare and NHS-funded Nursing Care should be organised so that individuals and carers understand the process, and receive advice and information to enable them to participate in informed decisions about their future care. Decisions and rationales relating to eligibility should be transparent from the outset – for individuals, carers, family, and staff.

5. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health needs and is **not** disease-specific, **nor** determined by either the setting where the care is provided **nor** who delivers the care. Access must be fair and there should be no discrimination based on age, condition or type of health need (e.g. physical, psychological or mental). An individual's preferences and wishes, as to how and where the care will be delivered, should be taken into account, along with the risks of different types of provision and fairness of access to resources, when deciding how their needs will be met. Where a person's express preferences are not met, then clear reasons should be given to them.

6. A decision on an individual's eligibility for NHS Continuing Healthcare should not be budget or finance led; the person's assessed health needs should be the primary indicator.

7. Eligibility for NHS Continuing Healthcare is dependent upon establishing that an individual's primary need is a health need, as set out in paragraphs 13-16 of the main Consultation Document.

This requires a clear, reasoned evidence base from a comprehensive assessment framework. A number of these are already in place and appropriate to the care group concerned, for example;

i. Single Assessment Process (SAP) for Older People

ii. Care Programme Approach (CPA) for Mental Health patients

iii. Person-Centred Plans for Learning Disability

These will be developed into a common assessment framework following on from the White Paper *Our Health, Our Care, Our Say: A New Direction for Community Services* published in January 2006.

8. Where an individual's primary need is a health need, the responsibility for providing or commissioning the care needed to meet those needs falls on the NHS.

9. **In summary**, the core values and principles of the policy on eligibility are set out in the table below:

- The decision on eligibility for NHS Continuing Healthcare should always be needs-led (acknowledging layers of complexity) and not diagnosis-led.
- NHS Continuing Healthcare is available in any setting, as is access to the assessment process.
- All decisions will be culturally sensitive and client-centred.
- The NHS Continuing Healthcare decision-making process recognises that the Single Assessment Process (SAP), or other comprehensive assessment processes, is the key to professional assessments for NHS Continuing Healthcare.
- Assessment for NHS Continuing Healthcare should always consider whether there is further potential for rehabilitation, or how the outcome of any treatments or medication may affect ongoing needs.
- Regular reviews are built into the process.
- Decision-making rationale should not include any elements which are based on who provides the care or the location of the care, or marginalise a need because it is successfully managed.
- The risks and benefits to the patient of a change of location or support (including funding) should be considered carefully before any move or change is confirmed.

The Assessment Framework

10. The NHS makes the decision on responsibility for NHS Continuing Healthcare working in collaboration with Social Services. The process can be initiated wherever the individual is residing. It is important that the process, including funding decisions, does not delay treatment or appropriate care being put in place.

11. The assessment framework has been developed to ensure that;

    i. Those staff whose responsibility it is to make the relevant decisions on eligibility for NHS funding have had the benefit of access to information on the overall policy and relevant guidance to support decision-making.

    ii. There is full and active involvement of individuals and, where appropriate, their carers in the process.

    iii. The policy on eligibility for NHS Continuing Healthcare is promoted so that the public, health and social care practitioners and the independent and voluntary sector understand who may be eligible and how to access an assessment.

    iv. Professionals work within the assessment framework to assess an individual's type and level of needs before eligibility is determined.

    v. The process of assessment and decision-making is co-ordinated.

    vi. Potential eligibility for NHS Continuing Healthcare is identified at an early stage through a screening process, so that full assessments are carried out appropriately and proportionately to streamline the process.

    vii. Individuals who require fast-tracking because of the nature of their needs (e.g. because a prognosis indicates a short-term life expectancy) can be identified through the screening process to make sure their needs are met as quickly as possible, without having to undergo a full assessment.

    viii. Eligibility for NHS Continuing Healthcare is awarded consistently and fairly for all adults across care groups, irrespective of the reason for their needs, or the type of those needs.

    ix. No decision is made unilaterally without reference to a multi-disciplinary team assessment.

    x. The process is underpinned by effective governance arrangements, including local audits of decision-making.

The Screening Tool

12. The national Screening Tool will be developed in conjunction with the Decision-Support Tool which underpins the full assessment for NHS Continuing Healthcare. As with full assessments, the use of the Screening Tool is not dependent upon the location of the individual, or who is currently providing care.

13. The purpose of the Screening Tool is twofold:

    i. to encourage proportionate assessments by targeting resources for full assessments at those for whom NHS Continuing Healthcare may be appropriate, and;

    ii. to identify those individuals who require fast-tracking to immediate care, for example because they have a short-term life expectancy.

14. The tool acts as a preliminary indication that a person needs a full assessment, and should not substitute for that full assessment nor exclude anyone who may be eligible for NHS Continuing Healthcare. If in doubt, a full assessment should always be undertaken.

15. The format of the Screening Tool will follow the needs-led approach set out in the Decision-Support Tool, by identifying generic areas in which the needs may fall (see paragraph 21 below). In order to minimise the risk of individuals being 'screened out' of the assessment process inappropriately, the point of referral indicated by the tool will be set intentionally low, following the principle that the tool be inclusive rather than exclusive.

16. In addition, the tool will support fast-tracking by identifying those individuals who are eligible for NHS Continuing Healthcare and for whom a full assessment is not appropriate because of the immediacy of their care needs.

17. The Screening Tool should be used at the first stage of the assessment process, before any comprehensive assessment of a person's needs is undertaken. For patients being discharged from acute settings, the tool should be the first step in considering eligibility for NHS Continuing Healthcare following the responsibility set out in the Community Care (Delayed Discharges etc) Act 2003. For those entering the assessment framework from another setting, or undergoing a review of their needs (for example, an annual review carried out in a care home), the tool should be the first point of reference in assessing for NHS Continuing Healthcare when a healthcare episode occurs, or as part of a regular review of care needs.

The Decision-Support Tool

18. The national Decision-Support Tool has been developed to support practitioners in the application of the national policy on eligibility for NHS Continuing Healthcare and to inform consistent decision-making in line with the primary health need approach.

19. The Decision-Support Tool does not make the decision on eligibility itself. Professional judgment is paramount and the tool does not seek to replace this. The tool helps describe and record an overall picture of the individual's needs to give an indication of whether a primary health need is present, but the task of deciding eligibility for NHS Continuing Healthcare falls to the assessors themselves.

20. The tool is only one part of the assessment framework. It is designed to assist practitioners in determining an individual's eligibility for NHS Continuing Healthcare by ensuring the full range of factors which have a bearing on an individual's eligibility are assessed, taken into account and given due weight when making a decision. It should be used following a comprehensive assessment of an individual's care needs, as a way of bringing together and recording the various needs in a single, understandable format, to facilitate logical and consistent decision-making.

21. The tool, provides practitioners with needs-led approach by assessing need on the basis of eleven 'care domains'. These domains represent generic areas of need into which the various needs of an individual can be placed. The domains are sub-divided into statements of need representing low, moderate, high, severe or priority levels of need, depending on the domain. The care domains are:

- Behaviour
- Cognitive Impairment
- Communication
- Mobility
- Nutrition – Food & Drink
- Continence
- Skin (including tissue viability)
- Breathing
- Drug Therapies & Medication
- Psychological/Emotional Needs
- Seizures/Altered States of Consciousness

22. The 'levels of need' described in the tool relate directly to the four key indicators of a primary health need which are described in the eligibility policy of the National Framework. These levels are relative to each other and to the other domains; some domains include needs which are so great that they could reach the 'priority' level, others do not.

23. An individual should be identified by the PCT to co-ordinate the assessment and liaise with the multi-disciplinary team to complete the decision-support tool and match, as far as possible, the individual's level of need with the description that most closely relates to their specific needs. This approach should build up a detailed analysis of a person's needs and provide the evidence to inform the decision on eligibility.

24. The levels of need described in the Decision-Support Tool may not always adequately describe every individual's circumstances. Professional judgment and clinical reasoning are paramount in ensuring an individual's needs are accurately assessed, taken into account and given due weight when making a decision. This will include how they may interact as part of the individual's overall need for care.

25. Care has been taken to avoid duplication and ensure that one specific need is not repeated in two separate care domains. However, assessors should consider how different but inter-related needs across more than one domain can complicate the individual's overall care needs and demonstrate sufficient complexity or intensity to demonstrate that the primary need is a health need. Examples of this might

include the relationship between skin integrity and continence, or cognitive impairment and behaviour and/or communication.

26. The tool brings together needs across the care domains, enabling assessors to determine whether the person's primary need is a health need. The tool is **not** prescriptive, and professional judgment should be exercised in all cases to ensure that the individual's overall level of need is correctly tested against the primary health need criterion, and that appropriate decisions are made.

27. There may be circumstances, on a case-by-case basis, where an individual may have particular needs which do not appear to match the care domains described in the Decision-Support Tool. In this situation, it is the responsibility of the assessors to determine the nature and extent of any other needs and, in conjunction with the needs covered using the tool, decide whether the person's primary need is a health need.

28. The decision-support tool is not relevant where an individual's needs are such that access to NHS Continuing Healthcare is fast-tracked, for example as result of rapid deterioration and short-term life expectancy. These needs should have been identified through the Screening Tool at the first stage of the assessment process.

29. A draft of the Decision-Support Tool has been published with the National Framework documents, to demonstrate how the national eligibility policy may be applied in practice. Contributions are welcomed separately on the content and format of this tool – for more information please see the separate publication.

Dementia, Mental Health Needs and Acquired Brain Injury

30. Individuals with dementia, mental health needs or acquired brain injury being considered for NHS Continuing Healthcare are likely to have a range of needs requiring assistance or intervention from others. Some needs are consistent and predictable, e.g. the need to be assisted with washing and dressing for an individual with fairly advanced dementia. Other needs are less predictable, e.g. unexpected distress, intermittent restlessness or variable resistance to care.

31. These needs will generally be most pronounced in the psychological/emotional, cognitive impairment and communication domains. However, it is essential that where there are ongoing or recurrent behavioural problems associated with meeting basic care needs or in communication with an individual, that the behavioural needs are taken into account and given due weight in the assessment.

Learning Disabilities

32. Learning disabilities means:

- A significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development.

33. Some of the domains within the assessment framework will not be relevant to these individuals; others may not fully reflect their needs. It is important that assessors consider the totality of the individuals needs and how those needs inter-relate to complicate their care. In particular, communication and behaviour are complex issues for this care group.

Palliative and End-of-Life Care

34. Palliative care is considered to be the model for quality and compassionate care for people facing an illness or injury. It involves a team-oriented approach to expert medical care, emotional and spiritual support and pain management, if required; all expressly tailored to the person's needs and wishes. Palliative care may be required for many years, but end-of-life care, which often includes specialist palliative care, is generally required for a relatively short period.

35. Where a person has needs that require the input of specialist palliative care services they should be referred to the specialist services for an assessment. The specialist service will assess both immediate needs and continuing care needs, in the light of the person's prognosis. Where the person's health needs are increasing rapidly and a delay in assessment is anticipated, the specialist service in consultation with the care manager should consider referring the person for NHS Continuing Healthcare through a fast track process to avoid delays in discharge from hospital or hospice to home.

36. Individuals with a rapidly deteriorating condition and short-term life expectancy will immediately qualify for NHS Continuing Healthcare. For the purposes of determining eligibility to NHS funding, 'short-term' should not to be defined prescriptively or restrictively, but should be based on an assessment of the person's care needs and considered as a period of time which can be expressed in days and weeks. Strict time limits are not relevant for end of life cases and should not be imposed – it is the responsibility of the assessor to make a decision based on the relevant facts of the case.

Co-ordination of the Assessment Framework

37. In order to ensure fair and consistent access to NHS Continuing Healthcare, the PCT is responsible for ensuring the assessment process and application for funding are co-ordinated effectively. Whatever local model is employed, it is essential that the functions be fulfilled by practitioners who have experience and expertise in assessment, a thorough working knowledge of the policy on eligibility and well developed leadership qualities, to ensure the assessment framework is adhered to in a timely manner. The co-ordination functions are set out below.

i. Ensuring that the Local Authority is involved appropriately in the process and, if so, informed of the outcome of the assessment.

ii. Case management of the assessment process to ensure all relevant input from the NHS multi-disciplinary team assessment is completed in a timely manner,

iii. Liaison with the individual and their carer/family, if appropriate, to ensure they are kept fully informed and involved throughout the process and informed of the outcome and reasons for the decision.

iv. Communication to individuals that eligibility for NHS Continuing Healthcare depends on needs and if those needs change both the care and the funding may change.

v. Identification of individuals who should be fast-tracked for funding.

vi. Co-ordination and evaluation of NHS multi-disciplinary team input using the Decision-Support Tool.

vii. Ensuring that the recommendation for funding is collated, evidenced and sent to the commissioning body.

viii. Referral to the commissioning body for funding the care package.

ix. Discussion with the individual and family on the next steps and timeframes to implement the care plan and/or inform the individual of their rights.

38. The relationship between assessors and commissioners of NHS Continuing Healthcare is a critical one and it is recommended that a decision on funding the care package is made and reported back to the referrer within 5 working days. As far as possible, a decision on funding should not be too far removed from the assessment itself, and should be communicated both verbally and in writing, evidencing, where applicable, why the person does not have a primary health need. The decision should be communicated to the individual, the referrer, the NHS multi-disciplinary team and the Local Authority, where appropriate.

39. Ongoing case management for those individuals in receipt of NHS Continuing Healthcare will be the responsibility of the NHS.

Communication with Individuals/Families

40. Primary Care Trusts (PCTs) have a responsibility for ensuring that all individuals and their carers who are referred for NHS Continuing Healthcare are aware of the process, and that the patient is kept informed throughout the process. The PCT should communicate any decisions made formally in writing to the patient or their representative, providing a clear rationale for that decision.

41. Clear timeframes should be followed, from referral to completion of assessment to decision. Timeframes should be agreed locally, with processes in place to establish reasonable targets for each stage. If the individual is currently in NHS care, the NHS continues to fund and provide care for the individual during this time. These timeframes should be made clear to the patient and their carer,

should be agreed and set with the multi-disciplinary team following completion of the screening process, and all team members should be informed of their responsibilities. Individuals who require fast tracking should be identified and all efforts made to ensure they receive NHS Continuing Healthcare as quickly as possible.

42. Timeframes are important for the following reasons;

i. It is in the best interest of the individuals for the outcome to be known as soon as possible,

ii. It highlights the importance of assessment, and

iii. It increases the likelihood of the patient being discharged in a timely manner, thereby reducing potential for a delayed discharge.

43. All records should be written in a clear and concise way, and individuals should be given copies of the assessment and decision rationale (their carers/families should also receive copies if consent is granted).

44. Individuals should also receive copies of the evidence considered to make a decision on their eligibility.

45. It is the responsibility of the PCT to communicate both verbally and in writing to the patient or their representative that eligibility for NHS Continuing Healthcare depends on assessed needs, and if those needs change both the care and the funding may change. Ongoing eligibility for NHS Continuing Healthcare will depend on regular reviews of assessed needs and the patient and their families or carers, where appropriate, will be involved in this with clear timeframes for notification.

Governance Arrangements

46. PCTs are responsible for establishing and managing NHS Continuing Healthcare governance. Amongst their primary responsibilities are the following;

i. Ensuring consistency in the application of the national policy on eligibility for NHS Continuing Healthcare,

ii. Promoting awareness of NHS Continuing Healthcare,

iii. Implementing and maintaining good practice,

iv. Ensuring quality standards are met and sustained,

v. Providing training and development opportunities for practitioners,

vi. Identifying and acting on issues arising in the provision of NHS Continuing Healthcare, and;

vii. Informing commissioning arrangements, both on a strategic and individual basis.

Commissioning

47. It is the responsibility of the PCT to identify, commission and contract for all services required to meet the needs of all such individuals who qualify for NHS Continuing Healthcare. However, it may be appropriate for Local Authorities to share information and databases in order to assist PCTs with their commissioning responsibilities.

Review

48. Individuals receiving NHS Continuing Healthcare may not remain permanently eligible. If the nature or level of their needs change significantly, a review of the patient's needs should be made.

49. Any such review should be transparent and supported by a rationale/explanation of the decision. Both verbal and written reports should be given to the individual.

50. All individuals should be reviewed on an agreed regular basis. A minimum standard is three months from the initial assessment, and then annually or more frequently according to needs.

Dispute Resolution

51. The existing procedures for dispute resolution, including the operation and formation of all review panels established following the 2004 Directions, will remain in place to ensure consistency and accountability during the transition to the National Framework. Practical matters, such as organisational responsibilities, will be considered as part of the update of the 2004 Directions.

52. Primary Care Trusts should deal promptly with any request to review decisions about eligibility for either NHS Continuing Healthcare or NHS-funded Nursing Care.

53. In the first instance, the PCT should refer the case to its local resolution process. This will usually take the form of a PCT review panel, though local procedures may be adapted to include reference to the review panel of a neighbouring PCT to provide greater patient confidence in the impartiality in decision-making.

54. Once local procedures have been exhausted, the case should be referred to the SHA's Independent Review Panel (IRP), who will consider the case and make a recommendation to the PCT. The panel's key task is to assess whether the PCT has correctly applied the national policy on eligibility for NHS Continuing Healthcare or NHS-funded Nursing Care, and has followed the processes set out in the National Framework. Based upon its review of the circumstances surrounding the case, the IRP can then make a recommendation on the validity of the PCT's decision.

55. The role of the IRP is advisory. The IRP will seek information from the patient's family or carer, and appropriate professional advice from relevant staff involved with the case (hospital, community health

and social services staff, the patient's GP). Although not legally binding, it is expected that in practice the decisions of the IRP will be usually accepted by the PCT.

56. If the IRP upholds the position of the PCT or cannot satisfy the claimant, the patient reserves the right to further their complaint through the Healthcare Commission and/or the Parliamentary and Health Services Ombudsman. The expectation will be that formal local resolution procedures will have been exhausted before this course of action can be taken. Either the Healthcare Commission or the Ombudsman may decide not to investigate the complaint, but will normally do so if there is evidence that calls the safety of decision-making into question.

57. The key principles for the dispute resolution process for NHS Continuing Healthcare, which have been adapted from best practice material produced by the Ombudsman's office, are set out below:

- Gathering and scrutiny of all available and appropriate evidence, including that from the GP, hospital (nursing, medical, mental health, therapies etc), community nursing services, care home provider, Social Services records etc, as well as any evidence submitted by the claimant.
- Compilation of a robust and accurate identification of the care needs.
- Audit of attempts to gather any records said to be not available.
- Involvement of claimant/carer as far as possible, including the opportunity for claimants to input information at all stages.
- There should be a full record of deliberations at all review panels.
- Clear and evidenced written decisions to the claimant setting out rationale for the panel's decision on their eligibility for NHS Continuing Healthcare on the basis of their needs only. This should include appropriate rationale related to the core national policy on eligibility.
- The recommendation or decision rationale should not be determined on the basis of:
  - the inputs required to manage the care needs,
  - the setting of care,
  - the ability of the care provider to manage care,
  - the use (or not) of NHS employed staff to provide care,
  - the need for/presence of 'specialist staff' in care delivery,
  - the existence of other NHS-funded care, or
  - any other input-related (rather than needs-related) rationale.
- Congruency and consistency between the panel deliberations and the recommendation/decision letter.

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