

Factsheet 20w ● November 2018

NHS continuing healthcare and NHS-funded nursing care in Wales



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Contents

1	Information about this factsheet	4
2	Introduction – what is NHS continuing healthcare (NHS CHC)?	5
	2.1 Does a care need fall within the remit of the health service (NHS) or the local authority social services department?	5
	2.2 What is the difference between a healthcare need and a social care need?	7
	2.3 Background to NHS CHC	8
3	Welsh Government guidance on NHS CHC	10
4	Who might be eligible for NHS CHC?	10
	4.1 Eligibility decisions – ‘primary health need’ and the National Framework	10
	4.2 What factors might demonstrate a ‘primary health need’?	11
	4.3 When should eligibility be considered?	13
5	Reaching an NHS CHC eligibility decision – Multi-disciplinary assessment, Checklist Tool, Decision Support Tool and other key elements	16
	5.1 The Checklist Tool	16
	5.2 Multi-disciplinary assessment	20
	5.3 The Decision Support Tool (DST)	22
	5.4 The multi-disciplinary team’s recommendation	26
	5.5 The Local Health Board’s decision	28
	5.6 ‘Underpinning Principles’ to the assessment and eligibility process (including a ‘person-centred’ approach)	29
	5.7 Case studies – examples of where NHS CHC eligibility may or may not be indicated	30
	5.8 Flowchart: the NHS CHC eligibility process	34
	5.9 How quickly should services be put in place?	35
	5.10 Fast Track assessments	35
6	Giving consent and mental capacity issues in regard to NHS CHC	37
7	Advocacy support in relation to NHS CHC decisions	38
	7.1 Advocacy services if someone has capacity	38
	7.2 Advocacy when someone lacks capacity	38
8	Arrangements if you are eligible – including locations where you may receive NHS CHC	39

8.1	Confirmation of the decision	40
8.2	The location of care	40
8.3	NHS CHC in a nursing care home (or sometimes a residential care home)	41
8.4	NHS CHC in your own home	44
8.5	NHS CHC in a hospice	45
8.6	Additional privately funded services	45
9	What happens if you wish to challenge a decision?	46
9.1	The Review process for challenging decisions	46
9.2	Funding your care once you challenge the LHB's decision	48
10	NHS CHC eligibility – refunds for unreasonable delays	49
11	Effect on state benefits of NHS CHC	50
12	Regular reviews of NHS CHC eligibility decisions	51
12.1	What happens if your needs have changed	52
13	Your care package if you are not eligible for NHS CHC	53
14	Retrospective challenges to NHS CHC decisions	54
14.1	Will your case qualify for a retrospective review?	54
14.2	Who can submit a claim?	55
14.3	Who should you contact?	55
14.4	Assistance with your claim	56
14.5	How is the claim processed?	57
14.6	What will happen if your claim is successful?	58
14.7	If you are dissatisfied with how your claim is treated	59
15	Weekly NHS-funded nursing care for people resident in a nursing home	59
15.1	NHS-funded nursing care – overview	59
15.2	How much is the NHS-funded nursing care payment?	61
15.3	How is eligibility for NHS-funded nursing care decided?	61
15.4	Regular reviews of NHS-funded nursing care needs	61
15.5	Hospital stays when you are receiving the weekly NHS-funded nursing care contribution	62
15.6	Which Local Health Board (LHB) has responsibility for your NHS-funded nursing care contribution?	63
16	Useful organisations	63
17	Further information about Age Cymru	65

1 Information about this factsheet

NHS continuing healthcare (NHS CHC)

This factsheet provides detailed information on NHS continuing healthcare (NHS CHC) in Wales, including:

- An explanation of what NHS CHC is and when possible eligibility should be considered;
- the process for deciding whether someone is eligible to receive it;
- how the services will be delivered for those who are eligible; and
- what to do if you are unhappy with the decision reached.

There is a brief flowchart on the NHS CHC eligibility process in section 5.8 below. This can be used in conjunction with the more in-depth information on the different stages and aspects involved in the process, which are covered in the rest of the factsheet.

Retrospective NHS CHC claims

There is a section on retrospective claims for NHS CHC where someone has paid for care in the past, but believes that they should have been eligible for CHC.

However, there are now strict cut off deadlines for making such claims – see section 14 below.

Weekly NHS-funded nursing care

Also in this factsheet, you can find further information on NHS-funded nursing care – the NHS's financial contribution towards the cost of meeting the nursing care needs of nursing home residents who are **not** eligible for NHS CHC, but **have** been assessed as needing services provided by a registered nurse – see section 15 below.

Note: The information given in this factsheet is applicable in Wales. Different rules apply in England, Northern Ireland and Scotland. Contact Age UK, Age NI and Age Scotland respectively for further information – see section 17 for their contact details.

2 Introduction – what is NHS continuing healthcare (NHS CHC)?

Note: NHS continuing healthcare will be referred to by the abbreviation NHS CHC throughout this factsheet.

NHS CHC is a package of care arranged and funded solely by the NHS to meet physical and/or mental health needs that have arisen because of disability, accident or illness. It can be provided in any setting including, but not limited to, a care home, a hospice or your own home.

Eligibility is decided via a full assessment (see section 4) where the *'nature', 'intensity', 'complexity' or 'unpredictability'* of someone's health needs mean that they have to be actively managed by the NHS.

Eligibility decisions for NHS CHC rest on whether your need for care is primarily due to your health needs – often referred to as having a **'primary health need'** (as opposed to a need for care due primarily to social care needs that fall within the remit of social services departments, rather than the health service – see below).

The quality and/or quantity of care required to meet an individual's needs may demonstrate a 'primary health need'.

2.1 Does a care need fall within the remit of the health service (NHS) or the local authority social services department?

When you have long-term care needs the type of help you need may be the responsibility of:

- the NHS; or
- of your local authority social services department.

Sometimes it will be obvious which of the two will have responsibility – however, if you have complex needs, the boundaries between health and social care may not always be clear (and indeed, you may receive a mixture of services from each organisation).

Over a number of years, NHS CHC has been a controversial subject, in part because of uncertainties and debate in regard to where the divide between healthcare and social care rests.

As services provided by the NHS are free, whereas those arranged by social services are generally means tested and therefore – depending upon your financial circumstances – you are likely to have to pay some or all of the costs for these services, the outcome of any decision as to who has overall responsibility for your care can have significant financial consequences.

Services beyond the powers of a local authority to provide

Certain services are beyond the powers of local authority (LA) social services departments to provide – this will be the case where legislation has stipulated that it is an area that the health service must cover (for example, this is confirmed in section 47 of the *Social Services and Well-being (Wales) Act 2014*¹). However:

“the fact that someone has health needs which are beyond [those LA powers], does not, of itself, mean that the individual is eligible for [NHS] CHC”².

For example, a person in this scenario may require (and be entitled) to services from both the NHS (those that are above what the LA can provide) and their local authority social services department at the *same* time, but would have been judged to not have a sufficient level of health needs to qualify for NHS CHC.

In other words, the ‘**primary health need**’ test, referred to above, will not have been met.

Note: Sections 4 and 5 of this factsheet examine the procedure that should be followed by professionals involved in your care in determining whether you have a ‘primary health need’ and thus will be eligible for NHS CHC.

¹ The Act states that “a local authority may not meet a person’s needs for care and support...by providing or arranging for the provision of a service or facility which is required to be provided under a health enactment, unless doing so would be incidental or ancillary to doing something else to meet needs under those sections”.

² Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

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

The Welsh Government has defined the difference between a healthcare and a social care need as follows:

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

“In general terms (not a legal definition) it can be said that a social care need is one that is focused on providing assistance with activities of daily living, maintaining independence, social interaction...and (in some circumstances) [finding and] accessing a care home or other supported accommodation”.

“Social care needs are directly related to the type of welfare services that [local authorities] have a duty or power to provide. These include, but are not limited to...practical assistance in the home; assistance with equipment and home adaptations; visiting and sitting services; provision of meals; facilities for occupational, social, cultural and recreational activities outside the home...and assistance in finding accommodation (e.g. a care home)”³.

Note: “Deciding on the balance between local authority and health service responsibilities with respect to long-term care has [also] been the subject of key court judgments”⁴. These have influenced developments in NHS CHC policies, including the introduction of a National Framework (which is covered in sections below).

³ This quote is from a previous version of Welsh Government best practice guidance in regard to NHS CHC (‘Continuing NHS Healthcare for Adults: Practice Guidance to support the National Framework for Implementation in Wales – Frequently Asked Questions, Welsh Government, November 2010’). This has since been superseded by new best practice guidance to accompany the 2014 National Framework; however, this version does not appear to include the same information as quoted above. Nevertheless, the general principles will still be accurate with regard to the differences in social care needs and healthcare needs.

⁴ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

2.3 Background to NHS CHC

Since the early 1990s, the Parliamentary and Health Service Ombudsman has investigated a large number of complaints about eligibility for NHS continuing healthcare (NHS CHC).

Additionally, following devolution, the Public Services Ombudsman for Wales has highlighted inconsistencies in the application of NHS CHC eligibility criteria in annual reports and investigations of individual cases. The legality of some eligibility decisions were challenged in the courts.

Note: You can access reports by the Public Services Ombudsman for Wales at: www.ombudsman.wales/case-books

The above link includes access to a number of the ‘Ombudsman’s Casebooks’. These are published on a quarterly basis and contain summaries of recent cases, including on the subject of NHS CHC.

Key events in relation to NHS CHC⁵:

- In 1999, an important Court of Appeal judgement – known as the **Coughlan judgement** (*R v. North and East Devon Health Authority ex parte Pamela Coughlan*) – ruled that eligibility criteria used by the health authority concerned were far too restrictive⁶.
- In 2003 a Health Service Ombudsman [in England] report, ‘NHS funding for long term care’, was published. It found that health authorities were using overly restrictive eligibility criteria that were not properly in line with government guidance or with the Coughlan judgment. The Ombudsman found that “a number of people had been wrongly charged for elements of their care when they should have been treated as eligible for CHC and all their care provided free by the NHS”. It was recommended that efforts should be made to remedy any financial injustice to patients (a recommendation also accepted by the Welsh Government).

⁵ Since the Government of Wales Act 1998, health is an issue that is devolved to the Welsh Government. The UK Government’s Department of Health has no jurisdiction in Wales. However, the issue of NHS CHC in Wales has developed against the background of developments in England.

⁶ The Court found social services had been asked to take on healthcare responsibilities for a nursing home resident that went far beyond the duties imposed upon them by law (hence current legislation now making clear that social services cannot be expected to carry out functions that are beyond their remit, as touched upon in section 2.1 above).

- In March 2006, the High Court heard a challenge, on behalf of Mrs Grogan (the ‘**Grogan case**’ – *R v. Bexley NHS Care Trust ex parte Grogan*), who argued that she had been wrongly denied fully funded care. In his judgement, the judge criticised the lack of clarity in government guidance in use at that time, including inconsistencies in the area of assessing and weighing the nature, complexity, intensity or unpredictability of people’s health needs when making eligibility decisions (these factors still play a key role in current Welsh Government guidance – see section 3 below).
- It was against this background that a National Framework for NHS continuing healthcare and NHS-funded nursing care was developed and first introduced in Wales in August 2010, with the aim of improving decision making for NHS CHC.

- In 2013, the following Wales Audit Office (WAO) report was published:

Implementation of the National Framework for Continuing NHS Healthcare: Report presented by the Auditor General for Wales to the National Assembly for Wales

It examined how the 2010 Framework was being applied in Wales. Amongst other findings and recommendations, the WAO called for “national policy and guidance [to] better support consistency and fairness”.

This led to the introduction, in 2014, of the National Framework currently in use – see below.

- In January 2015, the WAO published a further report:

Continuing NHS Healthcare – Follow-up Report

This examined whether the 2014 CHC National Framework had successfully responded to the issues raised previously. Overall the WAO found “that there has been a positive response from the Welsh Government to many of the issues raised and recommendations made previously by the Auditor General and the Public Accounts Committee. However, despite some progress [there were still] significant concerns over the approach to clearing retrospective claims”⁷ (see section 14 below for further information on retrospective claims).

⁷ ‘Continuing NHS Healthcare – Follow-up Report’, 29 January 2015, Wales Audit Office (WAO) website: www.wao.gov.uk/publication/continuing-nhs-healthcare-%E2%80%93-follow-report

3 Welsh Government guidance on NHS CHC

The following document is the Welsh Government's current guidance for NHS organisations and local authority social services departments on NHS CHC and the processes that should be followed when examining a person's eligibility:

Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

A copy can be accessed on the Welsh Government website at:

www.gov.wales/topics/health/nhswales/healthservice/chc-framework

There is also a *Complex Care Information and Support Site (CCISS)*⁸ that the Framework refers to as a source for further information, tools and policies to be used in conjunction with the Framework –

www.cciss.org.uk/home

CCISS includes a link to 'best practice guidance' to accompany the 2014 National Framework – ***Continuing NHS Healthcare for Adults: The National Framework for Implementation in Wales – Practitioners' Frequently Asked Questions (February 2015)***

A copy can be accessed at:

www.cciss.org.uk/guidance-associated-documents

4 Who might be eligible for NHS CHC?

4.1 Eligibility decisions – 'primary health need' and the National Framework

As stated in section 2 above, eligibility decisions for NHS CHC rest on whether your need for care is primarily due to your health needs. This is referred to as having a 'primary health need' and is the "sole criterion" for determining eligibility⁹.

⁸ This is a joint Welsh Government / NHS Wales website

⁹ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

The diagnosis of a particular disease or condition – for example, Alzheimer’s disease or cancer – does not determine eligibility, as people with the same diagnosis or health condition can have very different needs.

As touched upon in the previous section, the Welsh Government’s National Framework provides the rules and guidance for determining a primary health need. The Framework aims to improve the transparency and consistency of the decision making process and sets out:

- Clear principles and processes to be followed throughout Wales for establishing eligibility for NHS CHC – see section 4 and 5.
- Guidance that must be followed by all staff involved in the assessment process (for example, medical professionals in hospitals, or social workers from your local authority’s social services department).
- A national assessment process supported by a *Decision Support Tool (DST)* – see section 5.3 below – and (for use in certain circumstances) a *Checklist Tool*, though the Framework doesn’t mandate this – see section 5.1.
- Common paperwork to record evidence that will inform decision-making.
- The Framework also explains the interaction between the assessment for NHS CHC and NHS-funded nursing care.

4.2 What factors might demonstrate a ‘primary health need’?

The Framework states that certain characteristics of your needs – in combination or alone – may demonstrate a primary health need because of the **quantity and/or quality** of care needed to manage them (‘quality’ in this context refers to the type of care that is required to manage needs).

Establishing a primary health need will be based on the ‘totality’ of all the actual day-to-day care needs¹⁰.

Therefore, when assessing your needs, staff consider them in relation to the following characteristics:

¹⁰ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

Nature	The type of needs, including their particular characteristics. The needs can be related to physical health, mental health or psychological needs and consideration is required in regard to the overall effect on the individual's health and wellbeing. The type (quality) of interventions required to manage them will be important – for example, are there particular skills or training required to anticipate and address the need; or could someone do it without specific in-depth training? Also, is the person's condition deteriorating or improving? Consideration should also be given as to what the consequences would be if the needs were not met in a timely way.
Intensity	This regards both the extent (quantity) and severity (degree) of an individual's needs and the support required to manage them – for example, this might include a requirement for regular interventions and sustained/ongoing care (continuity) to ensure the needs are met. Consideration may need to be given to the number of carers needed at any one time to ensure needs are met; also, does the care provided relate to needs over several domains?
Complexity	How different needs present and interact to increase the knowledge and skill needed to manage care, monitor symptoms, treat individual and/or multiple conditions and/or the interaction between them (for example, if needs impact upon each other, it might make the situation more difficult to address overall). “It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need” ¹¹ – could this make it more difficult to provide the care required?

¹¹ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

Unpredictability	This includes unexpected changes and fluctuations in someone's condition that are difficult to manage and challenge the staff who provide care. A further factor will be the level (quantity) of monitoring required to ensure that the individual and others are safe and the degree of risk if adequate and timely care is not provided. Someone with unpredictable healthcare needs is likely to have either a fluctuating, unstable or rapidly deteriorating condition. Questions to be considered include whether the individual or those who support him/her are able to anticipate when the need(s) might arise? Does the level of support often have to change at short notice? To what extent is professional knowledge or skill required to respond spontaneously and appropriately?
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These characteristics are reflected in the descriptions of the different levels of need that feature in the **Decision Support Tool (DST)**. This tool helps inform staff making a recommendation about your eligibility for NHS CHC – see section 5 below.

Eligibility decisions should always be independent of budgetary constraints.

'Fast tracking'

The characteristics described above – 'nature', 'intensity' etc – are also considered by staff deciding whether to recommend 'fast tracking' a patient so they can receive an urgent package of NHS CHC in an appropriate location. Fast tracking is only available in certain situations, however – see section 5.10 below for further information.

4.3 When should eligibility be considered?

The role of Local Health Boards (LHBs)

A Local Health Board (LHB) must take reasonable steps to ensure that an assessment for NHS CHC is carried out in all cases where it appears to them that there may be a need for such care. LHBs are responsible for delivering all NHS healthcare services within the geographical area they cover – this will include services provided as part of an NHS CHC package.

There are seven LHBs which cover Wales. NHS Direct Wales (see section 16 for contact details) can tell you which LHB will cover your area.

Alternatively, you can obtain further information from their website at:

www.nhsdirect.wales.nhs.uk/pdfs/WALESMAP-eng.pdf

LHBs are responsible for overseeing the NHS CHC decision making process, though local authority social services departments *also* often have a role to play – see below.

The role of local authority social services departments

Adult social services teams are responsible for assessing people's need for social care services and deciding whether those needs meet national eligibility criteria (social care services include services such as personal care at home, respite care, community transport, meals on wheels, or assistance with a care home placement – for further information see Age Cymru's Factsheet 41w *Social care assessments for older people with care needs in Wales*).

As part of their care needs assessment process, the local authority social services department **must** inform the relevant LHB if they are reviewing someone's care needs and feel that there is a possibility that the person has needs that fall within the remit of the NHS, *including* where they suspect there is a potential that the person could be eligible for NHS CHC.

If so – as noted above – the LHB will at that point then need to co-ordinate the process for determining CHC eligibility.

Examples of scenarios where it may be appropriate to consider potential eligibility for NHS CHC

As outlined in earlier sections, not everyone with ongoing health needs is likely to be eligible, but there are times when it would be appropriate to consider whether someone has a need for such care, including:

- **When someone is ready to be discharged from hospital and their long term needs in regard to ongoing care and support are clear to the health and social care practitioners who have been working with them** (also see Age Cymru's Factsheet 37w *Hospital discharge arrangements for older people in Wales* for further information).
- **Once a period of intermediate care, rehabilitation or other NHS-funded service – offered at the end of a period of acute hospital treatment – has finished and it is agreed no further improvement in your condition can be expected** (also see Age Cymru's Factsheet 76w *Intermediate care and reablement in Wales* for further information).
- **When someone's social care and support needs are being reviewed via a care needs assessment by the local authority social services department** (also see Age Cymru's Factsheet 41w *Social care assessments for older people with care needs in Wales* for further information).
- **If your physical or mental health deteriorates significantly and your current level of care – at home or in a care home – seems inadequate.**
- **When, as a resident of a nursing home, your nursing care needs are being reviewed** (undertaken at least annually – see section 15 below).
- **If you have a rapidly deteriorating condition with an increasing level of dependency and may be approaching the end of your life** (in this case you may be eligible for your CHC care services to be set up via the 'fast track' route – see section 5.10 below).

Who should you contact in the above scenarios if NHS CHC has not been discussed with you?

In circumstances such as those outlined above, you can raise the issue of NHS CHC and the possibility of organising an assessment to see if you are eligible with:

- Hospital staff directly involved with your care (in particular, discharge staff).
- Staff co-ordinating your intermediate care.
- Social services.
- Your GP.

5 Reaching an NHS CHC eligibility decision – Multi-disciplinary assessment, Checklist Tool, Decision Support Tool and other key elements

Note: This section contains detailed information on the eligibility process and how decisions are made. However, there is also a brief **flowchart** towards the end of the section – section 5.8 – which seeks to summarise the different stages involved.

Health and social care staff involved in assessing your needs will need to follow the 2014 National Framework guidance and use the Decision Support Tool (DST).

In some, but **not all**, circumstances it may also be beneficial for them to use a Checklist Tool (see below).

You may find it helpful to see a copy of the DST in advance. It should be available from the staff involved in your care, or see section 5.3 of this factsheet below for a web link where you can access a copy.

5.1 The Checklist Tool¹²

The Checklist Tool can be used by health and social care professionals to identify when someone should move on to having a full assessment to determine NHS CHC eligibility – entailing the completion of the DST by a multi-disciplinary team – as opposed to considering other types of social and healthcare services instead (in cases where staff feel that someone is obviously below the threshold of requiring NHS CHC).

Welsh Government rationale behind the use of the Checklist Tool

Prior to the introduction of the most recent National Framework in October 2014, a Checklist Tool did **not** feature in the NHS CHC decision making process in Wales – that is, health and social care professionals were required to identify the appropriate levels of assessment to be offered at particular times in a person's care and, therefore, essentially:

¹² You may sometimes hear the Checklist Tool also referred to by other similar names, such as a 'Trigger tool' or 'Screening tool'.

- you either had a full assessment for NHS CHC (if the level of your needs suggested possible eligibility); or
- the possibility of NHS CHC was not looked into at all (other than the initial decision that you didn't have a level of need to necessitate its consideration). The assessment process would then, instead, examine other local authority or NHS services that could meet your needs.

In contrast, in England a Checklist Tool had already been used for some time.

Applying the Checklist Tool in Wales is not mandatory

As touched upon earlier, it should be noted that the 2014 Framework states that:

“The use of a screening tool or checklist is not mandated in [the] Framework” (emphasis added).

Rather, “there may be specific circumstances where such a tool may be useful” with regard to providing a rationale behind decisions not to progress a case forward for full CHC consideration, for example¹³.

Using the Checklist

The threshold for using the checklist is set **deliberately low** to ensure that all who require a full assessment have the opportunity.

As touched upon above, the Welsh Government also considers it a useful tool for recording the rationale for decisions of whether or not to proceed to full NHS CHC assessment. For example:

¹³ One of the reasons behind the Welsh Government's decision to introduce the Checklist in Wales might also have been related to a report by the Welsh Audit Office (into the previous 2010 Framework) which noted that “the adoption of a screening tool in Wales could lead to a number of benefits...both NHS and social services staff raised concerns with us during our fieldwork visits over difficulties they had encountered in getting colleagues to identify when someone needed to be assessed for CHC. We also identified a lack of consensus in some areas between social services and NHS staff about when a CHC assessment is needed” The Welsh Audit Office report was called ‘Implementation of the National Framework for Continuing NHS Healthcare: Report presented by the Auditor General for Wales to the National Assembly for Wales on 13 June 2013’.

- there may be “occasions where the checklist might be a useful tool in conversations between professionals [and/or] between professionals and families” and could be used “to illustrate where a person has low levels of need that do not require the comprehensive assessment process”¹⁴ and “the Multidisciplinary Team (MDT) believes a complex care package is clearly not required”¹⁵ (presumably the thinking here is that it could put people’s minds at rest that they, or a relative, were not missing out on funding that they should be getting); or
- where a care home resident’s “condition has changed and [an] earlier than planned review may be required”¹⁶.

Note: The Checklist Tool must not be misused to ‘screen people out’ of the CHC process

The Welsh Government has emphasised that “in order to comply with the ethos of [the National] Framework, the use of the Checklist must not replace professional judgement or dialogue with the individual and their family/representative”, *nor* should it be used in an attempt to “screen out” people from proper consideration of NHS CHC eligibility. Furthermore, it is “not acceptable for it to be completed unilaterally by the LHB; a social worker should **always** be involved” (emphasis added)¹⁷.

Obtaining a copy of the Checklist Tool

In circumstances where it is decided that a Checklist Tool should be applied, the Welsh Government has instructed that staff will need to use the same Checklist as their counterparts in England. This is produced by the Department of Health in England and the following link is provided within the Welsh Government’s National Framework for Wales:

www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

¹⁴ Continuing NHS Healthcare for Adults: The National Framework for Implementation in Wales – Practitioners’ Frequently Asked Questions, Welsh Government, February 2015

¹⁵ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

¹⁶ *Ibid*

¹⁷ Continuing NHS Healthcare for Adults: The National Framework for Implementation in Wales – Practitioners’ Frequently Asked Questions, Welsh Government, February 2015

The Checklist is based on the same ‘domains’ or ‘areas of need’ as the Decision Support Tool (DST). The DST is explained below, in section 5.3.

For each domain, there are descriptions that represent ‘*no and low*’ needs (found in column C of the Checklist Tool); ‘*moderate*’ needs (column B) and ‘*high*’ needs (column A).

The Checklist Tool contains further information on how it should be used and completed by staff. Broadly speaking, they must choose the description that most closely matches your current needs (including taking into account any well-managed needs and any increased needs that might be expected within the next three months). Their choices must be backed up by evidence.

Where the Checklist indicates that a full assessment is required

A full assessment would be required if the Checklist showed either of the following:

- *Two or more* domains rated as **high** (column A).
- *Five or more* domains rated as **moderate** (Column B).
- *One* domain rated as **high** (Column A) and *four* rated as **moderate** (Column B).
- One of the four domains that carries a ‘priority’ level in the DST rated as **high** (column A) and any levels of need in other domains (see section 5.3 for details of the domains within the DST that have a priority level).

If the Checklist result indicates a full assessment is not required

You have the right in this scenario to ask the LHB to reconsider the decision. The LHB should give your request due consideration, taking account of any new information, including extra information you or your representative are able to provide.

Where the Checklist Tool is not used

In situations where it is not thought necessary to carry out the Checklist Tool stage, *but* professional staff believe you *may* be eligible for NHS CHC, their decision will be based **purely on the two stages outlined below** in section 5.2 and 5.3 – that is:

- **a full multi-disciplinary assessment;** and
- **completion of the DST.**

If you are in a situation where use of the Checklist Tool has not been thought necessary **and** it has also been decided that you will not be referred for a full assessment, you could make a complaint if you believe you have been ‘screened out’ of the process too early – see section 9 below.

5.2 **Multi-disciplinary assessment**

Once you are referred for a full assessment for potential NHS CHC eligibility, the Local Health Board (LHB) is responsible for co-ordinating the whole process until:

- a decision about your eligibility and the funding of your care has been reached; and
- a care plan has been agreed.

The care co-ordinator

The Local Health Board (LHB) should appoint someone employed by them, or by mutual agreement by another organisation, to co-ordinate this process (the ‘care co-ordinator’).

You should be provided with the care co-ordinator’s name and contact number and they should keep you informed of progress throughout the assessment process (including advising you of potential delays and the reason for this). Where you have expressed a wish for your family to be involved, the care co-ordinator must also liaise with them.

The multi-disciplinary assessment process

A multi-disciplinary assessment is a full, detailed, assessment of an individual’s needs. It will actively involve a range of health and social care professionals, across different disciplines, in the collection and evaluation of the assessment information.

Note: It is worth noting that there is no separate assessment process for NHS CHC, in that this type of comprehensive needs assessment will be expected in all cases where someone has potentially complex needs (be they health needs, social care needs, or any other type of need) – what is **unique** to the NHS CHC process is the Decision Support Tool (covered in section 5.3 below). The National Framework stresses that practitioners “are expected to comply with existing Welsh Government...guidance on assessment and care planning” when carrying out a multi-disciplinary assessment – Age Cymru’s Factsheet 41w *Social care assessments for older people with care needs in Wales* contains further information on the main care needs assessment processes.

The professionals invited to provide their input into the multi-disciplinary assessment may include those not currently caring for you, but who have a direct knowledge of you and your needs. For example, this may include:

- nurse coordinator/assessors;
- social workers/care manager;
- physiotherapists;
- occupational therapists;
- dieticians/nutritionists;
- GPs/consultants/other medical practitioners;
- community psychiatric nurses;
- ward nurses, specialist nurses, discharge nurses and community nurses;
- care home/support provider staff.

Information or evidence that may be used as part of the multi-disciplinary assessment

This could include, for example:

- health needs assessments and/or nursing assessments;
- social care assessments;
- physiotherapy assessments;
- behavioural assessments;

- occupational therapy assessments;
- your own views on your needs and, where appropriate, your carer's views (see section 5.6 below for information on the importance of a 'person-centred' approach to the assessment and how your views should be considered alongside those of the professionals involved);
- your current care and support plan;
- care home records / non-residential care support records.

The multi-disciplinary assessment ensures that all your physical health, mental health and social care needs can be looked at and evaluated individually and together – including ways in which they interact with each other – to give an accurate reflection of your current needs and likely changes in the near future.

A good quality assessment is crucial both to determining your eligibility for NHS CHC and addressing how your needs can best be met – whether you are eligible for NHS CHC or not.

Information collected through the multi-disciplinary assessment is used by a multi-disciplinary team (MDT) to complete the Decision Support Tool. It will be the role of the co-ordinator to identify the appropriate individuals to comprise the MDT.

The MDT should have at *least* two professionals, usually from both health and social care professions. However, as outlined in the list above, in many situations the team may have more members than this, if there are other individuals who have an up-to-date knowledge of your needs.

5.3 The Decision Support Tool (DST)

The DST should draw on the multi-disciplinary assessment findings. It has been “designed to support the decision making process” and must only be used *following* a comprehensive multi-disciplinary assessment. The Welsh Government's guidance stresses that the DST “is not an assessment in itself and it does not replace professional judgement in determining eligibility. It is simply a means of recording the rationale and facilitating logical and consistent decision-making”¹⁸.

¹⁸ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

The DST is a national tool and cannot be altered in any way by individual Local Health Boards. Since the introduction of the 2014 Framework, the Wales DST has been brought in to line with the version used in England¹⁹.

The tool features **12 ‘domains’** (which are basically different areas of need). There are 11 specific domains and a twelfth which is an open domain for recording needs that don’t readily fit into the other 11.

Each domain is broken down into between four and six levels of need:

- **‘No need’**
- **‘low’**
- **‘moderate’**
- **‘high’**
- **‘severe’**
- **‘priority’**.

Note: A few of the domains have ‘high’ as the maximum level which they can be allocated in the assessment, whereas others can go up to ‘severe’ or ‘priority’.

The levels reflect the nature, intensity, complexity and unpredictability of a need (see section 4.1 above). Medical terms have been kept to a minimum when describing the levels of need in each domain.

The domains are:

¹⁹ The findings of a Wales Audit Office (WAO) review into how the old 2010 Framework was being applied in Wales played a significant part in how the Welsh Government updated the Framework for 2014 (‘Implementation of the National Framework for Continuing NHS Healthcare: Report presented by the Auditor General for Wales to the National Assembly for Wales on 13 June 2013’). For example, the WAO expressed concern because differences at that time between the CHC DSTs used in Wales and England (including some differences in the highest level of need) may have resulted in it being “more difficult for some people in Wales, most notably those with dementia, to meet CHC eligibility criteria”.

	Domain	Maximum level of need which can be allocated to the domain
1	Behaviour	<u>Priority</u>
2	Cognition	Severe
3	Psychological and emotional needs	<i>High</i>
4	Communication	<i>High</i>
5	Mobility	Severe
6	Nutrition (food and drink)	Severe
7	Continence	<i>High</i>
8	Skin (including tissue viability)	Severe
9	Breathing	<u>Priority</u>
10	Drug therapies and medication: symptom control	<u>Priority</u>
11	Altered states of consciousness	<u>Priority</u>
12	Other significant care needs to be taken into consideration	Severe

Note: The DST – ‘*Decision Support Tool for Continuing NHS Healthcare (June 2014)*’ – can be found in a separate document to the main National Framework. It contains examples of the sorts of issues that may come under each of the domains. A copy can be accessed at:

www.cciss.org.uk/guidance-associated-documents

Completing the DST

In advance of the DST meeting, the co-ordinator should explain the format and how you and/or your representative can participate.

You or your representative should be fully involved in the process and invited to contribute to the discussion in person or be represented where possible. You should be given sufficient notice of the date, so you can make arrangements to attend. If this is not possible, your views or those of your representative should be obtained and actively considered when completing the DST (also see section 5.6 below). When completing the tool, the following points are important:

- All care domains should be completed.
- The team should use the assessment evidence and their professional judgement to select the level that most closely describes your needs.
- Your needs should not be placed between levels. “If, after considering all the relevant evidence, it proves difficult to decide or agree on the level, the MDT should choose the higher of the levels under consideration and record the evidence in relation to both the decision and any significant differences of opinion”²⁰.
- Interactions between needs should be considered as appropriate.
- Needs not covered by one of the 11 domains should be recorded in the twelfth domain and taken into account when making an eligibility decision.
- Needs should **not** be marginalised because they are successfully managed. Well-managed needs are *still* needs and should be recorded appropriately.

If it can reasonably be anticipated that your condition will deteriorate and your needs in certain domains will increase in the near future, this should be recorded and taken into account when the final recommendation is made.

²⁰ Decision Support Tool for Continuing NHS Healthcare, Welsh Government, June 2014

Those completing the tool should state whether you or your representative were present when the DST was completed (the DST includes a section which specifically asks whether the individual was involved in the completion of the DST, asks for details of their own views on their care/support needs and “whether they agree with the domain levels selected. Where they disagree, this should be recorded” (including the reasons for disagreement).

“Where the individual is represented or supported by a carer or advocate, their understanding of the individual’s views should be recorded”²¹.

If you have concerns about any aspect of the MDT or DST process that are not resolved by discussing them at the time, your concerns should be noted within the DST, so they can be brought to the notice of the Local Health Board when making their final decision.

Note: The guidance says it is acceptable for the MDT to have a discussion without you or your representative present, in order to reach their recommendation.

5.4 **The multi-disciplinary team’s recommendation**

The multi-disciplinary team (MDT) uses evidence from the completed DST, along with relevant risk assessments and their professional knowledge and experience, to make a recommendation to the Local Health Board as to whether or not your needs have characteristics that demonstrate a ‘primary health need’ and hence eligibility for NHS CHC.

²¹ Ibid

When would a recommendation of eligibility be expected?

<p>A clear recommendation of eligibility would be expected if you have:</p>	<p>a.) <i>Priority</i> level of need in <i>any</i> of the four domains where that level can be allocated.</p> <p>b.) <i>Two or more</i> instances of severe needs across all domains.</p>
<p>A primary health need <i>may</i> also be indicated if there is:</p>	<p>a.) One domain recorded as severe <i>together with</i> needs in a number of other domains.</p> <p>b.) A number of domains with high and/or moderate needs.</p>

In the latter cases, the judgement about whether you have a 'primary health need' must be based on what the evidence indicates about:

- the **nature**; and/or
- **complexity**; and/or
- **intensity**; and/or
- **unpredictability** of your needs.

Note: The MDT is also asked to indicate whether they expect your needs to improve or deteriorate before a three-month review and whether they would recommend an earlier review.

Having taken into account any likely deterioration in your condition that could affect your needs, a recommendation for you to be ‘fast tracked’ on to NHS CHC may be appropriate – see section 5.10 below.

Where eligibility would be unlikely

If all are ‘low’ needs, this is *unlikely* to indicate eligibility.

The Welsh Government’s DST states, however, that “because low needs can add to the overall picture, influence the continuity of care necessary, and alter the impact that other needs have on the individual, all domains should be completed”.

Where someone will definitely not be eligible

If needs in *all* domains are ‘no need’, this would indicate definite ineligibility.

5.5 The Local Health Board’s decision

Only in exceptional circumstances – and for clearly articulated reasons – should the Local Health Board (LHB) not accept the recommendations of the multi-disciplinary team (MDT)²². A decision not to accept the recommendation should not be made by one person acting unilaterally. Once the LHB approves the recommendation, you should be informed in writing.

Note: A decision that you are eligible for NHS CHC is **not** a permanent one. It can be overturned at a later date if a review shows your condition has improved and your needs have changed.

²² The National Framework states exceptional circumstances under which the LHB may question a recommendation could include where the “DST is incomplete or if there is significant inconsistency between the evidence in the assessment, the DST and the recommendation made”. In such instances these matters should be referred back to the MDT to be addressed.

If the recommendation is that you are not eligible, but that you may need care in a nursing home, the completed multi-disciplinary assessment should contain sufficient information to determine the need for **NHS-funded nursing care** – see section 15.

5.6 ‘Underpinning Principles’ to the assessment and eligibility process (including a ‘person-centred’ approach)

The National Framework advises health and social care staff that “no guidance will address all of the potential situations that can present when assessing and meeting an individual’s complex needs. There will be occasions when a degree of interpretation is required to apply the guidance in real-life cases”. Therefore, practitioners must be able to demonstrate that they have applied certain “underpinning principles”. These are:

- **Principle 1: People first**

The best interests of the individual and treating them with dignity and respect must be the primary focus of those providing assessments.

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

“Members of the multi-disciplinary team are responsible for the integrity of their assessments...which should be underpinned with a rationale. Assessments can only be challenged on the basis of their quality” (and never on financial grounds).

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

“Individuals are the experts in their own lives. Including them and/or their carers (be they paid or unpaid) as empowered co-producers in the assessment and care planning process is not an optional extra”. Where the available care options carry financial or emotional consequences, professionals must not avoid honest and mature conversations with the individual and/or their representative. Professionals must be mindful that some individuals may need...advocacy to express their wishes” – see section 7 below for further information.

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

“The individual must not experience delay in having their needs met because agencies are not working effectively together”.

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

“Individuals do not define themselves by their medical diagnosis and nor should the professionals who are supporting them. Health and social care providers must work together to gain a holistic understanding of need and the impact on...daily life”.

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

“Fragmented care is distressing, unsafe and costly [and]...every effort must be made to avoid disruption to care arrangements wherever possible, or to provide smooth and safe transition where change is required”.

- **Principle 7: Communicate**

“The vast majority of complaints...have poor communication at their core”. Therefore, “where possible, the professional should attempt to establish the preferred means of communication...prior to undertaking any assessment”. Service users and carers should be able to speak with staff in Welsh if this is their preferred language.

5.7 **Case studies – examples of where NHS CHC eligibility may or may not be indicated**

The Welsh Government produced the following case studies to illustrate where someone would be likely to qualify for NHS CHC and where they would not²³:

²³ The case studies were used in a Welsh Government information leaflet produced as part of their awareness raising campaign for retrospective claims (prior to a deadline for particular cases in July 2014).

Case study 1

“A sixty six year old lady with vascular dementia, mini strokes and subsequent cognitive impairment was admitted [to hospital] following a fall which resulted in a fractured hip. Following rehabilitation Mrs Jones’ mobility improved but the ward were unable to continue supporting her due to her aggressive behaviour. Mrs Jones was transferred to an EMI hospital for...assessment and treatment”. Identified needs were:

- “Prolonged periods of agitation and restlessness over a 24 hour period [for example] frequently [trying] to remove her clothing in the lounge.
- Severe cognitive impairment with short and long term memory loss.
- Unable to find her way around the ward, know what time of day it was, or recognise others including her close family.
- No awareness of social boundaries and risk, interfering with other patients at times and at risk of retaliation from them.
- Limited mobility following [the] fractured hip; however, had no awareness of her limitations and would attempt to mobilise without staff help, making her at high risk of falls.
- Due to lack of awareness required supervision during the day and a sensor mat at night.
- Constant support and encouragement to meet personal care and continence needs, presenting with physical aggression on interventions. Staff required an awareness of care and restraint procedures, under the supervision of a registered mental health nurse.
- Unsettled over a 24 hour period, requiring half hourly checks at night and night time sedation; there was evidence of frequent periods over 24 hours where Mrs Jones required the support of 1–2 carers.
- Required the administration of medication on an ‘as and when’ basis.
- Most of the time her communication was muddled and incoherent, so she relied on staff to anticipate her needs.
- Able to eat independently, however she required supervision...and a soft diet...and had had a number of episodes of choking”.

Result: CHC agreed by panel

Case study 2

“Mrs Lee...was admitted to hospital with neurological problems and [an] increasing number of seizures. Following a medication review she remained seizure-free for six weeks. Her seizures were described as mild. In addition to this she had...Alzheimer’s [disease], which was diagnosed approximately 3 years previously and the symptoms of this had accelerated since she developed her neurological problems. There was no input from mental health services and she did not present with any management problems”. Identified needs were:

- “She had communication difficulties but was able to express and indicate her needs. She did not initiate any conversation but could respond by saying yes or no to direct questions. [Is reliant] on staff to anticipate needs.
- She required a hoist for all transfers from bed to [a] chair. She was able to sit independently in the chair for periods. Pressure relieving equipment was used to prevent any skin/pressure damage.
- She had a good appetite but required staff to cut up her food and on occasions required some assistance [to eat]. She was able to drink from a beaker, without prompting. There was no evidence of any weight loss.
- She was doubly incontinent and had a catheter in place; she was totally reliant on care staff for all continence care, including bowel management. There were no management problems with her catheter and interventions around this need were not considered complex.
- She had some areas of dry skin, scabs and scratch marks from chronic itching. She was seen by a dermatologist and was prescribed cream which was applied four times a day. All other pressure areas were intact.
- Required assistance for basic nursing care around washing, dressing grooming and continence.
- Administration of medication four time[s] daily, by a registered nurse”.

Result: Mrs Lee was assessed as **not** eligible for NHS CHC; **however** she did have nursing care needs and was granted NHS-funded nursing care (see section 15).

Case Study 3

“Mrs Jones was aged 60; she was diagnosed with multiple sclerosis a number of years previously and had recently moved into a residential home”. Identified needs were:

- “She required a lot of support with personal care, however she could wash her face...[and] was able to communicate her needs.
- She was [doubly incontinent and] she required support from carers to change her incontinence pad[s].
- She was immobile but had an electric wheelchair which she could use independently. She was at risk of falls when in her own home. However, now that she was in an environment where she has access to staff over a 24 hour period this was no longer a risk”.

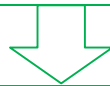
Result: Mrs Jones was assessed by the MDT as **not** being eligible for NHS CHC or NHS-funded nursing care.

5.8 Flowchart: the NHS CHC eligibility process

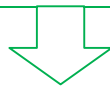
Circumstances indicate that you may require longer-term care and support (for example, hospital admission or a review of an existing care and support package – in your own home, or in a care home – indicates an increase in needs).



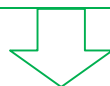
Named care co-ordinator allocated to you. They will oversee the process and answer any questions you have, keeping you informed of timescales and dates of meetings (the co-ordinator will seek your consent to begin the assessment process).



The care co-ordinator will start contacting the various staff who will need to input into the assessment and begin to compile all necessary information. They will also decide on the members of the multi-disciplinary team (MDT).

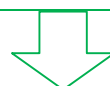


You may be contacted by various staff during the multi-disciplinary assessment stage. This is because they might need to work with you to undertake additional assessments to ensure they have all the information needed to make the NHS CHC eligibility decision.

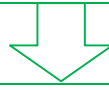


Once the multi-disciplinary assessment has been completed, you will be invited by the care co-ordinator to attend a meeting with the MDT where the Decision Support Tool (DST) will be completed. The Welsh Government's guidance (the National Framework) instructs staff that you should be able to contribute fully to the discussions about your needs and provide your views on the DST judgements.

It is at this DST stage that a recommendation will be made as to whether or not you qualify for NHS CHC funded services.



A written explanation of the recommendation about your NHS CHC eligibility will be sent to you. The care co-ordinator will arrange to meet you to discuss what will happen next, including what action you can take if you are unhappy with the decision.



Arrangements will be made to set up your NHS CHC services if you are eligible. Your needs will be reviewed again, once you have been receiving the services for a few months – see section 12 for further information on the review process.

If you are not eligible for NHS CHC, any other services which you are entitled to must be put in place – see section 13. If you want to pursue a review of the decision that you were not eligible for CHC, see section 9.

5.9 How quickly should services be put in place?

The 2014 National Framework includes information on expected timescales for the completion of the whole eligibility process – i.e. the completion of all assessments that inform NHS CHC decision-making and the subsequent agreement of a care package.

It says this “may vary but should generally be completed in **no longer than eight weeks**, from [the] initial trigger [that assessment is required] to agreeing a care package” (emphasis added).

This eight week period will include any “reablement and assessment at home or in [a] step down facility. Extension of [the] timeframe is acceptable where the individual needs a longer period of rehabilitation or reablement, but not in relation to delays in determining CHC eligibility”.

In ‘fast track’ cases this timescale will be much shorter – see below.

5.10 Fast Track assessments

When you have a rapidly deteriorating condition and may be approaching the end of your life, urgent consideration of your CHC eligibility would allow an appropriate care package to be arranged as quickly as possible.

Such changes in your condition could be observed while you are in hospital or by staff caring for you at home or in a care home. If this happens, they should contact an ‘appropriate clinician’ and ask them whether it would be appropriate to consider completion of a ‘fast track assessment’.

The National Framework defines appropriate clinicians as those who are “responsible for an individual’s diagnosis, treatment or care [and] who are registered nurses or medical practitioners. The clinician should have an appropriate level of knowledge and experience of the type of health needs to decide on whether the individual has a rapidly deteriorating condition that may be entering a terminal phase”.

Decisions to ‘fast track’ should be made on a case by case basis and the completed fast track assessment should be supported by a prognosis. Strict time limits basing eligibility on a specific ‘expected length of life remaining’ should **not** be imposed.

Where an appropriate clinician recommends an urgent package of care through the fast track process, this should be accepted and put into place immediately by the LHB – the Framework advises that in fast track cases they “should aim to complete the process within **two days**” (emphasis added).

Review of your needs where a fast track decision has been made

Care should be taken to explain why a fast track decision has been made and to minimise the chance of needing to reverse it within a short time. The National Framework advises “sensitive decision making is essential in order to avoid the undue distress that may result from an individual moving in and out of CHC eligibility within a very short period of time”.

No one who has been identified as eligible for NHS CHC through the fast track process should have their funding removed without going through the usual review process set out in the National Framework – see the above sections.

Where a multi-disciplinary team (MDT) reviews a fast track case and cannot subsequently reach agreement on whether the person remains eligible for NHS CHC, the case should go through an agreed Local Health Board and local authority dispute process.

Continuity of care and support for the person concerned should be maintained during this process.

6 Giving consent and mental capacity issues in regard to NHS CHC

Giving consent

At the outset, staff should seek your informed consent to the CHC assessment process and the necessary sharing of personal information about you between individuals and organisations involved in your care.

Note: If you decide not to give consent, the local authority cannot take responsibility for meeting needs that would normally be the responsibility of the NHS. Therefore, the consequences of not giving consent should be clearly explained to you.

When you lack capacity to give consent

If there is concern about your ability to give consent to an assessment and for the sharing of information, your capacity to make this particular decision should be determined according to the *Mental Capacity Act 2005*. This means taking account of the five principles of the Act, and includes taking all practicable steps to help you make the decision yourself.

Note: Parts 2.35 to 2.58 of the 2014 National Framework (in a section called '*Consent and Capacity*') provide further information about compliance with The *Mental Capacity Act 2005* (including the five principles) and what is expected of healthcare or social care professionals in these types of situations.

If it is agreed that you lack capacity to give consent, staff should check whether you have appointed an *attorney* via an **LPA (Lasting Power of Attorney)** to act on your behalf on health and welfare matters²⁴.

If not, they should check whether someone has been appointed a 'personal welfare' *deputy* by the **Court of Protection**²⁵.

²⁴ A person appointed as attorney or deputy in relation to your property and financial affairs only, would not have the authority to make decisions about health and welfare.

²⁵ See above footnote.

A partner, family member or other 'third party' **cannot** act on your behalf and give consent unless appointed to do so by either of the two ways described above.

If no one has been appointed to act in one of these ways, the person leading the assessment will be responsible for making a '**best interests**' decision on your behalf under the *Mental Capacity Act 2005*. To inform their decision, they must consult with those who have a genuine interest in your welfare. This will usually include consulting family and friends. The outcome of a 'best interests' decision should be recorded.

As touched upon above, the *Mental Capacity Act 2005* is the legislation which governs the rules to be followed where someone lacks capacity to make their own decisions and applies to anyone acting in their 'best interests'. Doctors, nurses, social workers, other health professionals and support staff have a duty to ensure they are trained in its implementation and are expected to understand it as it relates to their own responsibilities.

7 Advocacy support in relation to NHS CHC decisions

The National Framework advises that "LHBs and local authorities should ensure that individuals are made aware of local advocacy services that may be able to offer advice and support".

7.1 Advocacy services if someone has capacity

You can ask a family member or friend to act as an advocate and help you make your views known during the assessment process. Alternatively you can ask the person co-ordinating your assessment about local advocacy services. Our **Age Cymru Advice** service can also help identify whether there are any suitable advocacy schemes in your area – see section 16 for contact details.

7.2 Advocacy when someone lacks capacity

As stated above in section 6, a close family member or friend should be consulted if a 'best interests' decision needs to be made by healthcare or social care professionals.

The National Framework advises that “regardless of whether or not [someone] lack[s] capacity, they may still wish to be supported by an advocate”. Therefore, as outlined in section 7.1, a family member or friend may be able to act as an advocate, or they could seek support from a local advice organisation who may be able to offer an advocacy service.

Cases where an Independent Mental Capacity Advocate (IMCA) may be required

If an LHB (or local authority) has to make a ‘best interest’ decision that involves a change of residence or serious medical treatment – for example, it may be considering whether a permanent move to a care home is appropriate – and you do **not** have a family member or friend who is willing and able to represent you or be consulted during the process of reaching such an important ‘best interests’ decision, it has a duty under the *Mental Capacity Act 2005* to instruct and consult an **Independent Mental Capacity Advocate (IMCA)**.

The IMCA’s role is to seek information about what would be in their client’s ‘best interests’, represent those interests and challenge any decision by the LHB that appears to be against these. The *individual* is the IMCA’s client, **not** the LHB.

Note: Further information about IMCAs and the *Mental Capacity Act 2005* can be found in Age UK’s Factsheet 22 *Arranging for someone to make decisions on your behalf*.

8 Arrangements if you are eligible – including locations where you may receive NHS CHC

The Local Health Board (LHB) that holds the contract with your GP practice at the time of your assessment for NHS CHC is responsible for arranging and funding your care package. There will be a manager at each LHB with responsibility for NHS CHC.

8.1 Confirmation of the decision

The LHB should tell you their decision verbally and in writing, giving clear reasons and the basis on which the decision was made. A copy of the completed Decision Support Tool should also be made available to you if you wish to see it.

Note: The LHB is responsible for ensuring you are told who is responsible for monitoring your care and arranging regular reviews. A decision that you are eligible is not necessarily a permanent one as your condition and needs may change. On-going reviews are built into the process – see section 12.

The LHB must provide a care package it thinks appropriate to meet your assessed health and social care needs and the ‘outcomes’ your care package aims to achieve.

Your care can potentially be provided in a range of settings (see section 8 below), though often it will be in a nursing home.

8.2 The location of care

The final decision about your care plan and location of care rests with the funding Local Health Board (LHB); however, when drawing up and agreeing the plan, your preferences and those of your relatives or advocate on how and where your care is provided should be taken into account. The LHB should seriously consider your preferences, alongside any risks associated with different types of care and fair access to LHB resources.

The funding provided should be sufficient to meet needs identified in the care plan, based on the LHB’s knowledge of the costs of those services in their locality.

Note: If you are dissatisfied with the care package proposed by the Local Health Board and cannot resolve your concerns informally, you should be told how to access the NHS complaints procedure. See Age Cymru’s Factsheet 66w *Resolving problems and making a complaint about NHS care in Wales* for further information.

8.3 NHS CHC in a nursing care home (or sometimes a residential care home)

Note: Some care homes provide accommodation together with personal care only, whereas others can additionally provide nursing care.

The terms 'residential care home' and 'nursing care home' are sometimes used to differentiate between the two types of home.

If you are to live in a care home and qualify for NHS CHC, the NHS makes a contract with the home and pays fees covering your accommodation, board and to meet your assessed health and personal care needs. In most circumstances, this will be a nursing home.

The following are some issues to be aware of:

- As indicated in the previous section, if it is agreed that you should move into a care home, you do not have the right to choose either the location – i.e. the town – or actual care home, but your preferences are an important part of the evidence to be considered in reaching a decision.
- LHBs may have a contract with one or more nursing homes in the area, but your assessed needs will determine whether they are suitable. The National Framework recognises that there may be “exceptional circumstances...where [the] LHB should consider a higher than usual cost [placement]” and these should be looked at on a “case by case basis”.

LHBs are advised that they “must liaise with the individual and/or their representative(s) to identify the reasons for the preference [for the more expensive accommodation]. Where the need is for identified clinical reasons (for example, an individual with challenging behaviour who requires a larger room because it is identified that the behaviour is linked to feeling confined, or an individual considers that they would benefit from a care provider with specialist skills rather than a generic care provider), consideration should be given as to whether it would be appropriate for the LHB to meet this. If no clinical need is established the LHB will need to make a decision which balances the needs and preferences of the individual with the requirement for probity with public funds”²⁶.

²⁶ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

- As highlighted above, care will usually be provided in a nursing home, rather than a residential home, though this doesn't *necessarily* have to be the case. For example, if you have been awarded NHS CHC through the 'fast track assessment' and are already living in a residential home, you may have expressed a preference to remain there. However, the LHB would need to be satisfied that your assessed healthcare needs can be appropriately met in this particular residential setting. If it is not possible for your current care home to meet your needs, you will need to discuss your options with the LHB.

What will happen if you are already resident in a 'high cost' nursing care home at the time that you become eligible for NHS CHC?

If you are living in a nursing home when the decision to grant NHS CHC is made, you need to discuss with your LHB whether you can stay there. This is particularly relevant if your home is more expensive than the LHB would normally pay to meet needs such as yours. This can happen if you have been self funding your care or were part funded by the local authority with a relative or other third party 'topping up' to meet the fees.

Whereas 'topping up' is legally permissible in legislation governing social care, it is **not** allowed under NHS legislation.

In reviewing your current accommodation, the LHB should explore your reasons for wishing to remain in your current home/room and consider if there are clinical or overriding needs-based reasons for you to remain there (this could include personal needs, such as proximity to close family members). Any possible risks of moving you would need to be assessed before a final decision was made. For example:

LHBs "should consider whether there are reasons why they should meet the full cost of the care package, notwithstanding that it is at a higher rate. Such reasons could include for example, the frailty, mental health needs or other relevant needs of the individual which mean that a move to other accommodation could involve significant risk to their health and well being"²⁷.

²⁷ Ibid

Note: The National Framework advises that if someone becomes entitled to NHS CHC and have “an existing high-cost care package, LHBs should consider funding the cost of the existing higher-cost package until a decision is made on whether to meet the higher cost package on an ongoing basis or to arrange an alternative placement”.

Moving to a care home in a different area in Wales

It may seem more appropriate for you to move to a home closer to relatives who live in a different LHB area. You may propose this but cannot assume it will be acceptable to the funding LHB.

If it is agreed you can live in a care home in a different LHB area, your care home fees remain the **responsibility** of the LHB that **initially** decided your eligibility.

Once you move into the care home, you need to register with a local GP practice. Once registered, any other NHS services or treatment unrelated to the reason for your placement in the care home become the responsibility of your GP practice’s LHB – i.e. the LHB in the new area.

Moving to a different area within the UK

If you wish to receive care in England, Scotland or Northern Ireland, there would need to be a discussion between your funding Local Health Board (LHB) and the relevant health body in your chosen country (for example, the Clinical Commissioning Group (CCG) if it was in England).

As with moves within Wales, the LHB which initially decided on your eligibility retains responsibility for your care. Joint guidance between the Welsh Government and the NHS in England states that:

“Where a CCG or LHB arranges a package of NHS Continuing Healthcare (CHC), (other than a package that is only NHS funded nursing care), the placing body will remain responsible for that person’s CHC until that episode of care has ended”²⁸.

²⁸ England / Wales NHS Cross-border Healthcare Services: Statement of values and principles, Welsh Government, 6 November 2018 (available at: www.gov.wales/topics/health/nhswales/about/border)

8.4 NHS CHC in your own home

The LHB will be responsible for arranging and funding an appropriate care package to meet your assessed health and personal care needs²⁹.

This is often a more complex care package to arrange and local resources may influence whether care can be provided at home.

“In many circumstances there will be a range of options for packages of support and their settings that will be appropriate for the individual’s needs. The starting point for agreeing the package and the setting where continuing NHS healthcare services are to be provided should be the individual’s preferences. Individuals will not always be aware of the models of support that it is possible to deliver (for example, they may assume that it is only possible to receive support in a care home)”.

LHBs are able to take “comparative costs and value for money into account when determining the model of support to be provided”, but should consider, for example, “whether models such as assistive technology could meet some of [the] needs” and allow someone to remain in their own home, without costs being prohibitive.

“Cost has to be balanced against other factors in the individual case, such as an individual’s desire to continue to live in a family environment”³⁰ (emphasis added).

Note: If you were living at home prior to being eligible for NHS CHC and were receiving direct payments from your local authority, you should bear in mind that CHC cannot be provided through the direct payments system. However, LHBs may be able to arrange services to maintain a similar package of care. For example, the National Framework advises that “every effort should be made to maintain continuity of the personnel delivering the care, where the individual wishes this to be the case”.

²⁹ As the care is taking place in your own home, the cost of accommodation, food and normal utility bills will not be met (though if extra utility costs are incurred due to the running of specialist equipment, a contribution to related bills may be appropriate).

³⁰ These quotes are from a previous version of Welsh Government best practice guidance in regard to NHS CHC (‘Continuing NHS Healthcare for Adults: Practice Guidance to support the National Framework for Implementation in Wales – Frequently Asked Questions, Welsh Government, November 2010’). This has since been superseded by new best practice guidance to accompany the 2014 National Framework; however, this version does not appear to include equivalent information. Nevertheless, the general principles will still be relevant.

If a family member will also be providing care

If a family member is to provide care as an integral part of the care plan, the LHB should consider meeting training needs that the carer may require to undertake this role.

In particular, they may need to arrange a risk assessment to ensure the carer is able to participate in the care allocated to them and what needs to be put in place to protect the individual and the carer. The Local Health Board should let the carer know of their right to ask the local authority for a **carer's assessment**. This may result in the provision of services to help support the carer in their caring role.

Although local authorities have a statutory obligation for carers, the LHB may also need to provide additional support to care for the individual during periods where the carer has a break from their caring responsibilities. They will need to assure carers of the availability of this support when required.

8.5 NHS CHC in a hospice

Hospice care may be appropriate if you are reaching the end of your life. However, the Welsh Government's Framework recognises that there will be circumstances in which you may wish to remain at home at this time.

8.6 Additional privately funded services

Sometimes people may want to use additional privately funded services as well as receiving NHS CHC services. This will need to be considered by the LHB and the 2014 National Framework advises that:

'Additional services' "are defined as those which are over and above those detailed in the care plan". "Such personal contribution arrangements must never be utilised as a mechanism for subsidising the service provision for which the Local Health Board is responsible. Any decision to purchase additional private services must be borne purely through personal choice and not through a lack of appropriate NHS or Local Authority provision...if the individual advises that they have concerns [about] the existing care package...the LHB should offer [a] review".

The Framework does recognise that there will be instances where an additional private service will be legitimate. As an example it states this could be where “someone who is assessed as requiring, and is provided with, one NHS physiotherapy session a week...wishes to purchase an additional session privately”. In such circumstances “the financial arrangements for the privately funded service will be entirely a matter between the individual and the relevant provider and it should not form part of any service agreement between the LHB and the provider”.

9 What happens if you wish to challenge a decision?

You can challenge a decision where you are dissatisfied with the LHB in regard to:

- **the procedure followed in reaching their NHS CHC eligibility decision;** or
- **the application of the criteria for eligibility** – i.e. the ‘primary health need’ test and whether this has been applied in a correct and consistent manner.

Note: If you are dissatisfied with issues other than the above – for example, issues such as the type, location or content of your care package – you should be told how to raise these using the NHS complaints procedure. This is explained in Age Cymru’s Factsheet 66w *Resolving problems and making a complaint about NHS care in Wales*.

You would also use the above route if you felt that you had been ‘screened out’ of the NHS CHC eligibility process too early – for example, if the Checklist Tool was applied and the results indicated that your needs were not sufficient to go through to a full CHC assessment, but you felt this was an unfair decision.

9.1 The Review process for challenging decisions

There are two stages in the review process, as outlined below – a **local review** stage and an **Independent Review Panel** stage.

You may also take your case to the *Public Services Ombudsman for Wales* if you remain unsatisfied, effectively adding a third stage to the process.

Local review stage

If you or your family approach the relevant LHB for a review of their decision, it will initially be dealt with via that LHB's 'local review process'. The LHB should deal promptly with any such request.

The local review process, including timescales, should be made publicly available by the LHB and sent to anyone who requests a review of a decision.

The local process should include 'peer review':

"Where the individual...disputes the clinical assessment of the MDT [multi-disciplinary team], external (from another Directorate or LHB) peer review should be offered as a matter of course. This may avoid escalation to the formal appeals or complaints procedure"³¹.

If the issue cannot be resolved at the local review stage, the National Framework instructs that your case "should be referred to the Independent Review Panel".

Note: If using the local review process would cause undue delay, the LHB has the discretion to put your case straight to the Independent Review Panel.

The Independent Review Panel stage

As with the LHB's local review process, the Independent Review Panel's remit does not cover aspects such as reviewing content of care plans, only the decision-making process relating to whether someone will be eligible for NHS CHC.

The National Framework advises that LHBs "must have access to a standing [Independent Review] panel, comprising as a minimum an independent chair, representative of a LHB and a local authority. It will also have access to expert opinion".

³¹ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

The Independent Review Panel (IRP) process should normally be completed within **four weeks** of the request to initiate the panel being received. This period begins “once any action to resolve the case informally [i.e. the local review stage] has been completed, and should be extended only where unavoidable because of exceptional circumstances”³².

The LHB can decide not to convene a panel, though 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”.

Prior to taking this type of decision “the LHB should seek the advice of the chairman of the review panel. In all cases where a decision not to convene a panel is made, the LHB should give the patient [or] family or carer a full written explanation of the basis of its decision”³³.

The IRP is required to make a recommendation to the LHB in light of its findings. Its role is advisory, but the LHB should accept its recommendations in all but exceptional circumstances. In all cases the outcome of the IRP review should be communicated to you in writing, together with the reasons for the conclusions which have been reached.

Public Services Ombudsman for Wales

If the original decision is upheld and you still wish to challenge it, you can contact the Public Services Ombudsman for Wales and ask if they will examine your case – see section 16 for contact details.

9.2 Funding your care once you challenge the LHB’s decision

Once the LHB tells you that you are not eligible, this decision remains in place unless or until the local review process or Independent Review Panel recommends that you should be eligible. You should receive appropriate care while awaiting the outcome of the review, but may have to contribute towards the cost of your care package during this time.

³² Ibid

³³ Ibid

Your circumstances when you ask for a review will affect who is responsible for arranging and/or paying for your care. The local authority and/or NHS may be involved or you may already be arranging and/or funding your own care.

The review procedure “**must not delay the provision of care and the local protocol should make clear how funding will be provided pending the resolution**”³⁴ (emphasis added).

10 NHS CHC eligibility – refunds for unreasonable delays

Note: This section has information in regard to possible reimbursement of care costs where there has been a delay regarding a current NHS CHC eligibility decision – if you are seeking reimbursement in regard to a retrospective claim, see section 14 instead.

Reimbursement for a delay in reaching an initial NHS CHC eligibility decision

The 2014 National Framework advises that the Local Health Board (LHB) has a legal responsibility to fund care from the point that it confirms the multi-disciplinary team’s advice is “consistent and fair” (see section 5.4 and 5.5 above).

“However, the principles of good public administration dictate that, if an individual has paid for their care in the interim, they should be reimbursed...such reimbursement would normally commence from the date on which the MDT [multi-disciplinary team] met and made its determination of eligibility. However the MDT should advise the [LHB] if they can, in their reasoned professional judgement, identify a date at which the primary health need became evident and the individual should be reimbursed accordingly”³⁵.

³⁴ Ibid

³⁵ Ibid

Note: The Framework doesn't address reimbursements for a delay in the MDT carrying out (or finishing) an assessment (rather, it focuses on the LHB being responsible for the delay once the MDT have reported to them). If you feel that you have paid an excess amount for care, due to a delay with assessments and the MDT reaching decisions, you could request that the LHB provides a reimbursement for costs you wouldn't otherwise have incurred (on a similar 'principle of good public administration' basis, as outlined above). Section 5.9 has information on how long the whole CHC process should take.

If you are unhappy with the way the LHB handles this request, you could use the NHS complaints procedure – see Age Cymru's Factsheet 66w *Resolving problems and making a complaint about NHS care in Wales* for further information.

Reimbursement of costs when challenging a decision?

The 2014 Framework does not appear to include guidance in regard to reimbursement where costs have been incurred by an individual during the local review or Independent Review Panel (IRP) stages of challenging a decision.

However, if you are in this situation, you could request that the LHB provides a reimbursement for costs you wouldn't otherwise have incurred, on the same basis as the 'Note' above.

11 Effect on state benefits of NHS CHC

Disability benefits

Notify the Department for Work and Pensions **Disability Service Centre** if you get a disability benefit and are due to receive NHS CHC funding – see section 16 for contact details. The main disability benefits are *Attendance Allowance (AA)*, *Disability Living Allowance (DLA)* or *Personal Independence Payment (PIP)*.

If you will receive NHS CHC in a **nursing home**, AA and both care *and* mobility elements of DLA and PIP are suspended after 28 days from the time the LHB funding begins, or sooner if you were recently in hospital.

If you will receive NHS CHC in a **residential home**, the care component of disability benefits is suspended after 28 days from the time LHB funding begins, *but* DLA or PIP mobility components continue.

If you will live at home with an NHS CHC care package, you can continue to receive these disability benefits. You can check that you are receiving them at the appropriate level.

State Pension and Pension Credit

State Pension is not affected by eligibility for NHS CHC.

If you receive Pension Credit, you will lose the severe disability element of your Pension Credit award when you are no longer entitled to AA, DLA (care component) or PIP (daily living component) and this is likely to affect the amount of Pension Credit you are eligible for.

12 Regular reviews of NHS CHC eligibility decisions

If you have been considered for NHS CHC and the NHS is providing or funding any part of your care package, the following reviews should be carried out:

- “As a minimum” there will need to be an initial review of the care plan within **three months** of the care package first being provided (“unless this is triggered earlier by the individual, their family/representative or the [care] provider”³⁶).
- Following this, a further case review should take place *annually*, as a minimum.

The multi-disciplinary team (MDT) making the original recommendation after a full determination of your eligibility for NHS CHC may have made a specific recommendation about the timing of your next review. More regular reviews than those outlined above may be necessary in certain circumstances – for example, where it is anticipated from the outset that someone’s condition is likely to deteriorate.

³⁶ Ibid

You, and where appropriate a family member or carer, must be fully involved in the review process. You should be informed about why the review is required, where it will take place, and which professional staff will be involved.

If you are receiving NHS CHC as a result of ‘fast tracking’ and it is appropriate to consider your longer term needs, your review should include completion of the Decision Support Tool (DST) by the MDT along with their subsequent recommendation on future eligibility – see sections 5.2 to 5.5.

12.1 What happens if your needs have changed

The review will determine whether your needs have changed and consequently whether your care plan needs to be revised. You may continue to be eligible for NHS CHC or, alternatively, if you are judged to no longer qualify, you may be eligible for other types of care instead (see section 13 below for further information).

However, it is important to note that any decision to remove eligibility should be undertaken **jointly** by the LHB and relevant local authority.

There should be a dispute resolution process in place for use when the LHB and local authority disagree about eligibility – where this happens **“current funding arrangements should remain in place until the dispute has been resolved”**³⁷ (emphasis added).

Note: The National Framework addresses the potential issue of a change in a progressive condition affecting NHS CHC eligibility. It states that:

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

³⁷ Ibid

13 Your care package if you are not eligible for NHS CHC

If you are found to not be eligible for NHS CHC, but “an alternative package of care is required (e.g. NHS funded nursing care in a care home, or a joint package of care in the community), the lead role will normally lie with the **local authority**, or, as agreed between agencies, in their local care management arrangements. The NHS will work **alongside** the local authority to develop and implement an appropriate care plan”³⁸ (emphasis added).

Needs identified during your multi-disciplinary assessment should inform the subsequent care plan. You will be **means-tested** for services that are the responsibility of the local authority social services department.

NHS services that may be provided in their own right, regularly or on an occasional basis, alongside care from social services include:

- Care provided in a nursing home by a registered nurse – **i.e. the weekly NHS-funded nursing care payment**, which is covered below in section 15.
- Rehabilitation and recovery services, such as speech therapy.
- Assessment and/or support from community-based NHS staff (known as ‘Community health services’), such as district nurses, continence nurses or specialist diabetic nurses.
- Palliative care services.

For more information about care assessments and charging procedures when care services are provided by a local authority, see Age Cymru’s other factsheets on these topics, including:

- Factsheet 41w *Social care assessments for older people with care needs in Wales*;
- Factsheet 46w *Paying for care and support at home in Wales*;
- Factsheet 10w *Paying for a permanent care home placement in Wales*.

³⁸ Ibid

14 Retrospective challenges to NHS CHC decisions

Note: Retrospective reviews are “different from an appeal against a current CHC assessment and decision on eligibility”³⁹ (for a current case, see section 9 of this factsheet for further information).

Since October 2014 there have been strict cut off dates for how far back a retrospective claim can be pursued – the current rules are outlined below.

A request for a retrospective review can be made when someone believes that they may have been wrongly charged for care, due to their potential eligibility for NHS CHC not being considered adequately at the time. For example, you may have reason to believe that you should have met the eligibility criteria because:

- The LHB carried out an assessment in the past, but there is evidence that the criteria were not applied appropriately; or
- it should have been reasonably apparent to the NHS at the time that you might be in need of CHC services, but the LHB failed to arrange and carry out an assessment.

14.1 Will your case qualify for a retrospective review?

Both the Welsh Government’s *2014 National Framework* and the *Practitioners’ Frequently Asked Questions* guidance, state that since October 2014 there has been an annual rolling cut off date for submitting a retrospective claim.

The rules are that the “**claim period to be considered will [have to] be no longer than 12 months back from the date of application for review**”⁴⁰.

³⁹ Ibid

⁴⁰ Continuing NHS Healthcare for Adults: The National Framework for Implementation in Wales – Practitioners’ Frequently Asked Questions, Welsh Government, February 2015

Note: The National Framework does make some provision in *exceptional circumstances* for a retrospective claim to be submitted where a cut off deadline has been missed. It advises that:

“Claims outside of the stated cut off dates may be considered in exceptional circumstances”. These “can include for example, the claimant suffering critical illness...or living abroad”.

14.2 Who can submit a claim?

In addition to the actual person concerned, who feels they missed out on CHC funding, the following people can make a retrospective claim:

- A person “authorised by the patient to receive reimbursement on his/her behalf”.
- Someone who holds “a registered Power of attorney or who is a Court-appointed receiver for a mentally incapacitated patient”.
- Where the care user is now deceased, “an executor named in the Grant of Probate in respect of the deceased’s estate or an administrator named in the Grant of Letters of Administration of the estate”⁴¹.

14.3 Who should you contact?

You should make your request for a retrospective review to the relevant LHB which covers the area where the care took place.

“Each LHB should publish a point of contact to which retrospective claims may be submitted”⁴².

NHS Direct Wales (see section 16 for contact details) can advise you of the correct LHB if you are unsure. Alternatively, you can obtain further information from their website (see the link above, in section 4.3 of this factsheet).

⁴¹ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

⁴² Ibid

14.4 Assistance with your claim

Is legal representation required?

You do **not** have to use a solicitor. You can go through the process yourself and this will be free of charge (the LHB should also provide appropriate information to assist you to navigate through the process).

The process for making a claim can be complicated, so some people choose to appoint a solicitor to assist them. If you do use a solicitor it will be important to find one who is experienced in this particular type of work.

You should discuss their fees with them first before you ask them to take on your case.

The National Framework advises that: “if eligibility is found [in a retrospective case], reimbursement will not cover the costs of any legal fees incurred”.

You may also wish to bear in mind that there may be an independent advice and/or advocacy service in your area who could offer free assistance – see below.

Important: You may hear about ‘claims management companies’ who offer a service to reclaim care fees that potentially should have been met via NHS CHC. You should be aware that although these companies may be offering a ‘no-win-no-fee’ deal, it is likely that they will charge a ‘success’ fee which will be a certain percentage of any sum recovered (and possibly a substantial percentage).

Are there other organisations who can help you through the process?

A local advice organisation, such as your local Age Cymru, or a Citizens Advice Bureau may be able to offer you assistance. Contact **Age Cymru Advice** for information on whether there are any independent advocacy services in your area.

Your local Community Health Council (CHC) may also have some experience in this area and be able to offer you advice. CHCs are a statutory and independent voice in health services in Wales. They should work to enhance and improve the quality of local health services. Each CHC runs a Complaints Advocacy Service.

See section 16 for contact details for all the organisations listed above.

14.5 How is the claim processed?

- The LHB will need you to supply proof of care fees that have been paid during the period in question (if you're applying on behalf of someone else, the LHB will need to see documentation to show that you have the relevant legal authority to pursue the claim – see section 14.2 above)
- You will be sent a questionnaire by the LHB. In this document you will outline your case for why you believe you should have qualified for NHS CHC.
- When they receive the completed questionnaire, the LHB will make requests to the relevant care providers for records of your care. The LHB will produce a “chronology of need” from the records⁴³.
- An “All Wales Needs Assessment Document...will be used by [an LHB] reviewer to analyse the information in the chronology using the 4 key indicators of Nature, Intensity, Complexity and Unpredictability [see section 4 of this factsheet] and by applying the Primary Health Need approach for the whole of the claim period. The ‘All Wales Needs Assessment Document’ can be found at: www.cciss.org.uk/retrospective-reviews.
- Once completed, the above document will be peer reviewed by a different clinician – or in cases where no eligibility is found, by 2 different clinicians – to ensure the recommendation is correctly supported by the evidence and that criteria have been applied consistently. If there is disagreement between the clinicians, the case will be passed to an Independent Review Panel (IRP)⁴⁴.
- The eligibility recommendation will be either of the four options below:

⁴³ Ibid

⁴⁴ Independent Review Panels are discussed further in section 9.

Matching	In these cases, “the period of eligibility found matches the claim period in totality”. As such, this type of case will proceed towards full reimbursement of fees for the relevant period.
Partial	This is where “eligibility is found for part of the claim period”. This will result in a ‘negotiation meeting’ between the LHB and the claimant (or their representative). The aim of the meeting will be “to reach a mutually acceptable period of eligibility based on the evidence available”. If agreement is reached at this stage, the case will move on to reimbursement for the relevant period. If agreement cannot be reached, the case will be sent to the IRP for further consideration and a final decision.
No eligibility	This is where review indicates that there is no eligibility for any part of the claim period. However, the claimant (or their representative) will still be invited to a further meeting to provide an “opportunity for further explanation of CHC criteria and to check that the claimant/representative has understood the lack of evidence on eligibility”.
Panel case	This will occur where the reviewer “has been unable to make a decision as the information available is [too] complex”. An IRP will be convened in these circumstances to further examine the case and reach a decision. You will be invited to attend and participate fully in the panel meeting.

- At the end of the process, an “All Wales Decision Document” will be completed to confirm the final decision. A copy will be provided to the “claimant/representative and the LHB Finance Department”⁴⁵.

14.6 What will happen if your claim is successful?

The 2014 National Framework is quite brief on this matter, but states that:

⁴⁵ Continuing NHS Healthcare: The National Framework for Implementation in Wales, Welsh Government, June 2014

“If eligibility is demonstrated for either the full or part period of the [retrospective] claim, the principles of good public administration demand that timely restitution be made”.

You will receive reimbursement of the care fees paid, during the period identified in the retrospective review as when you should have been eligible for NHS CHC funding. You won't receive any compensation – it is just reimbursement of care fees which were paid.

14.7 If you are dissatisfied with how your claim is treated

If you are dissatisfied with the way your retrospective NHS CHC claim has been handled, you can make a complaint using the NHS complaints procedure. This is explained in Age Cymru's Factsheet 66w *Resolving problems and making a complaint about NHS care in Wales*.

If you remain unhappy with the outcome of the complaints procedure, you could choose to escalate your case to Public Services Ombudsman for Wales – see section 16 for contact details.

15 Weekly NHS-funded nursing care for people resident in a nursing home

Important: If you may be eligible for fully funded NHS CHC, this possibility needs to be considered first. Eligibility for the weekly NHS-funded nursing care should only be considered instead, *once it has been agreed that you are **not** eligible for NHS CHC*.

15.1 NHS-funded nursing care – overview

The NHS is responsible for meeting the registered nursing costs of all residents in care homes that provide nursing care (nursing homes).

This is known as the NHS funded nursing care contribution and you should receive it if you are not eligible for fully funded NHS CHC, but have still been assessed as requiring certain services from a registered nurse in providing, planning or supervising elements of your care.

Note: Residential homes do not employ registered nurses because their residents receive nursing and other health related care from NHS staff based in the community. Consequently these homes do not receive an NHS-funded nursing care contribution from their LHB.

What services do registered nurses provide?

Services provided on a regular basis by a registered nurse are likely to involve:

- provision of nursing care;
- supervision or monitoring of care provided by a non-registered nurse;
- planning and reviewing a care plan;
- monitoring and reviewing medication needs; and/or
- identifying and addressing potential health problems.

How will the rest of the nursing home fees be covered?

The NHS-funded nursing care contribution is only for the registered nursing part of someone's care. It does not include time spent by any other staff who are involved in your personal care and, as such, the NHS funded nursing care contribution will only meet a relatively small part of the overall care home fees.

All other aspects of the care package will be paid for by the person themselves, if self funding, or alongside funding assistance from their local authority social services department, should the authority's financial means test indicate that the person doesn't have sufficient resources to fully self fund (see Age Cymru's Factsheet 10w *Paying for a permanent care home placement in Wales* for further information).

You may need to ask for clarification regarding the NHS funded nursing care contribution if it isn't clearly separated from the main fee in the information provided to you about the fee and how it has been worked out.

15.2 How much is the NHS-funded nursing care payment?

The NHS funded nursing care contribution is currently **£149.67 per week** towards the nursing home fees. The figure is the same for the whole of Wales (it may change again from April 2019, however. If you are reading this factsheet after that date, you may wish to consult Age Cymru's Factsheet 10w *Paying for a permanent care home placement in Wales*, which should have the amended figure).

The NHS does not make these payments to you. Instead, it makes them either:

- directly to the nursing home; or
- to the local authority, if the contract for providing your care and accommodation is between the local authority and the nursing home.

15.3 How is eligibility for NHS-funded nursing care decided?

As noted at the beginning of this section, it is not appropriate to consider your need for NHS-funded nursing care in a nursing home until it has first been agreed that you are not eligible for NHS CHC and that a place in a nursing home is the best option for meeting your needs.

If you are found not eligible for NHS CHC following a full assessment, your need for registered nursing care should be recorded on the Decision Support Tool (DST) by the multi-disciplinary team (MDT). This information should then be used to draw up your care plan.

15.4 Regular reviews of NHS-funded nursing care needs

A case review should be undertaken no later than **three months** after the initial eligibility decision.

This is to reassess your care needs, ensure they are being met and confirm that a nursing home place is still appropriate.

Following this three month review, reviews should take place at least **annually**. It may be clinically appropriate to have more frequent reviews and a review should be arranged if your healthcare needs change significantly.

Note: The LHB “must ensure that the individual, their family/representative and care home provider have the information and contacts available to enable them to identify changes in need which indicate a timely review is required. Care home providers may find it helpful to use the Department of Health Checklist [Tool] themselves and alert the LHB when an assessment for CHC eligibility is required”⁴⁶ – see section 5.1 above for information on the Checklist Tool.

As part of each review, your potential eligibility for NHS CHC should always be considered.

If you self fund your place in a nursing home, you need to ensure you have the three month and annual reviews. The care home manager should be aware of the LHB arrangements for nursing care reviews.

15.5 Hospital stays when you are receiving the weekly NHS-funded nursing care contribution

If you are admitted to hospital, the Local Health Board (LHB) does not pay nursing care costs to the care home during your hospital stay.

However, you can ask the LHB to pay a retainer to help safeguard your care home place during your hospital stay. Welsh Government guidance advises that:

A payment equivalent to the NHS funded nursing care rate should “be made by the NHS to the care home to retain a resident’s bed for a period (normally up to six weeks, but this may be varied to co-ordinate with local authority contractual arrangements where appropriate) during periods of hospital admission. The Local Health Board and/or the local authority, where appropriate, will make arrangements with the home manager for the latter to inform them when such admissions occur, and when the resident returns to the home. There must be mutual agreement between the local authority and the Local Health Board, in consultation with the resident and/or an appropriate representative, before the decision is made that a placement need no longer be retained, and funding withdrawn.

⁴⁶ Ibid

The effect of this on delaying the resident's discharge from hospital must be taken into account. Any changes in needs following hospitalisation will be taken into account in determining any potential change in care home requirements"⁴⁷.

15.6 Which Local Health Board (LHB) has responsibility for your NHS-funded nursing care contribution?

The LHB which covers the area where your nursing home is located will have responsibility for the NHS-funded nursing care contribution.

If you move to a nursing home in a *different* LHB area, you will become the responsibility of that LHB when you register with a GP there.

16 Useful organisations

Age Cymru Advice

Free and confidential information and advice on matters affecting the over 50s in Wales.

Tel: 08000 223 444

E-mail: advice@agecymru.org.uk

Age Cymru organisations (local)

Your local Age Cymru may be able to provide advice and support on issues around NHS CHC. **Age Cymru Advice** can provide details of your local Age Cymru (see above), or visit the Age Cymru website at:

www.agecymru.org.uk

⁴⁷ Welsh Health circular and National Assembly for Wales circular (NAFWC 25/2004 / WHC (2004)024): NHS Funded Nursing Care in care homes Guidance, April 2004 (Note: The 2014 National Framework advises that "the NHS Funded Nursing Care in Care Homes Guidance 2004 remains in effect, though will be subject to review".

Citizens Advice Bureaus (CABs)

National network of free advice centres offering confidential and independent advice, face to face or by telephone.

Tel: 03444 77 20 20

Details of your nearest CAB can be found at: www.citizensadvice.org.uk

Community Health Councils (CHCs)

CHCs are a statutory and independent voice in health services in Wales. They work to enhance and improve the quality of local health services. For information on the CHC covering your area, see the NHS Direct Wales website at:

www.nhsdirect.wales.nhs.uk/localservices/communityhealthcouncils

Disability Service Centre

Website: www.gov.uk/disability-benefits-helpline

Healthcare Inspectorate Wales (HIW)

The HIW is the independent inspector and regulator of NHS healthcare and independent healthcare organisations in Wales.

Tel: 0300 062 8163

E-mail: hiw@gov.wales

Website: www.hiw.org.uk

NHS Direct Wales

NHS Direct Wales can provide contact details for local services and telephone or web advice on health issues and common illnesses.

Tel: 0845 46 47

Website: www.nhsdirect.wales.nhs.uk

Older People's Commissioner for Wales

Independent champion for older people across Wales.

Tel: 03442 640670

E-mail: ask@olderpeoplewales.com

Website: www.olderpeoplewales.com

Public Services Ombudsman for Wales

The Ombudsman looks to see whether people have been treated unfairly or have received a bad service from a public body, such as the NHS or local authority social services department.

Tel: 0300 790 0203

Website: www.ombudsman-wales.org.uk

Welsh Government

The devolved government for Wales.

Tel: 0300 060 4400

E-mail: customerhelp@gov.wales

Website: www.wales.gov.uk

17 Further information about Age Cymru

Age Cymru is the leading charity for all older people in Wales. We campaign, we research and we fundraise to make sure we build a better life for all older people. We ensure older people's voices are heard, we challenge and change attitudes, we fight discrimination wherever we find it and we tackle elder abuse in all its forms. Together with our local Age Cymru partners we provide vital services in communities across Wales.

The Age UK family

Along with Age UK, Age Scotland and Age NI, Age Cymru is a member of the Age UK family.

Age UK (Age UK Advice: 0800 169 65 65; website: www.ageuk.org.uk)

Age NI (Age NI Advice: 0808 808 7575; website: www.ageni.org)

Age Scotland (Tel: 0845 833 0200; website: www.agescotland.org.uk)

Our information materials

Age Cymru and Age UK publish a large number of free Information Guides and Factsheets on a range of subjects, including money and benefits, health, social care and housing.

Some resources, such as this factsheet, are produced 'in-house' by Age Cymru, whilst others are branded Age UK and – depending on the subject matter – contain either information which is applicable in England and Wales, or for the whole of the UK.

Contact details

Age Cymru Advice

Tel: 08000 223 444

E-mail: advice@agecymru.org.uk

Website: www.agecymru.org.uk



www.facebook.com/agecymru



www.twitter.com/agecymru



www.youtube.com/agecymru

Contact us if you would like:

- To order copies of any factsheets or information guides.
- Further advice if you cannot find the information you need in this factsheet.
- Details of your nearest local Age Cymru organisation.

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Cardiff
CF24 5TD

Can you help Age Cymru?

Please complete this donation form with a gift of whatever you can afford and return to: Age Cymru, FREEPOST RLTL-KJTR-BYTT, 13/14 Neptune Court, Vanguard Way, Cardiff CF24 5PJ. Alternatively, you can phone 029 2043 1555 Monday to Friday 9am – 5pm or visit www.agecymru.org.uk/donate. Thank you.

Personal details

Title:	Initials:	Surname:
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Address:
Postcode:

Tel:	Email:
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By providing your email address and/or mobile number you are agreeing to us contacting you in these ways. You may contact us at any time to unsubscribe from our communications.

Your gift

I would like to make a gift of: £

I enclose a cheque/postal order made payable to Age Cymru

Card payment

I wish to pay by (please tick) MasterCard Visa CAF CharityCard

Maestro American Express

(Maestro only)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Signature X
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Expiry date / Issue no. (Maestro only)

Gift aid declaration

(please tick) Yes, I want Age Cymru to treat all donations I have made for the four years prior to this year, and all donations I make from the date of this declaration until I notify you otherwise, as Gift Aid donations. I confirm I pay an amount of income tax/capital gains tax to cover the amount that all charities and Community Amateur Sports Clubs will reclaim on my donations in the tax year. Date: ___/___/___
I understand that other taxes such as VAT and Council Tax do not qualify.



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