Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Quality, Safety and Experience Committee

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| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 26 April 2024 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Operational Policy for Long Term Care (LTC) |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Jill Paterson, Director of Primary and Long-Term Care |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Julia McCarthy, Head of Long Term Care<br>Tracy Devantier, Performance and Improvement Manager |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

This paper is for information purpose. The Long Term Care (LTC) team work within/take guidance from the National Framework for NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC). It includes Practice Guidance to support staff delivering NHS Continuing Healthcare. The updated LTC operational policy has been amended to include any new changes in the revised National Framework in July 2022

## Cefndir / Background

The Welsh Assembly Government had produced a 2021(revised July 2022) Framework for Continuing NHS Healthcare (CHC). It sets out the Welsh Assembly Government's policy for eligibility for CHC and the Responsibilities of NHS organisations and local authorities under the framework and related matters. Hywel Dda University Health Board's (HDdUHB) LTC Operational Policy is based on this National Framework.

The revised National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care and the approach to be taken by practitioners to the assessment and decision making process and indicates the governance arrangements surrounding the application and process.

The updated Operational policy reflects updated guidance and new processes to be followed.

The effective date for the Framework was 1st April 2022. From that date Hywel Dda University Health Board was required to follow the Framework. The Framework has been approved by all Wales Health Boards.

Hywel Dda University Health Board (HDUHB) has worked with partner organisations to develop this operational policy for Hywel Dda residents. In doing so, the National Framework for Continuing Healthcare (CHC) issued by Welsh Assembly Government has been very closely followed, to ensure consistency of approach across Wales.

## Asesiad / Assessment

The HDdUHB is responsible for:

Ensuring consistency in the application of the Continuing NHS Healthcare National Framework; promoting awareness of CHC.

Implementing and maintaining good practice, ensuring quality standards are met and sustained, delivering joint, consistent training and development opportunities for all relevant health and social care practitioners

Identifying and acting on issues arising in the provision of CHC.

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

Ensuring best practice in assessment and record keeping

The provision of strategic leadership and organisational and workforce development, and ensuring systems operate effectively and deliver improved performance.

HDdUHB is responsible for ensuring access to assessment, decision-making and provision should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, or type of health need (for example whether the need is physical, mental or psychological). LHBs are responsible for ensuring that discrimination does not occur and should use effective monitoring to monitor this issue.

When an individual has been assessed as having a primary health need, and is therefore eligible for CHC, the HDdUHB has responsibility for funding the full package of health and social care. Where the individual is living at home, this does not include the cost of accommodation, food or general household support. HDdUHB will contract with other organisations and, in particular, the independent sector, and will be responsible for ensuring that the quality and range of services are sufficient to meet the individual's

Regular reviews will be arranged to ensure those services remain fit for purpose.

## Argymhelliad / Recommendation

- For Approval

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| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
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| Committee ToR Reference:<br>Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 3.6 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans. |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | |
| Parthau Ansawdd:<br>Domains of Quality<br><br>**(see Appendix 2 for more guidance)**<br><br>Quality and Engagement Act (sharepoint.com) | 7. All apply |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br><br>**(see Appendix 2 for more guidance)**<br><br>Quality and Engagement Act (sharepoint.com) | 6. All Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Amcanion Cynllunio<br>Planning Objectives | 7a Population Health |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 8. Transform our communities through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
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| Ar sail tystiolaeth:<br>Evidence Base: | |

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| Rhestr Termau:<br>Glossary of Terms: | |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ceisiadau Gofal Sylfaenol:<br>Parties / Committees consulted prior to Committee: | |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Not Applicable (NA) |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Equality Impact Assessment Completed |
| **Gweithlu:<br>Workforce:** | NA |
| **Risg:<br>Risk:** | NA |
| **Cyfreithiol:<br>Legal:** | NA |
| **Enw Da:<br>Reputational:** | NA |
| **Gyfrinachedd:<br>Privacy:** | NA |
| **Cydraddoldeb:<br>Equality:** | EQIA completed |

**Appendix 2** – Diagram to illustrate the six domains of quality supported by the five quality enablers.


The Board has collective responsibility for ensuring the duty of quality is delivered and they must demonstrate this in their actions and behaviours. They must demonstrate their long-term commitment to improving quality when setting the strategic direction and seeking assurance of delivery.

The Board needs to ensure they adhere to the duty of quality in their decision-making and seek assurance with regard to decisions made by others.

For further information refer to:

Health and Care Quality Standards - NHS Wales Executive

# CONTINUING NHS HEALTHCARE OPERATIONAL POLICY FOR LONG TERM CARE

## Policy information

Policy number: 309

Classification: Corporate

Supersedes: Operational policy 1.3v

Local Safety Standard for Invasive Procedures (LOCSSIP) reference: NA
National Safety Standards for Invasive Procedures (NatSSIPs) standards: NA

Date of Equality Impact Assessment: 21/12/2023

## Approval information

Approved by: QSEC
Date of approval: Click or tap to enter a date.
Date made active: Click or tap to enter a date.
Review date:

Summary of document:
The Welsh Assembly Government has produced a 2021 Framework (referred to throughout this document as the "Framework") for Continuing NHS Healthcare (CHC). It sets out the Welsh Assembly Government's policy for eligibility for CHC and the Responsibilities of NHS organisations and local authorities under the framework and related matters.

Hywel Dda University Health Board's (HDdUHB) Operational Policy is based on this National Framework.

The policy outlines the approach to be taken by practitioners to the assessment and decision making process and indicates the governance arrangements surrounding the application and process.

Scope:
This Policy applies to all HDdUHB staff in Long Term care and Independent stakeholders, contractors, other third parties working in UHB and those who work in partnership with HDdUHB. All Managers working clinical and non-clinical, as well as corporate services in the HDdUHB

To be read in conjunction with:
Welsh Government: Continuing NHS Healthcare Framework 2021

Sustainable Care Planning in Continuing NHS Healthcare Feb 2011
NHS Funded Nursing Care in Care Homes 2004
Responsible Body Guidance Wales
Social Services and Well Being (Wales) Act 2014

Patient information:
Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers (gov.wales)

Owning group:
QSEAC

Executive Director job title:
Director of Primary care, Community and Long Term Care

Reviews and updates:
Version 1 – November 2012
Version 2 – 3 August 2018 (archived)
Version 3 -

Keywords
CHC / Continuing Health Care/ NHS Funded Care / Decision Support Tool / DST / Care Planning.

Glossary of terms

| Term | Definition |
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| All Wales Retrospective CHC Review Document | There are different arrangements concerning the administration of ongoing or contemporary CHC cases and those of backdated, or retrospective ones. The DST is used in contemporaneous assessments and provides a picture of the needs at one point in time. A retrospective review covers a long period of time, and it is necessary to identify changes in need over that period that may indicate eligibility /no eligibility at different times based on identified need. The All Wales Retrospective CHC Review document (formerly the All Wales Needs Assessment document) is based on the DST but facilitates the identification of needs over an extended period of time which may be divided into a number of periods depending on the length of the whole claim period |
| Assessment | The process whereby the needs of an individual are identified and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned. Assessment involves both professionals and those with the needs thinking through different explanations for how needs have arisen, and how different needs interact with each other. Further information on assessment is contained in the guidance 'Social Services and Well Being (Wales) Act 2014' |

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| Behaviours that challenge | Behaviours that challenge are defined as "culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities. |
| Care Co Ordinator | An identified NHS clinical professional or social care professional that takes the lead in ensuring that an individual's package of care is properly managed and monitored. In addition the care co-ordinator ensures that the individual is kept informed of the process and involved in discussions about their care |
| Care Home | An establishment registered under the Regulations and Inspections of Social Care Act 2016 to provide accommodation, together with nursing or personal care. |
| Care Management | A process whereby an individual's needs are identified and evaluated, eligibility for services is determined, Personal Plans of Care are drafted and implemented, and needs are monitored and reassessed. ("Case management" is an alternative term.) |
| Care Package | A combination of support and services designed to meet individual's assessed needs |
| Care Plan | A document recording the reason why support and services are being provided, what they are, who provides them and what outcomes they seek |
| Care Planning and Review | Care Planning and Review is a dynamic process, bringing together the individual, their carers and professionals to agree how their needs can best be met, the actions needed and who will do them. |
| Care and Support Package | A combination of support and services designed to meet individual's assessed health and social care needs, as detailed in the Care and Support Plan. |
| Care and Support Plan | A Care Plan must contain:  plans and actions to be undertaken to help achieve the desired outcomes;<br>• The roles and responsibilities of the individual, carers and family members and practitioners (including for example GP, Nurse), and the frequency of contact with those;<br>• The resources (including financial resources) required from each party; and<br>• The review and contingency arrangements and how progress will be measured. |
| Carers | The Social Services and Well-being (Wales) Act 2014 defines a carer as a person who provides or intends to provide care for an adult or disabled child. The definition excludes those who |

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| | provide or intend to provide care under, or by virtue of, a contract or as voluntary work. |
| Care Worker | Care workers provide paid support to help people manage the day-to-day activities of living. Support may be of a practical, social care nature or to meet a person's healthcare needs. |
| Cognition | The higher mental processes of the brain and the mind including memory, thinking, judgement, calculation, visual spatial skills etc. |
| Cognitive impairment | Cognitive impairment applies to disturbances of any of the higher mental processes, many of which can be measured by suitable psychological tests. Cognitive impairment, especially memory impairment, is the hallmark and often the earliest feature of dement |
| Commissioning | Commissioning involves a set of activities by which local health boards and local authorities ensure that services are planned and organised to best meet the health and social care outcomes of people in Wales. It involves understanding the need of their populations, best practice and local resources and using these to plan, implement and review changes in services. It encompasses both planning and procurement.<br><br>Commissioning requires a whole systems perspective and applies to services across all sectors. Commissioning services to respond to the needs of people with continuing health care should not be undertaken in isolation to commissioning other closely related services.<br><br>Local health boards can delegate the function of commissioning to local authorities and local authorities can delegate the function of commissioning to local health boards whilst still retaining their statutory responsibilities. This facilitates the development of a coherent approach to commissioning services such as, for example, residential and nursing home care or re-ablement and intermediate care services with one approach to developing contracts, service specifications, fee settings and quality assurance |
| Continuing NHS Healthcare (CHC) | A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need. Continuing NHS healthcare can be provided in any setting. In a person's own home, it means that the NHS funds all the care that is required to meet their assessed health and social care needs to the extent that this is considered appropriate as part of the health service. This does not include the cost of accommodation, food or general household support. In care homes, it means that the NHS also |

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| | makes a contract with the care home and pays the full fees for the person's accommodation as well as their care |
| Decision Support Tool (DST) | The Decision Support Tool (DST) is designed to support the decision-making process. The tool must only be used following a comprehensive assessment of an individual's care needs. It is not an assessment in itself and it does not replace professional judgement in determining eligibility. It is simply a means of recording the rationale and facilitating logical and consistent decision-making.<br><br>The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. It provides practitioners with a method of bringing together and recording the various needs in 12 'care domains' (see below), or generic areas of need. Each domain is broken down into a number of levels of severity. |
| Domain | One of 12 key areas of consideration within the integrated assessment and the Decision Support Tool. These are breathing, nutrition, continence skin integrity, mobility, communication, psychological & emotional needs, cognition, behaviour, drug therapies and medication, altered states of consciousness and other significant care needs. |
| End-of-Life Care | Care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes the management of pain and other symptoms, and the provision of psychological, social, spiritual and practical support. |
| General Household Support | Such services as cleaning, laundry, meal preparation, shopping, cooking, collecting benefits, sitting with or accompanying on social outings |
| IRP | Independent Review Panel |
| Lead Professional/Care Co-ordinator | This is the person who:<br>• Co-ordinates the assessment process, and draws in additional specialists as required;<br>• Acts as a focus for communication for different professionals and the individual to make sure that information is recorded correctly; and,<br>• Ensures that any problems or difficulties in the co-ordination or completion of an assessment are resolved. For people with mental health needs the Mental Health |

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| | Measure makes specific requirements regarding who the Care Co-ordinator should be. |
| LA | Local Authority |
| LHB | Local Health Board |
| Long-term Care | This is a general term that describes the care which people need over an extended period of time, as the result of disability, accident or illness in order to address both physical and mental health needs. It may require services from the NHS and/or social care, and can be provided in a range of settings, such as a NHS hospital, a care home (providing either residential or nursing care), hospice, and in people's own homes. Long-term care is distinct from intermediate/transitional/interim care which has specific time limited outcomes for rehabilitation, reablement or recuperation. |
| LTCSpN | Long Term Care Specialist Nurse |
| Mental Capacity | The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is explained in Section 2 of the Mental Capacity Act 2005: ' a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain'. |
| Mental Disorder | Mental disorder is defined in Section 1(2) of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) as meaning 'any disorder or disability of the mind'. |
| Multi-disciplinary or Multi-agency | These terms refer to professionals across health and social care and the third sector who work together to address the holistic needs of their patients/clients in order to improve delivery of care and reduce fragmentation. |
| NHS | National Health Service |
| NHS Funded Nursing Care (FNC) | The provision of NHS Funded Nursing Care derives from Section 49 of the Health and Social Care Act, 2001 (now replaced, in relation to Wales, by Section 47(4) and (5) of the Social Services and Well-being (Wales) Act 2014), which excludes nursing care by a registered nurse from the services which can be provided by local authorities. NHS Funded Nursing Care applies to all those persons currently assessed as requiring care by a registered nurse in care homes. The decision on eligibility for NHS Funded Nursing Care should only be taken |

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| | when it is considered that the person does not fall within the eligibility criteria for CHC. |
| Nursing Needs Assessment | An assessment undertaken by a registered nurse to determine the type of care required and appropriate setting to meet the needs |
| Palliative Care | The active holistic care of patients with advanced, progressive illness. This includes the management of pain and other symptoms and provision of psychological, social, spiritual and practical support. The goal of palliative care is the achievement of the best quality of life for patients and their families. |
| Power of Attorney | An applicant with an Enduring or Lasting Power of Attorney registered with the Court of Protection may, in general, exercise the patient's rights of access to records on behalf of that patient, but only to the extent that the information is necessary for them to be able to carry out their duties as an attorney or deputy. There is an important distinction between:<br><br>a) Someone acting as Lasting Power of Attorney (health and welfare) who will generally be able to exercise the patient's rights of access to health and social care records in order to make informed decisions about their health and welfare. This includes being able to consent (or refuse consent) to the NHS CHC process and to sharing information with relevant professionals involved in the process. The Power of Attorney (POA) has to be registered and this type of POA can only be used if the individual has lost the capacity to make the relevant decision about their health and welfare.<br><br>b) Someone with Enduring Power of Attorney (EPA) or someone acting as Lasting Power of Attorney (property and finance). Again the EPA or LPA has to be registered but can be used with the donor's permission to help them make decisions about property and finance even if they still have capacity to make such decisions themselves. More usually, the POA (property and finance) or EPA is used once the individual has lost capacity. Because CHC can have a significant impact on an individual's finances someone with this type of LPA or an EPA may well have legitimate reason for having access to health and social care records but only in so far as these are necessary for them to make a particular decision at a particular time regarding property and finance. An obvious example would be for them to have sufficient information to decide whether or not they agree with the eligibility decision made and whether or not to seek a review of that decision. Any health or welfare records which are not directly relevant should not be shared as they may contain sensitive information which the individual would not have wanted shared with the person to whom they gave the right to manage |

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| | their financial affairs. Generally speaking the information that they are likely to need should be contained within the Decision Support Tool and the assessments which underlie it. |
| Primary Health Need | An individual is deemed to be eligible for CHC when their primary need is a health need: ‘’the primary health need approach’. This is determined by consideration of the four key characteristics of need: nature, intensity, complexity and unpredictability |
| Registered Nurse | A nurse registered with the Nursing and Midwifery Council. Within the UK all nurses, midwives and specialist community public health nurses must be registered with the Nursing and Midwifery Council and renew their registration every three years to be able to practise. |
| Rehabilitation | A programme of therapy and reablement designed to maximise independence and minimise the effects of disability |
| Social Care | Social care is care provided to support an individual’s social needs. It refers to the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships. Social care services are provided for people who need help/assistance to live their lives as independently as possible in the community (either at home or in a care setting), people who are vulnerable and people who may need protection. Local authorities, the voluntary sector and the independent sector can provide social care. This definition should be viewed in the context of the policy of the Welsh Government to move to a more integrated approach. The Social Services and Well-being (Wales) Act 2014 emphasises the duty of local authorities and local health boards to work together to develop integrated primary, community and wellbeing services that are focussed on the holistic needs of people. |
| Social services and Wellbeing (Wales) Act 2014 | The Social Services and Well-being (Wales) Act (SSWBA) came into force on 6 April 2016.<br><br>The SSWBA 2014 provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales. It transforms the way social services are delivered, promoting people’s independence to give them stronger voice and control.<br><br>The fundamental principles of the SSWBA 2014 are:<br><br>Voice and control – putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being. |

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| | • Prevention and early intervention – increasing preventative services within the community to minimise the escalation of critical need.<br>• Well-being – supporting people to achieve their own well-being and measuring the success of care and support. Co-production – encouraging individuals to become more involved in the design and delivery of services |
| Social Work | Social work is a professional activity/service provided by a Registered Social Worker. It is an activity that can enable individuals, families and groups to identify personal, social and environmental difficulties adversely affecting them. It is a range of activities that can provide supportive, rehabilitative protective or corrective action. This can include care management, social care assessment and planning and counselling |
| Sustainable Care Planning Policy | This is a policy which has been developed and adopted by all local health boards in Wales for use when considering care planning options appropriate to meet the assessed need for people eligible for CHC. It describes the approach to fair and sustainable care planning within CHC and to the management of a fair allocation of resources within the wider context of care planning considerations. |
| WNCR | Welsh Nursing Care Records |

**Key points:**

For individuals who are eligible to receive it, CHC is an entitlement. It is essential to aim for a decision on eligibility to be right first time. Incorrectly denying someone eligible for CHC access to their entitlement can potentially have a negative impact on the individual's health and incur significant financial costs, leading to distress for them and their families. It may also result in retrospective claims which can be expensive and time consuming.

The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need. The Framework sets out the process for the NHS, working with LA partners, to assess an individual's health needs and to ensure that the appropriate care is provided to meet those needs.

Individuals may require services from both the NHS and their LA. The NHS is responsible for assessing, funding and providing health services to meet the needs of its population. LAs are responsible for the provision of social services and there may be a charge to the individual for some of these.

There must be a clear and transparent rationale to support the decision-making process. Professional integrity is vital.

Individuals and/or their representatives must be fully involved and informed throughout the assessment process, in the language or format of their choice.

The services provided in response to assessed need must be proportionate to need and effectively co-ordinated, in order to avoid unnecessary disruption to the individual and their family

# Contents

# Introduction

The Welsh Assembly Government has produced a 2021 Framework (referred to throughout this document as the "Framework") for Continuing NHS Healthcare (CHC). It sets out the Welsh Assembly Government's policy for eligibility for CHC and the Responsibilities of NHS organisations and local authorities under the framework and related matters.

Framework - Continuing NHS Health Care (gov.wales) (opens in a new tab)

Hywel Dda University Health Board's Operational Policy is based on this National Framework.

The policy outlines the approach to be taken by practitioners to the assessment and decision making process and indicates the governance arrangements surrounding the application and process.

The effective date for the Framework is 1st April 2022. From that date Hywel Dda University Health Board was required to follow the Framework. The Framework has been approved by all Wales Health Boards.

Hywel Dda University Health Board (HDUHB) has worked with partner organisations to develop this operational policy for Hywel Dda residents. In doing so, the National Framework for Continuing Healthcare issued by Welsh Assembly Government has been very closely followed, to ensure consistency of approach across Wales.

The policy outlines the approach to be taken by practitioners to the assessment and decision making process and indicates the governance arrangements surrounding the application process.

CHC is a complete package of ongoing care arranged and funded solely by the NHS through local health boards (LHBs), where an individual's primary need has been assessed as health based.

CHC is one element of a range of services that local authorities (LAs) and NHS bodies need to have in place to support people with health and social care needs. CHC is one aspect of care which people with complex needs may need as the result of disability, accident or illness to address both physical and mental health needs. Given the nature, intensity, complexity and unpredictability of those needs, these services account for a significant proportion of NHS healthcare overall.

CHC can be provided in any setting outside hospital, such as in a person's own home, in a care home, hospice or in a prison and is part of the continuum of care and support that an individual with complex needs may move in and out of.

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

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

## Policy statement

It is the policy of HDdUHB that all staff involved with decision around assessment and eligibility for Long Term Care are aware of the procedure to follow and are also aware of the legal and professional guidance and requirements of the WG Continuing NHS Healthcare Framework 2021.

## Scope

HDdUHB is responsible for establishing and maintaining governance arrangements for consideration of CHC eligibility and purchasing and securing care in response to the assessed needs of an individual.

The HDdUHB is responsible for:

- Ensuring consistency in the application of the Continuing NHS Healthcare National Framework; promoting awareness of CHC
- Implementing and maintaining good practice, ensuring quality standards are met and sustained, delivering joint, consistent training and development opportunities for all relevant health and social care practitioners
- Identifying and acting on issues arising in the provision of CHC.
- Informing commissioning arrangements, both on a strategic and individual basis.
- Ensuring best practice in assessment and record keeping
- The provision of strategic leadership and organisational and workforce development, and ensuring systems operate effectively and deliver improved performance.

HDdUHB is responsible for ensuring access to assessment, decision-making and provision should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, or type of health need (for example whether the need is physical, mental or psychological). LHBs are responsible for ensuring that discrimination does not occur and should use effective monitoring to monitor this issue.

When an individual has been assessed as having a primary health need, and is therefore eligible for CHC, the HDdUHB has responsibility for funding the full package of health and social care. Where the individual is living at home, this does not include the cost of accommodation, food or general household support. HDdUHB will contract with other organisations and, in particular, the independent sector, and will be responsible for ensuring that the quality and range of services are sufficient to meet the individual's

Regular reviews will be arranged to ensure those services remain fit for purpose.

## Aim

It is the policy of HDdUHB that all staff involved with decision around assessment and eligibility for Long Term Care are aware of the procedure to follow and are also aware of the legal and professional guidance and requirements of the WG Continuing NHS Healthcare Framework 2021.

The aim of this document is:

- To improve fairness, public understanding and consistency in the application of the eligibility criteria for Continuing NHS Healthcare.

- To support the HDdUHB to provide high quality and safe Continuing NHS Health Care services for the residents of Carmarthenshire, Ceredigion and Pembrokeshire.
- Achieving value for money.

## Objectives

The aim of this document will be achieved by the following objectives:

- To enable a consistent approach across the HDdUHB to the delivery of the Welsh Government published Continuing NHS Healthcare Framework 2021
- To outline the approach to be undertaken by practitioners to the assessment and decision making process around Continuing NHS Health Care.
- To outline the governance arrangements surrounding the application and decision making process.
- To ensure that robust processes are in place to enable Hywel Dda Health Board to be legally compliant with the processes and requirements outlined in the Welsh Government Continuing NHS Healthcare Framework.

## SECTION 1 INTRODUCTION

CHC is a complete package of ongoing care arranged and funded solely by the NHS through local health boards (LHBs), where an individual's primary need has been assessed as health based. It is one element of a range of care services for those with complex needs. Given the nature and intensity of those needs these services account for a significant proportion of NHS healthcare overall.

CHC can be provided in any residential or non-residential setting and is part of the continuum of care and support that an individual with complex needs may move in and out of.

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

### Legal Framework

The Legal Framework Legislation and Case Law.

Primary legislation governing the health service does not use the terms "continuing care", "Continuing NHS Healthcare" or "primary health need". However, Section 1 of the National Health Service (Wales) Act 2006 requires Welsh Ministers to continue the promotion in Wales of a comprehensive health service, designed to secure improvement in: (i) the physical and mental health of the people of Wales; and (ii) the prevention, diagnosis and treatment of illness.

Deciding on the balance between local authority and health service responsibilities with respect to long-term care has been the subject of key court judgments. This Framework reflects relevant Welsh legislation with particular emphasis on the various provisions contained within the Social Services and Well-Being (Wales) Act 2014 ("The SSWB Act").

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| Social Services and wellbeing Act 2014 | Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk) |

## Equality and Human Rights Legislation

LHBs and LAs have statutory duties to have due regard to the need to promote equality and human rights and ensure it is integral to the way in which health and social care is prioritised and delivered. This should allow people to enjoy quality of life and to be treated with dignity and respect. Such objectives will be supported by:

- Equality of access to care and support, meaning that LHBs and LAs should not preclude anyone from having an assessment for community health and social care services, if their needs appear to be such that they may be eligible for support.
- Equality of outcomes from care and support, meaning that within the same area, individuals with similar levels of needs should expect to achieve similar quality of outcomes, although the type of support they choose to receive may differ depending on individual circumstances.
- Equality of opportunity, meaning that LHBs and LAs should work together with individuals to identify and overcome any barriers to economic and social participation within society.

Equality Act 2010 can be found on the below link

https://www.legislation.gov.uk/ukpga/2010/15/contents (opens in a new tab)

## Welsh Language Requirements

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

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

Evidence of implementation of the Welsh language guidance as defined in the strategic framework below

More than just words | Care Inspectorate Wales (opens in a new tab)

## Performance Framework and Reporting

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

## SECTION 2 POLICY

The policy of Welsh Ministers on eligibility for CHC is based on whether an individual's primary need is a health need (this is known as the "primary health need approach").

The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need.

Establishing that an individual's primary need is a health need requires a clear, reasoned decision which is based on evidence of needs from a comprehensive assessment.

Health and social care practitioners involved are expected to comply with existing Welsh Government practice guidance on assessment and care planning including:

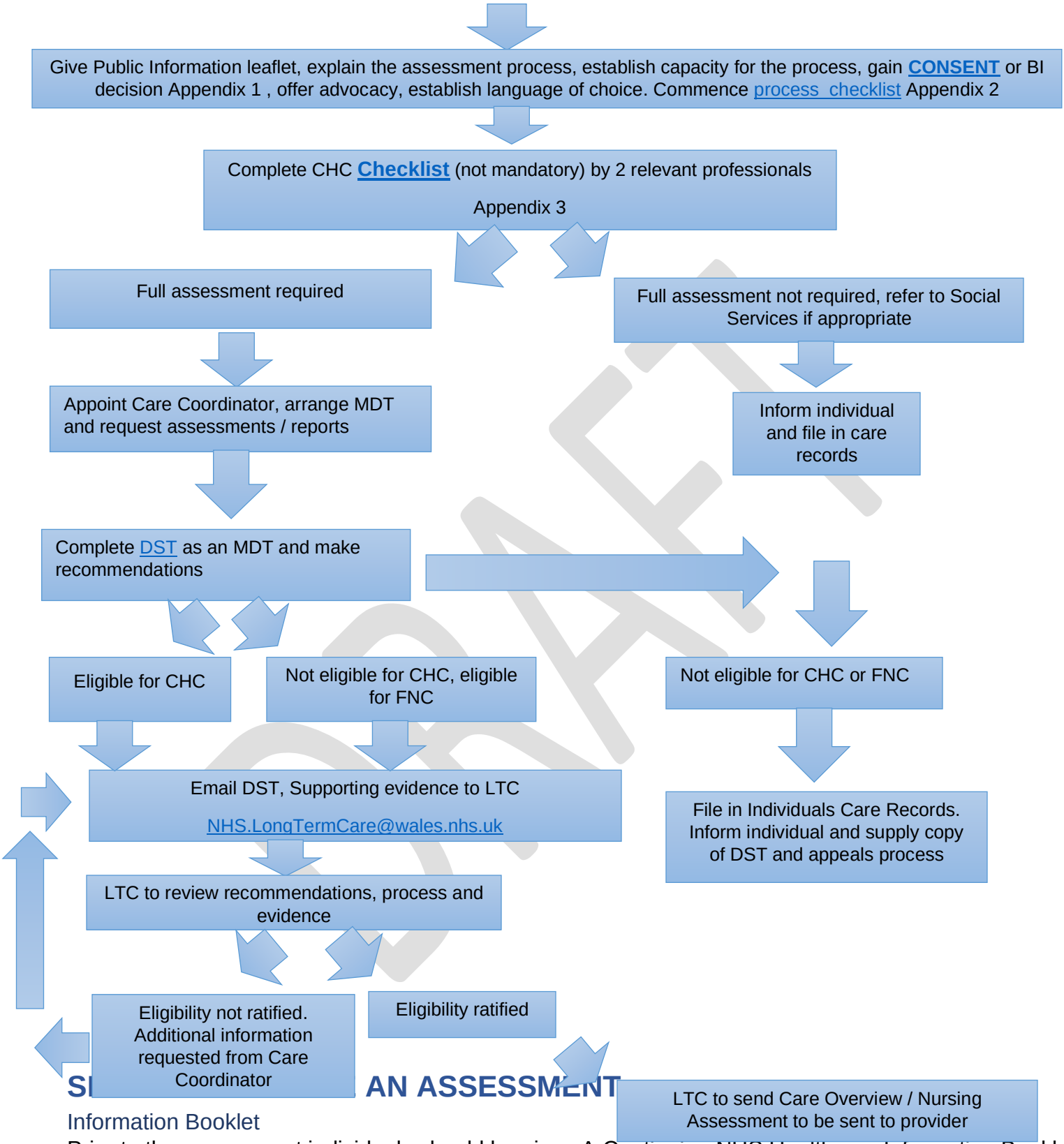
Social Services and Well-being (Wales) Act 2014 Code of Practice relating to Part 3 - Assessing the Needs of Individuals

| | |
|---|---|
| Social Services and Wellbeing Act Part 3 and 4 | https://gov.wales/sites/default/files/publications/2019-05/part-3-code-of-practice-assessing-the-needs-of-individuals.pdf (opens in a new tab<br><br>https://gov.wales/sites/default/files/publications/2019-05/part-4-code-of-practice-meeting-needs.pdf (opens in a new tab |
| Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 | gen-ld8880-e-English.pdf (Senedd. Wales) (opens in a new tab |
| Welsh Health circular re Discharge Planning | http://www.wales.nhs.uk/documents/WHC_2005_035.pdf (opens in a new tab |
| Passing the Baton | https://www.adss.cymru/en/blog/post/passing-the-baton-a-practical-guide-to-effective-discharge-planning (opens in a new tab |
| Hospital Discharge Service Requirements COVID 19 | https://gov.wales/hospital-discharge-service-requirements-covid-19 (opens in a new tab |



### CHC Assessment Process:

Individual may have a PHN / Nursing needs or have requested a full assessment




## SI AN ASSESSMENT

### Information Booklet

Prior to the assessment individuals should be given A Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers in order to ensure informed consent is obtained prior to the commencement of the process.

| | |
|---|---|
| CHC Information booklet (English) | Continuing NHS Healthcare (CHC): information booklet for individuals, families and carers \| GOV.WALES - (opens in a new tab |
| CHC Information booklet (Welsh) | Not yet available |
| Easy Read Information Leaflets | Not yet available |
| Easy Read guide to eligibility | Not yet available |
| Easy Read How CHC is organised | Not yet available |
| Easy Read What if I am not eligible for CHC | Not yet available |

## Consent

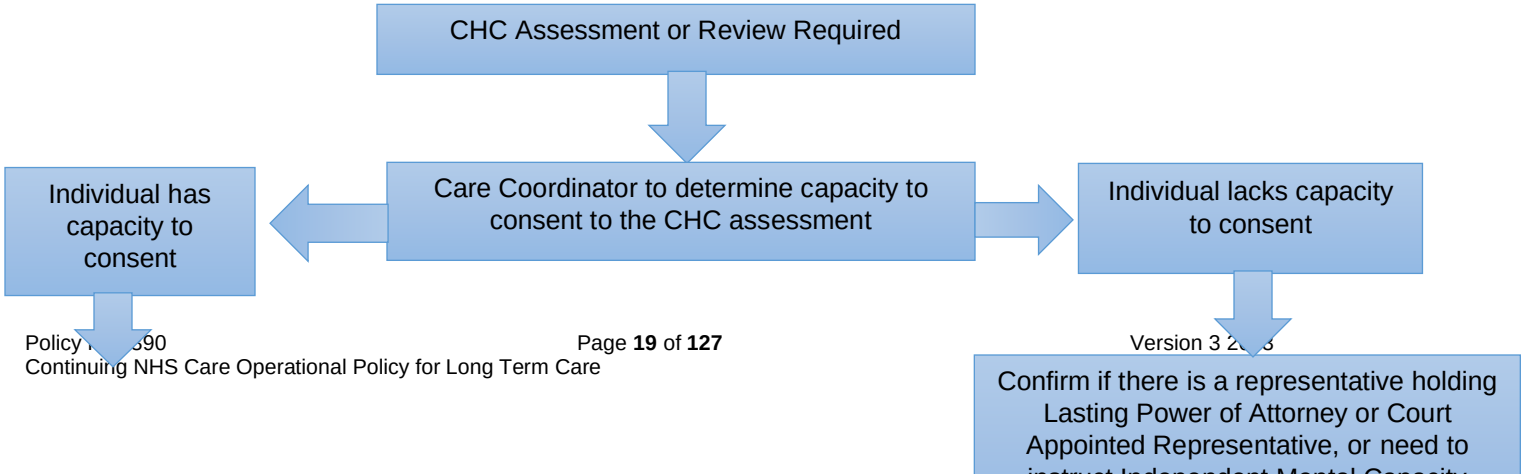
Where the individual concerned has capacity, their informed consent should be obtained before the start of the process to determine eligibility for CHC. This consent will need to encompass permission to undertake the CHC assessment process and also to the 'sharing and processing of data' (i.e. sharing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

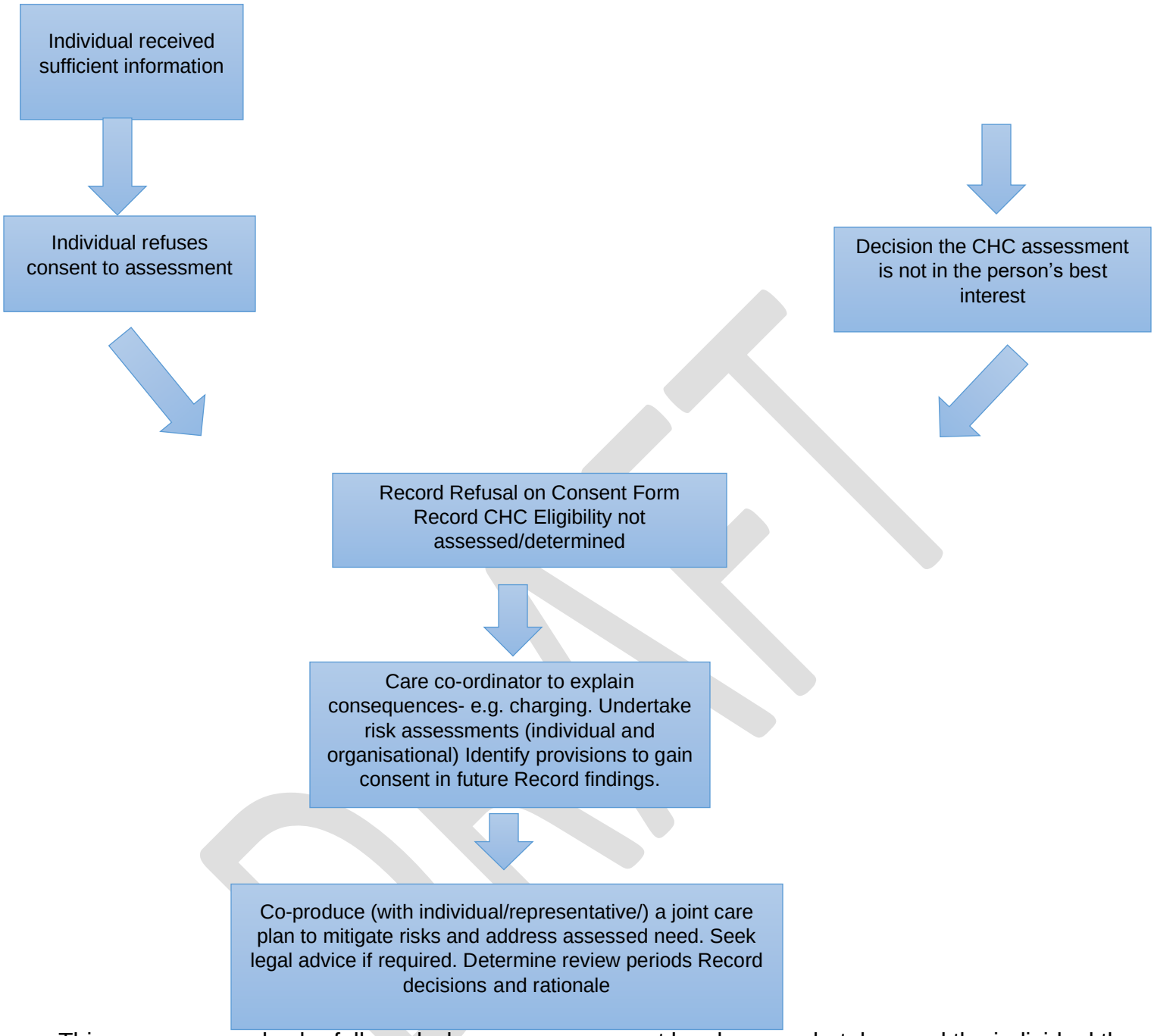
The individual must be made aware that they can withdraw their consent at any time, and made aware of the process for doing so, and that this includes withdrawing consent to share information.

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



## Refusing Consent to a CHC Assessment






This process can also be followed where an assessment has been undertaken and the individual then changes their mind or refuses a CHC care package.

## Capacity

If there is a concern that the individual may not have capacity to give their consent or to participate effectively in the decision-making process, this should be determined in accordance with the Mental Capacity Act 2005 and the associated Code of Practice. The five key principles of the Mental Capacity Act 2005

Capacity Assessment Template.doc (sharepoint.com) (opens in a new tab

## Best Interest

If an individual lacks capacity to consent to the assessment, then a best interest decision needs to be made.

Best Interests Template.doc (sharepoint.com) (opens in a new tab

### *Fast Track*

Occasionally, it will be necessary to safeguard an individual's well-being by 'fast tracking' them for immediate provision of CHC. An example of this may be individuals who are rapidly deteriorating. In such circumstances, people can be supported in their preferred place of care without waiting for the full CHC eligibility process to be completed. LHBs must have a robust fast track process in place to complete the assessment process within two days. However, streamlined processes should still ensure that the individual and/or their representative is fully involved.

Fast Track assessment template Appendix 4

The use of the checklist tool Appendix 3 (opens in a new tab

It's essential to that reasonable steps are taken to ensure that individuals are assessed for CHC in all cases where it appears that there may be a need for such care. Although not mandatory, if an initial screening process is used to identify where there may be a need for such care, then the Checklist is the only screening tool that can be used for this purpose. The Checklist encourages proportionate assessments of eligibility and rationale is provided for all decisions regarding eligibility.

## NHS Long Term Care discharge to assess pathway

Assessments should take place in a person's home or in another suitable community setting, not in an acute hospital bed. 'Home first' and the Discharge to Recover Then Assess (D2RA) pathways should be the default position.

It should always be borne in mind that an assessment of eligibility for CHC that takes place in an acute hospital might not accurately reflect an individual's longer-term needs. This could be because, with appropriate support, the individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment.

Where an individual is ready to be safely discharged from acute hospital it is very important that this should happen without delay. Therefore, the assessment process for CHC should not be allowed to delay hospital discharge.

A person who is admitted to a general hospital / MH ward may, at some point during their stay, be identified as 'complex' and / or requiring long-term nursing care, and therefore requiring additional support during and after their discharge.

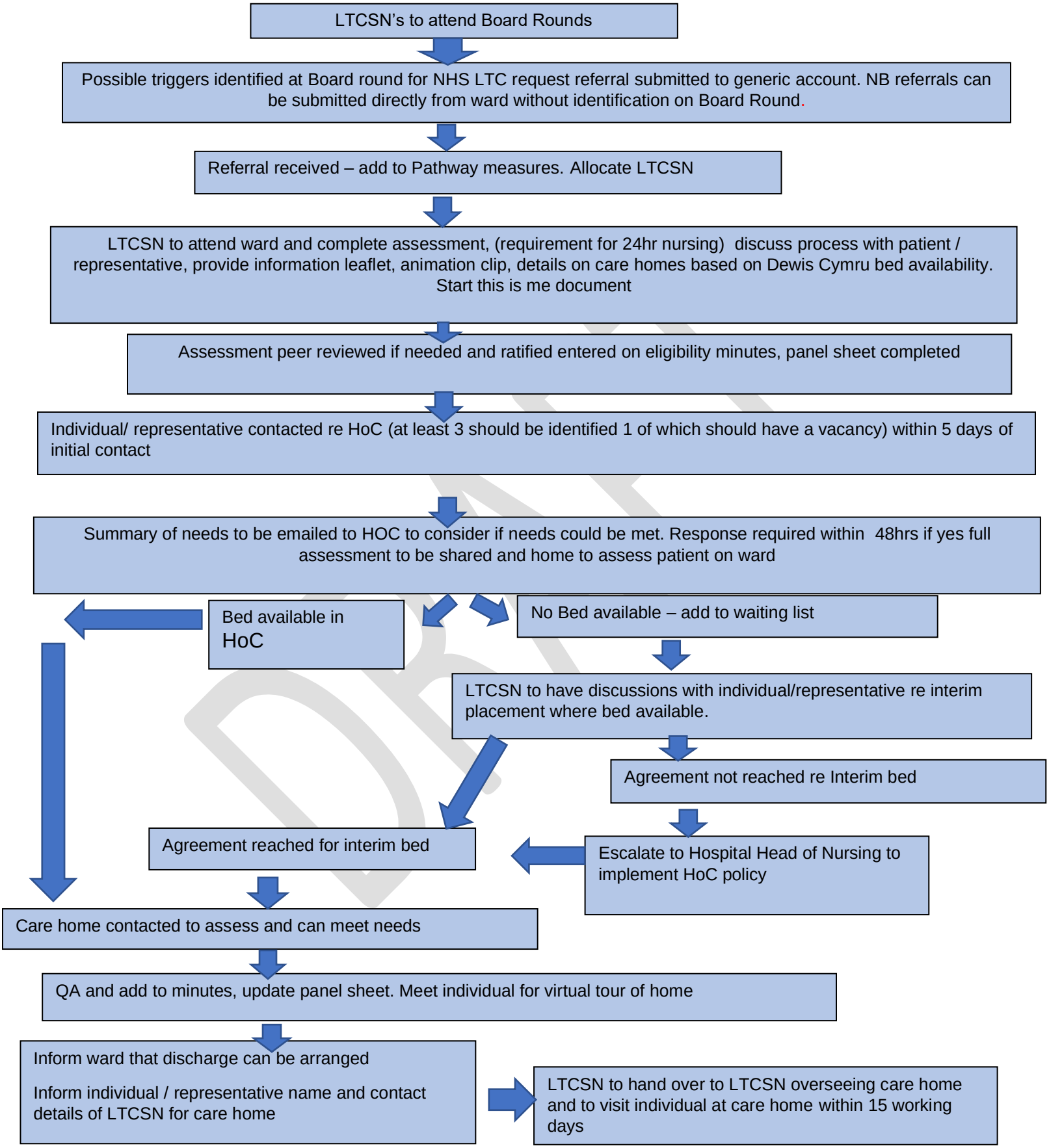
HDdUHB have developed an NHS discharge to assess pathway where it has been identified a person has nursing needs requiring long term care in a 24hour care facility within the Health Boards footprint.

The LTC Team provides one type of support that might be needed, i.e., the assessment of eligibility for CHC and the sourcing of a care home placement / community PoC.

Please see appendix 9 for Referral form

Long Term Care patient information sheet Patient Information Leaflet .pdf

## NHS Long Term Care Discharge to Assess Pathway



# SECTION 4 ASSESSMENT OF ELIGIBILITY FOR CHC

Establishing whether an individual has a primary health need requires a clear, reasoned decision, based on evidence of needs from a comprehensive range of assessments relating to the individual. A good-quality multi-disciplinary assessment of needs that looks at all of the individual's needs 'in the round' – including the ways in which they interact with one another – is crucial both to addressing these needs and to determining eligibility for CHC. The individual and any representative should be enabled to play a central role in the assessment process

## Using the Decision Support Tool

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

The MDT should use this tool to support consideration of not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments. Conversely, the DST should not be completed without a multidisciplinary assessment of needs

The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. The tool provides practitioners with a method of bringing together and recording the various needs in 12 'care domains', or generic areas of need. Each domain is broken down into a number of levels. The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided.

| | |
|---|---|
| Decision Support Tool Template | Continuing NHS healthcare: Decision Support Tool (DST) for practitioners \| GOV.WALES (opens in a new tab |

## Pandemic and other emergency situations

The Health Board appreciates that completing a full CHC assessment in hospital during a declared emergency, such as pandemic influenza, would be problematic. As CHC is an assessment of long-term needs, decisions on CHC eligibility should not take priority in these situations. The priority instead should be the safety of the patient, and ensuring they receive the care they need.

In the event of a pandemic or other emergency situation the Health Board will refer to the Welsh Government's webpage for up to date information on CHC.

## Making the recommendation on eligibility

The MDT is required to make a recommendation to the LHB as to whether or not the individual has a primary health need, bearing in mind that where the LHB decides that the individual has a primary health need they are eligible for CHC

In coming to this recommendation, the MDT should work collectively using professional judgement. All members of the MDT should be present when an eligibility decision is being made.

The written recommendation needs to be clear and concise whilst providing sufficient detail to enable the LHB and the individual to understand the underlying rationale for the recommendation. In doing so, it should;

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

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

### Quality Assurance

HDdUHB has robust quality assurance (QA) mechanisms pay way of Eligibility and Quality assurance panel (The panel) in place to ensure consistency of decision-making.

Whilst the majority of cases are agreed outside of the panel process the scope of the panel is that

- The eligibility and quality assurance panel will provide a quality assurance role in scrutinising and ratifying the eligibility and quality assurance of services from across the Board.
- Panel meetings will be held on a weekly basis and minuted
- A submission to the Long Term Care Team will be as a result of and supported by a comprehensive MDT assessment/ review along with identified care package / provider. If a new placement is recommended within a long term care setting a preadmission assessment is required along with confirmation that they can meet the individuals needs
- The panel will not consider cases for individuals under the age of 18 or adults with an overriding Mental Health or Learning Disability

The objectives of panel are to:

- Ensure eligibility criteria are fairly applied consistently.
- Ensure assessment decision making is clear and robust, has an evidence base and will stand up to scrutiny from other professionals, carers and relatives, service providers, statutory authorities and legal challenge
- Audit/review physical and mental health needs to ensure no further input is required.
- Provide a multi-disciplinary review of professional practice.
- Ensure a decision making process is in place that looks objectively at needs.
- Determine whether all appropriate documented evidence has been provided to support the MDT decision / recommendation.
- Ensure assessment decision making is clear and robust, has an evidence base and will stand up to scrutiny from other professionals, carers and relatives, service providers, statutory authorities etc.

- Ensure that the Welsh Government Guidance is adhered to.
- Ensure that the package recommended is appropriate to meet the needs of the individual.

## Exceptionality Panel

There are occasions when it will be necessary to arrange an exceptional panel to discuss cases that are in excess of a standard Nursing Home placement. These meeting are help on an as required basis.

The aim of the exceptionality panel is to facilitate comprehensive discussions regarding sustainable care planning for complex cases and / high cost packages of care, to provide assurance to the Health Board's Executive Team that robust consideration has been given, and all options considered. These discussions would be taken in line with the National Framework for CHC (2021), the Sustainable care planning Policy (2011) and the Social Services and Wellbeing Act (2014).

| | |
|---|---|
| National Framework 2021 | Continuing NHS Health Care (gov.wales) (opens in a new tab |
| Sustainable Care Planning | Sustainable-Care-Planning-Policy---FINAL.pdf |
| Social Services and wellbeing act 2014 | Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk) (opens in a new tab |

## Communicating the decision on eligibility to the individual

Once the eligibility decision is made by the Long Term Care team, the decision will be communicated via letter from the Long Term Care Department. Details within the letter will include:

- The decision on primary health need, and therefore whether or not they are eligible for CHC
- The reasons for the decision
- A copy of the completed DST
- Details of who to contact if they need further information
- Details on how to request an appeal of the eligibility decision if they are dissatisfied with the decision
- Where an individual is not eligible for CHC, the decision letter may also include, where applicable and appropriate, information regarding FNC or a joint package of care.
- Where an individual is eligible for CHC, an indication of the proposed care package, if known, could be included within this communication, or if not known at that stage, information on what the next steps are.
- Eligibility for CHC is not indefinite, as needs could change. This should be made clear to the individual and/or their representative.

# SECTION 5 SERVICE PROVISION AND REVIEW

## Service Provision

Where a person is eligible for CHC. The HDdUHB will be responsible for making the necessary arrangements for the individual's care irrespective of their setting.

The HDdUHB will work with other organisations to establish an appropriate package of care, accommodation (where appropriate) and support. Whilst the overall responsibility for the care provision will lie with the HDdUHB there will be ways in which other agencies, such as (but not only) social services may become involved, for example through:

- Ongoing social work services
- Agreed delegated responsibility, under formal partnership arrangements, for purchasing or providing care
- Agreed delegated or shared responsibility for providing ongoing assessment and/or care management
- Locally developed joint service provision
- Their housing, education and leisure services responsibilities, local authorities have a corporate role in enabling people to have fulfilling lifestyles and to participate in and contribute to the wider community
- The provision of equipment via the integrated community equipment services

The CHC package to be provided is that which HDdUHB assesses as appropriate for the individual's health and personal care needs.

It is the responsibility of the HDdUHB to plan, specify outcomes, procure services, and manage demand and provider performance for all services that are required to meet the health and personal care needs of individuals who are eligible for CHC.

Regional partners are expected to develop an integrated approach to the commissioning of care home services, including in relation to negotiating contracts, service specifications, fee negotiations and quality assurance.

HDdUHB and Local Authority partners have set out to develop a regional contract for the placement of Older Adults in residential care or residential care with nursing.

Partners must establish a pooled fund in relation to care home accommodation functions to support these integrated arrangements.

The LTC Team has been working with the Regional Commissioning Group (RCG) since the financial year 2018/19 to establish a 'virtual' pooled fund for the commissioning of older adults' care home (OACH) placements, as required under Part 9 of the Social Services and Well-being (Wales) Act 2014.

Unless the function is formally delegated LHBs continue to have responsibility for the case management/care co-ordination role for those entitled to CHC as well as for the NHS component of a joint care package, including an assessment and review of individual patient needs.

HDdUHB have arrangements in place for brokering and commissioning the services required to deliver the detailed care plan. The MDT recommendations and the individual's preferences will be balanced in accordance with the Sustainable Care Planning Policy

| | |
|---|---|
| Sustainable Care Planning Policy 2011 | Sustainable-Care-Planning-Policy---FINAL.pdf (opens in a new tab |

## Reviews

HDdUHB will be responsible for monitoring quality, safety, access and patient experiences within the context of provider performance. The ultimate responsibility for arranging and monitoring the services required to meet the needs of those with CHC rests with the LHB.

Where individuals eligible for CHC are cared for in a Care Home, escalating concerns will be managed in accordance with the Welsh Government's 'Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults' Guidance (May 2009). In accordance with this guidance, LHBs and social care agencies should have in place systems and processes which enable registered providers, contract managers, care managers and other professionals to clearly understand what is expected and required from each setting and how such requirements will be delivered and monitored.

## Care Home monitoring

Monitoring of all Nursing Homes within the HDdUHB area and within which the Health Board commissions care is undertaken on a quarterly basis. Long Term Care Specialist Nurses have allocated Nursing Homes and it is their responsibility to ensure that these visits are undertaken and a report submitted. Should there be concerns outside of the quarterly arranged visits, further monitoring will be arranged and at times with LA colleagues. Monitoring on a more informal basis takes place whenever a LTCSN attends the Nursing Homes for reviews of individual residents.

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

The NHS provides a comprehensive service available to all. Access to NHS services is based on clinical need and not on an individual's ability to pay.

Public funds for healthcare will be devoted solely to the benefit of people that the NHS serves.

As overriding principles, it is essential that: the NHS should never subsidise private care with public money (which would breach core NHS principles) and patients should never be charged for their NHS care, or be allowed to pay towards NHS care (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.

To avoid these risks, there should be as clear a separation as possible between private and NHS care.

In such cases HDdUHB will ensure that the care plan should set out the services to be funded and/or provided by the NHS. It may also identify services to be provided by other organisations such as local authorities and third sector providers. Where such non-NHS funded support is provided as part of a total package, the individual and their carers should be signposted by the local authority to clear information on charging arrangements and by the voluntary sector to potential alternative funding sources e.g. benefits and charitable organisations.

In addition to such arrangements, there may be circumstances, where individuals and/or their representative may choose to access additional services or premium accommodation by making, and paying for, separate arrangements themselves.

### Responsible Body Guidance

The Responsible Body Guidance provides a framework for establishing the body responsible for securing secondary and tertiary health care for an individual within the NHS in Wales.

| | |
|---|---|
| Responsible Body guidance Wales | Responsible Authority Guidance (gov.wales) (opens in a new tab |
| Who Pays England | Who-Pays-final-24082020-v2.pdf (england.nhs.uk) (opens in a new tab |

### Direct Payments Independent User Trusts

It is currently unlawful for Direct Payments to be used to purchase health care which the NHS is responsible for providing, however it is not unlawful for local authorities and health boards to work together to provide individuals with voice and control in respect of their health and social care needs.

Where an individual whose care was arranged utilising Direct Payments becomes eligible for CHC funding, the HDdUHB will work with the individual in a spirit of co-production. Although Direct Payments will no longer be applicable where an individual has a primary health need, this should not mean that the individual loses their voice, choice and control over their daily lives.

There may be circumstances where it is possible for an individual to retain some Direct Payment for the elements of their care for which the local authority is still responsible, e.g. opportunities for social inclusion. HDdUHB and the relevant local authority will work together to explore all the options available to maximise an individual's independence.

An individual in receipt of Direct Payments (or any individual) retains the right to refuse to consent to a CHC assessment and /or care package, as detailed in Section 3. In such cases, partner agencies must work together with the individual and their family/carers to ensure that the risks are fully understood and mitigated as far as possible. If a person is assessed as eligible for CHC but refuses a care package, there may be an impact on the way their care is delivered. It cannot automatically be assumed that LAs will continue to provide those services, as this may mean that they are acting outside of their legal authority. Further guidance on these measures will be published on the Welsh Government website.

### Joint Packages of Health and Social Care

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

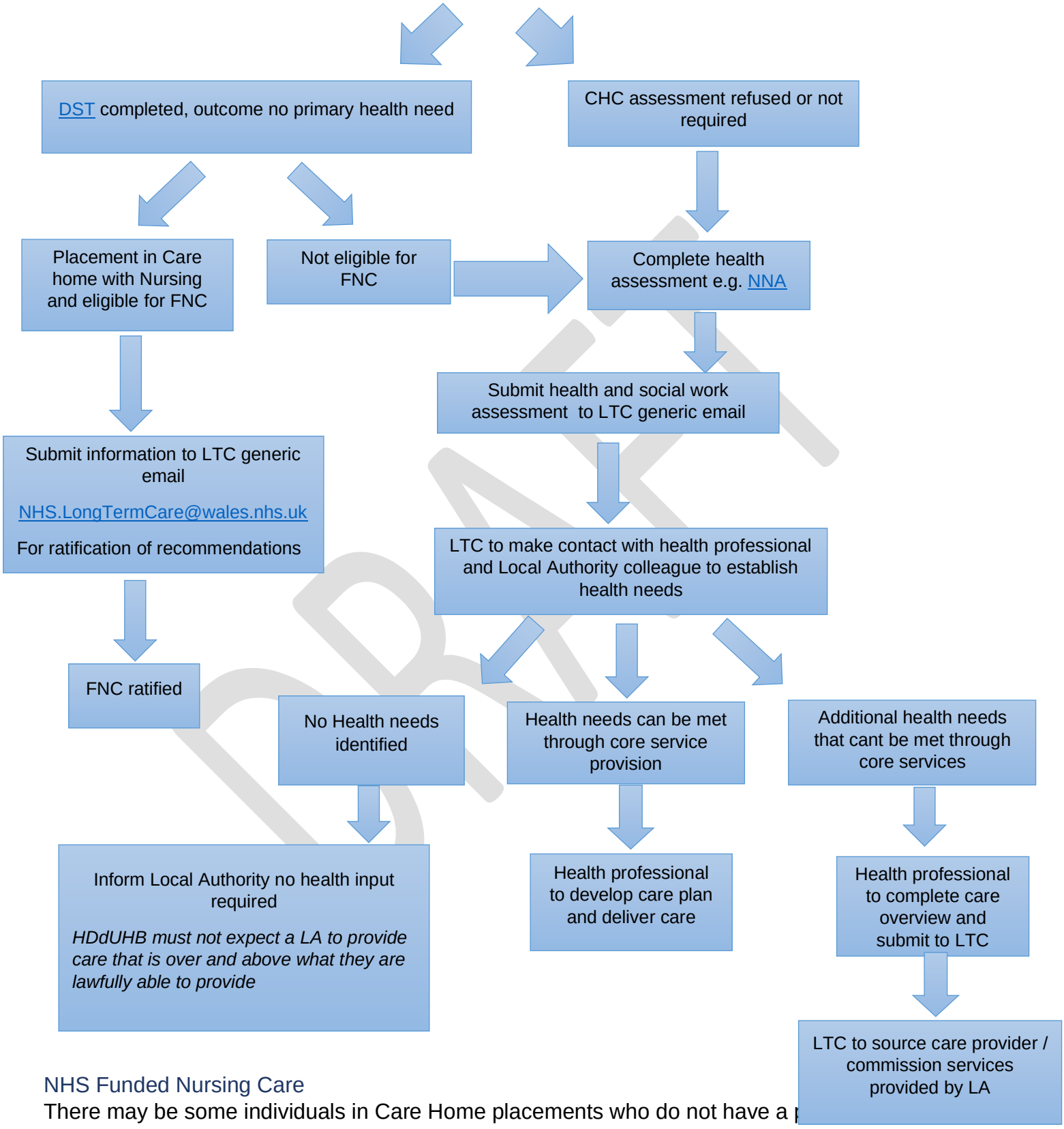
As a matter of principle, if an individual has existing Direct Payment arrangements, these should continue wherever and for as long as possible within a tailored joint package of care.

HDdUHB will work with relevant Local Authorities to identify any Health Needs and meet these needs if appropriate through core service provision or commissioned services.

### Joint funding process



Possible health need identified




## NHS Funded Nursing Care

There may be some individuals in Care Home placements who do not have a p
indicating eligibility for CHC but are acknowledged to have nursing needs greater than would normally

be expected to be covered by the FNC rate and what can be reasonably expected for an LA to commission.

Welsh Government is in the process of developing an interim FNC policy statement.
The intended purpose of the Interim policy is to provide an update on legislative changes and court judgements subsequent to the 2004 FNC Guidance, in advance of a longer-term review of FNC policy.

| | |
|---|---|
| NHS Funded Nursing Care 2004 | Microsoft Word - WHC_2004_024.doc (wales.nhs.uk) (opens in a new tab |

## Reviews

Any care package, regardless of the funding source, should be regularly reviewed in partnership with the individual and/or their representatives to ensure that it continues to meet their needs.

As a minimum there should be an initial review of the care plan within 3 months of services first being provided unless this is triggered earlier by the individual or their representative or the provider. Thereafter, reviews should be at least annually.

Where an individual's condition is anticipated to deteriorate, more regular review may be necessary. The frequency of such reviews will be determined by professional judgement based on the individual's assessed needs or if there is a change in circumstances. They should be proportionate to the situation in question in order to ensure that time and resources are used effectively. Where there is an obvious deterioration in circumstances, reviews should also be held within 2 weeks and acted upon appropriately.

The individual and/or their representative and the service provider must be provided with the contact details of a named care co-ordinator, so that any changes in the individual's condition or circumstances can be promptly addressed.

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

The responsibility of the Health Board to provide or commission care (including CHC) is not indefinite as needs might change. This should be made clear to the individual and their family or carer at the time of the initial assessment and at each subsequent review and confirmed in writing. The individual and the carer or representative should be provided with the Continuing NHS Healthcare Information Booklet at the commencement of their CHC care package

The review will determine whether:

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

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

The review information should be used to inform the individual's care plan. A copy of the review and care plan should be drafted, agreed and given to the service user. Subject to the constraints of confidentiality, the findings of the review and changes to the care plan should also be shared with those involved in the individual's care.

If the individual and/or their representative relative or their carer is not satisfied with the care plan which has been developed, they will need to raise this with the person responsible for it in the first instance. They may request a re-assessment of their needs and review of the care plan. If they continue to be dissatisfied, they will need to consider making use of the complaints process.

The CHC Independent Review Panel (see Section 7) is not designated to review the content of care plans, only the decision-making process relating to the application of the primary health need approach

Services cannot be discontinued without a full re-assessment being carried out at a formal MDT meeting.

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

Neither the HDdUHB nor the LA will unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual and without first consulting one another and the individual about the proposed change of arrangement. Therefore, in order to ensure continuity of care, if there is a change in eligibility, it is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If joint agreement cannot be reached upon the proposed change, the local disputes procedures should be invoked and current funding arrangements should remain in place until the dispute has been resolved.

Appendix 5 LTCSN Assessment Template form

Appendix 6 Community assessment template

### Contingency Planning for individuals receiving Care Packages within their own home

Where an individual is eligible for Continuing NHS Health Care, HDdUHB will be responsible for sourcing and commissioning the care package based on the individuals assessed need. Whilst we endeavour to achieve this there may be times where an individual is left without care due to staffing capacity with the care provider To reassure HDdUHB and the individual and / or their family it is essential that a contingency plan is completed to establish action plans in the event of carer disruption.

Appendix 7 Contingency Plan Template (opens in a new tab).

## SECTION 6 LINKS TO OTHER POLICIES

### Section 117 aftercare

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

services. It should be borne in mind, however, that some people may be eligible for care and support under both CHC and Section 117.

Section 117 is a free-standing joint duty. Local health boards (LHBs) and local authorities (LAs) should develop protocols to help determine their respective responsibilities for the delivery of Section 117 aftercare (see for example Mental Health Act 1983 Code of Practice for Wales, chapter 31). This Framework does not therefore attempt to provide additional guidance on this issue, but focusses on the interface between Section 117 and eligibility for Continuing NHS Healthcare.

Responsibility for the provision of Section 117 is shared between LAs and LHBs, although this does not necessarily mean there should be a 50/50 split in all cases. Where a patient is eligible for services under Section 117 these should be provided under Section 117 and not under CHC.

All those subject to Section 117 are considered to be in receipt of secondary mental health services, as defined under the Mental Health (Wales) Measure 2010 (the Measure) and will therefore have a Care Co-ordinator and an outcome-focussed prescribed Care and Treatment Plan (CTP) that is reviewed at least annually. Detailed guidance regarding care and treatment planning is given in the Code of Practice to Parts 2 and 3 of the Measure.

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

However, an individual in receipt of after-care services under Section 117 may also have additional needs which are not related to their mental disorder. For example, an individual may be receiving services under Section 117 and develop separate physical needs, for example following a stroke, which may then mean they are eligible for CHC or FNC.

In such cases, the general approach set out in this Framework of considering the totality of need in assessing eligibility for CHC still applies. The individual may as a result, have the services required to meet their total care needs funded by the NHS, but this does not necessarily remove the shared duty under Section 117. The Section 117 shared duty remains unless a joint assessment and agreement by both the LA and the LHB determines that those arrangements are no longer needed.

Where an individual in receipt of Section 117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase (or a catastrophic health event which clearly requires CHC), consideration should be given to the Fast Track process.

Where an individual is to be discharged from Section 117, eligibility for CHC or FNC will need to be considered where the transition assessment and plan indicates that new or other services may be required. 6.10 Information should be provided to the individual or their representative on the effect that discharge from Section 117 may have on their financial circumstances.

### Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act 2005 contains provisions that apply to a person who lacks capacity and where care arrangements amount to a deprivation of their liberty. The fact that a legal authorisation is being sought or is in place in relation to a deprivation of liberty of capacity does not affect the consideration of whether that person is eligible for CHC. The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and replaces the Deprivation of Liberty Safeguards (DoLS). LHBs must ensure they are compliant with this new legislation when it is implemented.

Where an individual is in receipt of CHC, and they lack mental capacity to consent to their accommodation, or care and support arrangements, the LHB must ensure that the arrangements they commission are lawful and compliant with provisions under the Mental Capacity Act.

For more information on DoLS click the link/s below

| | |
|---|---|
| DoLS Policy and Code of Practice | Deprivation of Liberty Safeguarding Policy and Code of Practice (sharepoint.com) (opens in a new tab |
| DoLS Standards | Deprivation of Liberty Safeguards (DoLS) (sharepoint.com) (opens in a new tab |

### Transition from Child and Young Persons to adult services

Initial planning for transition to adult CHC services must commence when the young person is aged 14, where the need is already identified or as soon as possible, if problems emerge that will require ongoing care, after this age. A lead professional must be identified and supported by all the agencies involved. This person will act as the Transition Co-ordinator and key point of communication for the individual and their family.

Once the young person reaches 16 years of age there should be a formal referral for screening to the appropriate adult CHC team. At the age of 17, eligibility for adult CHC should be determined in principle by the relevant HB, bearing in mind that, in complex cases, needs can change in the course of a year. Local multi-disciplinary teams will need to use their professional judgement regarding the timing of assessment and review to ensure that effective packages of care can be planned and commissioned in time for the individual's 18th birthday. If needs are likely to change, it may be appropriate to make a provisional decision and then to recheck it be repeating the process as adulthood approaches.

Even if a young person is not entitled to adult CHC, provision of services for health needs is the responsibility of the NHS. In such circumstances, LHBs should continue to play a full role in transition planning for the young person and should ensure that services to meet these needs are provided. The focus should always be mutually agreed and take into account the individual preferences.

Financial implications for the young person and their family, including any changes to benefits or other funding sources such as Direct Payments, must be clearly explained at the earliest possible opportunity. Accommodation and independent living choices should be fully explored, and a clear explanation provided of entitlements and options. Support for carers must be included in the care plan, in accordance with the Social Services and Well-Being Act

HDdUHB is currently revising the transition process

Appendix 8 Transition Referral Form

## SECTION 7 DISPUTES AND APPEALS

### Disputes

The dispute process should be invoked when the HDdUHB and Local Authority are unable to agree on recommendations in relation to a Primary Health Need

A dispute resolution process is currently being developed between HDdUHB and partner Local Authorities (Carmarthenshire County Council, Ceredigion County Council & Pembrokeshire County Council)

## Appeals against eligibility decisions from individuals

The formal responsibility for informing individuals of the decision about eligibility for CHC and of their right to request an appeal against that decision lies with the LHB. Whether or not it is considered that an individual has a primary health need, the LHB must give clear reasons for its decisions, setting out the basis on which the decision was made, and explain the arrangements and timescales for dealing with a review of the eligibility decision in the event that the individual or someone acting on their behalf disagrees with it.

If an individual or their representative disagrees with the eligibility decision for either CHC or NHS Funded Nursing Care, and intend to appeal that decision, they must inform the relevant LHB of their intention to appeal within 28 days of receipt of the decision letter.

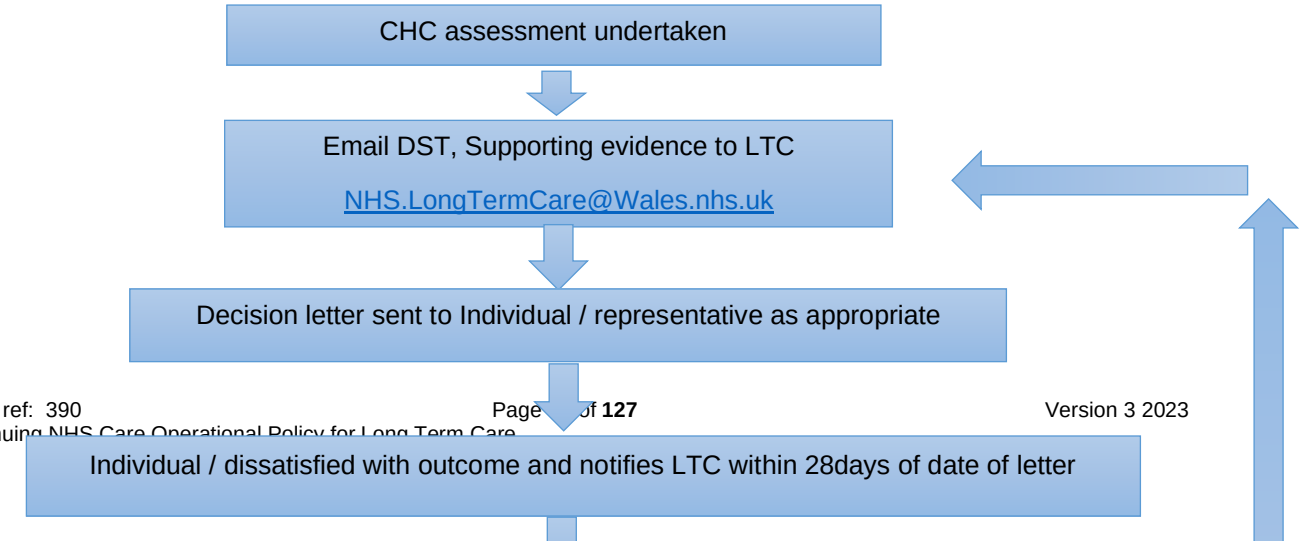
Written notification of intention to appeal a decision outside of the 28 days period will only be accepted in exceptional circumstances.

The individual must submit their written appeal to the relevant LHB within 6 months of the individual /or their representative being informed of that decision. Requests made after this time period will only be considered in exceptional circumstances.

- An individual or their representative may appeal to the relevant LHB if they are dissatisfied with: the procedure followed by the LHB in reaching its decision on the individual's eligibility for CHC or FNC, or
- How the primary health need was considered.



## Appeals process



## Complaints

If an individual wishes to make a complaint about NHS funded services, they should initially speak to the service provider, if possible, or to the LHB. Under the Regulation and Inspection of Social Care (Wales) Act 2016, individual complaints about the provision of care will be considered by regulated establishments via their own procedures; local authorities will consider complaints relating to the commissioning process (such as the appropriateness of a type of placement); and the Care Inspectorate Wales (CIW) has discretionary powers to investigate complaints where that complaint may inform its role as a regulator of care homes. Any agency receiving a complaint needs to consider whether a referral should be made in line with procedures for protecting adults at risk.

| | |
|---|---|
| Complaint's procedure | NHS Wales complaints and concerns: Putting Things Right \| GOV.WALES (opens in a new tab |
| Adults at risk Multi Agency Referral Form | Refer to the HB Datix system to access the documentation for referral |

# SECTION 8 RETROSPECTIVE CLAIMS FOR REIMBURSMENT

An individual and/or their representative may request a retrospective review where they contributed to the cost of their care but have reason to believe that they may have met the eligibility for CHC due to the nature, intensity, complexity and/or unpredictability of their healthcare needs.

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

As with the process of determining CHC eligibility, the retrospective claim process is not a legal process. Consideration of an individual's eligibility for a retrospective claim involves the use of distinct processes such as the All Wales Retrospective CHC Review to analyse the chronology of need over the entire period of the claim, as opposed to the Decision Support Tool, which provides indications of need over a snapshot in time. It is delivered by the LHB and therefore no charge will be made to the individual.

The claim may be submitted by either:

- The individual who is the subject of the claim.
- A person authorised by the individual to receive reimbursement on his/her behalf.
- A person holding a registered Enduring or Lasting Power of Attorney or who is a Court-appointed deputy for an individual who lacks mental capacity
- In the case of a deceased individual, an executor named in the Grant of Probate in respect of the deceased's estate or an administrator named in the Grant of Letters of Administration of the estate.

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

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

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

Within 5 months of registering the claim, claimants will be required to provide evidence of:

- Proof of fees paid to care home or domiciliary agency
- Where the claimant is not the patient, their right to make the claim on the individual's behalf (i.e., Enduring/Lasting Power of Attorney or Grant of Probate).

HDdUHB will need to balance their requirement to provide timely restitution with that of demonstrating probity with the public purse.

Making an application does not mean that reimbursement is guaranteed; LHBs must satisfy themselves that the application is genuine and that the person was indeed eligible for CHC during the disputed period.

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

The process for considering retrospective claims is as follows:

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

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

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

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

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

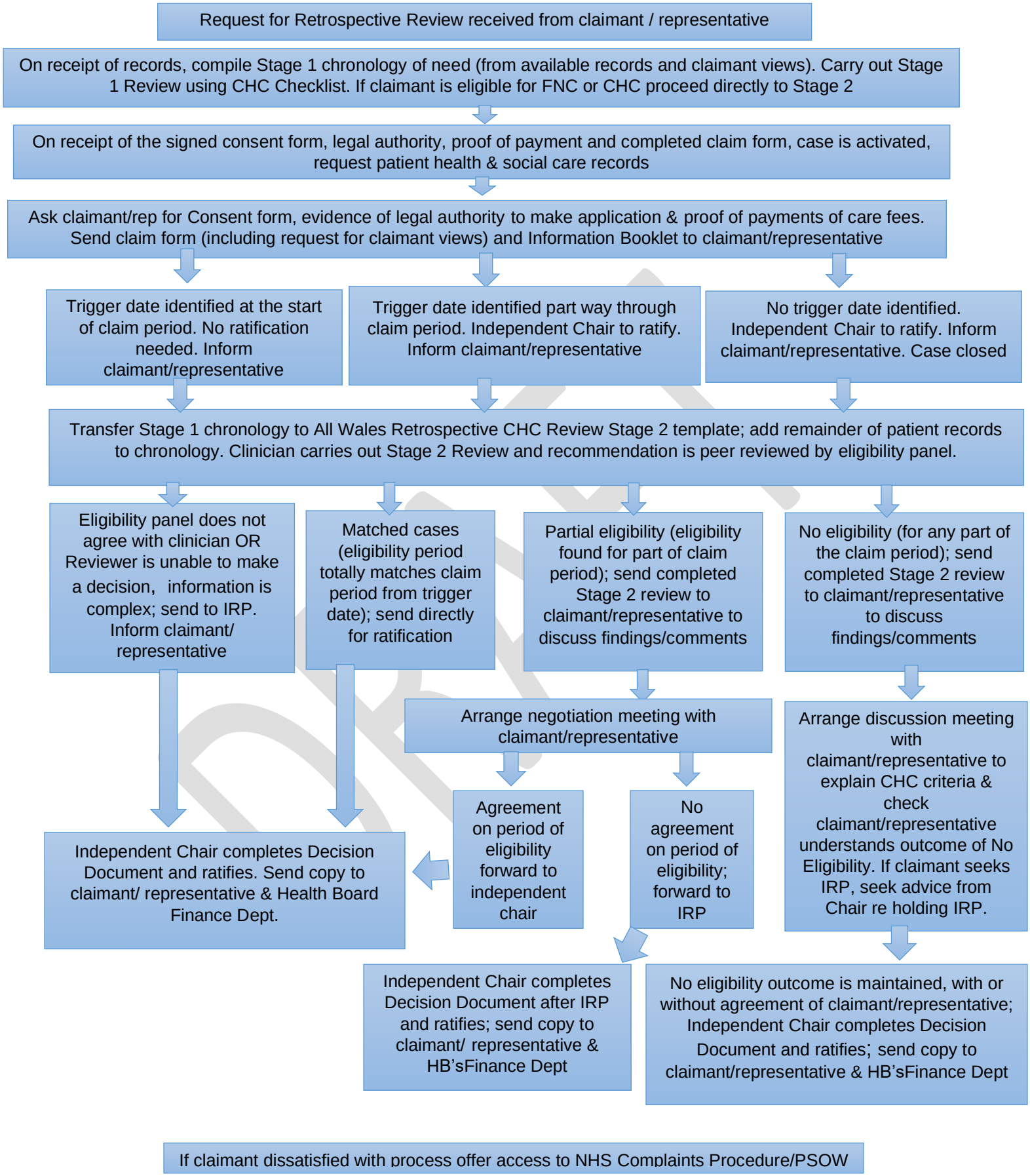
### Independent Review Panel

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

There should be recourse to the IRP process if the individual or their representative has significant additional information to present or exceptional circumstances apply.

Before taking a decision, the LHB will seek the advice of the Chair of the review panel. The Chair provides the lay perspective in the review process. In all cases, where a decision not to convene a panel is made, a full written explanation of the basis of its decision should be provided to the individual and/or their representative, together with a reminder of their rights under the NHS Complaints Procedure and access to the Public Services Ombudsman for Wales.

- The following principles and processes should be followed for all IRP cases:
- All decisions of the IRP should be unanimous. (The Panel attempts to reach a unanimous decision but if not possible a majority decision is accepted.)
- An All-Wales Decision Document will be completed by the person scrutinising and ratifying the recommendation made/Chair of the IRP.
- A copy of the completed Decision Document is provided to the claimant/representative and the LHB Finance Department.
- In cases of no eligibility, if a claimant does not wish to attend a meeting in person, the recommendation should be discussed over the telephone or in writing as far as possible.
- In cases of partial eligibility, a claimant not wishing to attend the negotiation should be able to discuss the recommendation over the phone. An IRP should then be convened


Request for Retrospective Review received from claimant / representative
On receipt of records, compile Stage 1 chronology of need (from available records and claimant views). Carry out Stage 1 Review using CHC Checklist. If claimant is eligible for FNC or CHC proceed directly to Stage 2
On receipt of the signed consent form, legal authority, proof of payment and completed claim form, case is activated, request patient health & social care records
Ask claimant/rep for Consent form, evidence of legal authority to make application & proof of payments of care fees. Send claim form (including request for claimant views) and Information Booklet to claimant/representative
Trigger date identified at the start of claim period. No ratification needed. Inform claimant/representative
Trigger date identified part way through claim period. Independent Chair to ratify. Inform claimant/representative
No trigger date identified. Independent Chair to ratify. Inform claimant/representative. Case closed
Transfer Stage 1 chronology to All Wales Retrospective CHC Review Stage 2 template; add remainder of patient records to chronology. Clinician carries out Stage 2 Review and recommendation is peer reviewed by eligibility panel.
Eligibility panel does not agree with clinician OR Reviewer is unable to make a decision, information is complex; send to IRP. Inform claimant/ representative
Matched cases (eligibility period totally matches claim period from trigger date); send directly for ratification
Partial eligibility (eligibility found for part of claim period); send completed Stage 2 review to claimant/representative to discuss findings/comments
No eligibility (for any part of the claim period); send completed Stage 2 review to claimant/representative to discuss findings/comments
Arrange negotiation meeting with claimant/representative
Agreement on period of eligibility forward to independent chair
No agreement on period of eligibility; forward to IRP
Arrange discussion meeting with claimant/representative to explain CHC criteria & check claimant/representative understands outcome of No Eligibility. If claimant seeks IRP, seek advice from Chair re holding IRP.
Independent Chair completes Decision Document and ratifies. Send copy to claimant/ representative & Health Board Finance Dept.
Independent Chair completes Decision Document after IRP and ratifies; send copy to claimant/ representative & HB'sFinance Dept
No eligibility outcome is maintained, with or without agreement of claimant/representative; Independent Chair completes Decision Document and ratifies; send copy to claimant/representative & HB'sFinance Dept
If claimant dissatisfied with process offer access to NHS Complaints Procedure/PSOW

## APPENDIX 1 - CLIENT CONSENT FOR ASSESSMENT OF A PRIMARY HEALTH NEED (CONTINUING NHS HEALTH CARE ELIGIBILITY)

1. **Statement of Health Professional / Care Co-ordinator :**

I confirm that I have discussed and explained the reason for the assessment, all the options and consequences along with the submission process with the Client named above, provided the Continuing NHS Health care for Adults in Wales Public information leaflet and have explained the sharing and processing of information to relevant organisations involved for the purpose of the assessment and where appropriate audit and monitoring of decisions

**Signature:** _____ **Print Name:** _____

**Job Title:** _____ **Date:** _____

2. **Statement of Client:**

I confirm that the reason for assessment, all options and consequences and the submission process have been explained to me, I have received the Continuing NHS Health care for Adults in Wales Public information leaflet. and the sharing and processing of information to relevant organisations involved for the purpose of the assessment and where appropriate audit and monitoring of decisions has been explained

- I am in agreement that I should be assessed for a Primary Health Need and that this involves sharing relevant information. (Delete as appropriate)

- I am NOT in agreement and Do NOT want to be assessed for a Primary Health Need (Delete as appropriate)

**Signature of Client:** _____**Date:** _____

3. **To be completed by the lead health professional where the Client does not have the capacity to consent:**

I can confirm that the multi professional team involved in the care, assessment and submission of the identified Client are satisfied that the application is in the Client's best interest. This decision has been made in consultation with the Client's Next of Kin / Advocate / Enduring Power of Attorney (delete as appropriate)

Please attach capacity assessment and Best Interest minutes

**Signature:** _____**Print Name:** _____

**Job Title:** _____ **Date:** _____

1. **Statement of Next of Kin / Enduring Power of Attorney:**

I confirm that the reason for the assessment and submission has been explained to me, I have received the Continuing NHS Health care for Adults in Wales Public information leaflet and the sharing and processing of information to relevant organisations involved for the purpose of the assessment and where appropriate audit and monitoring of decisions has been explained

I am in agreement that the submission should be made for consideration.

**Signature:** _____ **Date:** _____

**Relationship:** _____

**Contact Details:** _____

# APPENDIX 2 - STANDARD ASSESSMENT & ELIGIBILITY PROCESS CHECKLIST

| |
|---|
| **Name:** |
| **DOB:** |

| Date | | Tick if complete | Comments |
|---|---|---|---|
| | Care Co-ordinator/Lead professional identified<br>Name:<br><br>Contact Details:<br>Individual/family informed | | |
| | Rehabilitation/reablement/ recovery programme recommended/commenced<br>Date: | | |
| | Most appropriate place for assessment agreed<br>Rationale/justification required if assessment takes place in acute hospital environment | | |
| | **CHC Checklist Tool if required, CHC Information Leaflet & Consent Form** | | |
| | Assessment process explained to individual and their family/carer(s)<br>Consent Form completed Yes/ No **(delete as applicable) –** if no explain why in comment box | | |
| | Preferred language for assessment identified | | |

| | | | |
|---|---|---|---|
| | Mechanisms in place to accommodate language preference e.g., Welsh speakers in MDT | | |
| | Advocacy offered | | |
| | Appropriate and proportionate MDT input determined: (tick as appropriate)<br>• The individual<br>• Nominated family member as key contact or other unpaid carer<br>• Advocate<br>• Specialist and/or community based practitioner who has regular contact<br>• Existing service provider(s) e.g., care home, domiciliary care agency, voluntary sector service<br>• Social Worker<br>• Occupational Therapist<br>• Physiotherapist<br>• Dietician<br>• Speech & Language Therapist<br>• Benefits advice<br>• Other | | |
| | Assessments completed and collated | | |
| | Formal CHC eligibility meeting arranged<br>Date:<br>Venue: | | |
| | CHC eligibility determined by MDT | | |
| | Outcome and rationale clearly recorded and communicated to individual and/or carer or advocate | | |

# APPENDIX 3 - CONTINUING NHS HEALTHCARE (CHC) CHECKLIST

## Introduction

This Checklist, although not mandatory, is a tool to help practitioners identify people who need a full assessment for Continuing NHS Healthcare (CHC), either for current or retrospective cases. Please note that referral for assessment for CHC is not an indication of the outcome of the eligibility decision. This fact should also be communicated to the individual and, where appropriate, their representative.

The Checklist is based on the Decision Support Tool for Continuing NHS Healthcare (DST). The notes to the DST and *Continuing NHS Healthcare – The* National Framework for Implementation in Wales 2021 (the 2021 Framework) will aid understanding of this tool. Practitioners who use this tool should have received suitable training.

The Checklist should be completed in line with guidance set out in the 2021 Framework. It must be completed by at least 2 practitioners, including a representative of the LA. It can be completed by a variety of health and social care practitioners, who have been trained in its use. This could include, for example: registered nurses employed by the NHS, GPs, other clinicians or LA staff such as social workers, care managers or social care assistants.

Care homes should contact the relevant CHC team to arrange for a Checklist to be completed for their residents. The intention is for the Checklist to be completed as part of the wider process of assessing or reviewing an individual's needs. Therefore, it is expected that all staff in roles where they are likely to be involved in assessing or reviewing needs should have completion of Checklists identified as part of their role and receive appropriate training.

The Practitioners completing the Checklist must establish the individual, or their representatives, language of choice prior to any assessment taking place. All written and verbal communication must be in the individual or their representatives' choice of language as set out in **Principle 7: Communicate.**

Individuals may request an assessment for CHC. In these circumstances, the organisation receiving the request should make the appropriate arrangements for a Checklist to be completed. All staff who apply the Checklist will need to be familiar with the principles of the 2021 Framework and with the DST.

## How to use the Checklist

Before applying the Checklist, it is necessary to ensure that the individual and (where appropriate) their representative understand that completing the Checklist is not an indication of the likelihood that the individual will necessarily be determined as being eligible for CHC.

The individual should be informed that the Checklist is to be completed and should have the process for completion explained to them. The individual and (where appropriate) their representative should be supported to play a full role in the process and should be given an opportunity to contribute their views about their needs. As set out in **Principle 3: No decisions about me without me.** Decisions and rationales should be transparent from the outset.

As with any examination or treatment, the individual's informed consent should be obtained before the process of completing the Checklist commences

If there is a concern that the individual may not have capacity to give their consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. Anyone who completes a Checklist should be particularly aware of the five principles of the Act:

- **A presumption of capacity:** A person must be assumed to have capacity unless it is established that they lack capacity.
- **Individuals being supported to make their own decisions:** A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- **Unwise decisions:** A person is not to be treated as unable to make a decision merely because they makes an unwise decision.
- **Best interests:** An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- **Least restrictive option:** Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

It must also be borne in mind that consideration of capacity is specific to both the decision to be made and the time when it is made – i.e., the fact that a person may be considered to lack capacity to make a particular decision should not be used as a reason to consider that they cannot make any decisions. Equally, the fact that a person was considered to lack capacity to make a specific decision on a given date should not be a reason for assuming that they lack capacity to make a similar decision on another date.

If the person lacks the mental capacity to either give or refuse consent to the use of the Checklist, a 'best interests' decision, taking the individual's previously expressed views into account, should be taken (and recorded) as to whether or not to proceed. Those making the decision should bear in mind the expectation that everyone who might meet the Checklist threshold should have this opportunity. A third party cannot give or refuse consent for an assessment of eligibility for CHC on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (Welfare) or they have been appointed a Welfare Deputy by the Court of Protection. Before making a best interest decision as to whether or not to proceed with the completion of the Checklist the assessor should be mindful of their duty to consult with appropriate third parties. This is particularly important if the decision is not to complete a Checklist.

Further information on consent and mental capacity can be found in, **Section 3** of the 2021 Framework.

## Completion of the Checklist

In an acute hospital setting, the Checklist should not be completed until the individual's needs on discharge are clear.

Please compare the descriptions of need to the needs of the individual and select level A, B or C, as appropriate, for each domain. Consider all the descriptions and select the one that most closely matches the individual. If the needs of the individual are the same or greater than anything in the A column, then

'A' should be selected. For each domain, please also give a brief reference, stating where the evidence that supports the decision can be accessed, if necessary.

Where it can reasonably be anticipated that the individual's needs are likely to increase in the next three months (e.g. because of an expected deterioration in their condition), this should be reflected in the columns selected. Where the extent of a need may appear to be less because good care and treatment is reducing the effect of a condition, the need should be recorded in the Checklist as if that care and treatment was not being provided.

A full assessment for CHC is required if there are:

- two or more domains selected in column A;
- five or more domains selected in column B, or one selected in A and four in B; or
- one domain selected in column A in one of the boxes marked with an asterisk (i.e.

those domains that carry a priority level in the DST), with any number of selections in the other two columns.

There may also be circumstances where a full assessment for CHC is considered necessary, even though the individual does not apparently meet the indicated threshold.

Whatever the outcome, assessors should record written reasons for the decision and should sign and date the Checklist. Assessors should inform the individual and/or their representative of the decision, providing a clear explanation of the basis for the decision. The individual should be given a copy of the completed Checklist. The rationale contained within the completed Checklist should give enough detail for the individual and their representative to be able to understand why the decision was made.

Individuals and their representatives should be advised that, if they disagree with the decision not to proceed to a full assessment for CHC, they may ask the Local Health Board (LHB) to reconsider it. This should include a review of the original Checklist and any new information available, and might include the completion of a second Checklist. If they remain dissatisfied they can pursue the matter through the normal complaints process.

Each LHB should have clear local processes that identify where a completed Checklist should be sent, in order for the appropriate next steps to be taken. Completed Checklists should be forwarded in accordance with these local processes.

The Equality Monitoring Form should be completed by the individual who is the subject of the Checklist. Where the individual needs support to complete the form, this should be offered by the practitioner completing the Checklist. The practitioner should forward the completed data form to the appropriate location, in accordance with the relevant LHB's processes for processing equality data.

## Checklist Record Form

| | |
|---|---|
| Date of completion of the Checklist | |
| Name | |
| Date of birth | |
| NHS number | |
| GP and practice | |

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

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

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

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

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

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

| |
|---|
| |

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

## Please highlight the outcome indicated by the Checklist:

- Referral for full assessment for Continuing NHS Healthcare is necessary ***or***

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

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

**Rationale for decision**

| |
|---|
| |

| Name of patient | Date of completion | | | |
|---|---|---|---|---|
| **Please circle statement A, B or C in each domain. AN ASTERISK placed against each category indicates a PRIORITY domain** | | | | |
| *LEVEL→ CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |
| **1 Breathing *** | Normal breathing, no issues with shortness of breath.<br>**OR**<br>Shortness of breath, which may require the use of inhalers or a nebuliser and has no impact on daily living activities.<br>**OR**<br>Episodes of breathlessness that readily respond to management and have no impact on daily living activities. | Shortness of breath, which may require the use of inhalers or a nebuliser and limit some daily living activities.<br>**OR**<br>Episodes of breathlessness that do not respond to management and limit some daily activities.<br>**OR**<br>Requires any of the following:<br>• low level oxygen therapy (24%);<br>• room air ventilators via a facial or nasal mask;<br>• other therapeutic appliances to maintain airflow where individual can still spontaneously breathe<br>e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep. | Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers.<br>**OR**<br>Breathlessness due to a condition which is not responding to therapeutic treatment and limits all daily living activities.<br>**OR**<br>A condition that requires management by a non-invasive device to both stimulate and maintain breathing (non-invasive positive airway pressure, or non-invasive ventilation) | |
| *LEVEL→ CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |

| | | | | | |
|---|---|---|---|---|---|
| **2 Nutrition** | Able to take adequate food and drink by mouth to meet all nutritional requirements.<br>**OR**<br>Needs supervision, prompting with meals, or may need feeding and/or a special diet.<br>**OR**<br>Able to take food and drink by mouth but requires additional/supplementary feeding. | Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed.<br>**OR**<br>Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a nonproblematic PEG. | Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway.<br>**OR**<br>Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR**<br>Nutritional status 'at risk' and may be associated with unintended, significant weight loss.<br>**OR**<br>Significant weight loss or gain due to an identified eating disorder.<br>**OR**<br>Problems relating to a feeding device (e.g. PEG) that require skilled assessment and review. | | **Name(s) and** |

**signature(s) of assessor(s)** **Date**

| | |
|---|---|
| | |

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

| |
|---|
| |



## CHC Checklist

| *LEVEL→ CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |
|---|---|---|---|---|
| **3 Continence** | Continent of urine and faeces.<br>**OR**<br>Continence care is routine on a day-today basis.<br>**OR**<br>Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc.<br>**AND**<br>Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation. | Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract mes and/or the management of constipation. | Continence care is problematic and requires timely and skilled intervention, beyond routine care. (for example frequent bladder wash outs, manual evacuations, frequent recatheterisation). | |
| *LEVEL→ CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |

| | | | | |
|---|---|---|---|---|
| **4 Skin Integrity** | No risk of pressure damage or skin condition.<br>**OR**<br>Risk of skin breakdown which requires preventative intervention once a day or less than daily, without which skin integrity would break down.<br>**OR**<br>Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound.<br>**OR**<br>A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment. | Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down.<br>**OR**<br>Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment.<br>**OR**<br>A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment. | Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment.<br>**OR**<br>Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is responding to treatment.<br>**OR**<br>Specialist dressing regime in place which is responding to treatment. | |

| *LEVEL→ CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |
|---|---|---|---|---|

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



| *LEVEL→ CATEGORY ↓* | **C** | **B** | **A** | **Recorded evidence to support level** |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **6 Communication** | Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.<br>**OR**<br>Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing. | Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through nonverbal signs due to familiarity with the individual. | Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them. | |

| *LEVEL→*<br>*CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **7 Psychological and Emotional Needs** | Psychological and emotional needs are not having an impact on their health and well-being.<br>**OR**<br>Mood disturbance or anxiety or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance.<br>**OR**<br>Requires prompts to motivate self towards activity and to engage in care planning, support and/or daily activities. | Mood disturbance or anxiety symptoms or periods of distress which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or wellbeing.<br>**OR**<br>Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in support, care planning and/or daily activities. | Mood disturbance or anxiety symptoms or periods of distress that have a severe impact on the individual's health and/or well-being.<br>**OR**<br>Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and daily activities. | |

| *LEVEL→ CATEGORY↓* | **C** | **B** | **A** | Recorded evidence to support level |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **8 Cognition** | No evidence of impairment, confusion or disorientation.<br>**OR**<br>Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident.<br>**OR**<br>Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment. | Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident.<br>The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration. | Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues, they are unable to do so on most issues, even with supervision, prompting or assistance.<br>The individual finds it difficult, even with supervision, prompting or assistance, to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration. | |

| *LEVEL→*<br>*CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |
|---|---|---|---|---|
| **9 Behaviour *** | No evidence of 'challenging' behaviour. **OR**<br>Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care. | 'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care. | 'Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions. | |

| *LEVEL→ CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |
|---|---|---|---|---|
| **10 Drug therapies and medication *** | Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.<br>**OR**<br>Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime.<br>**OR**<br>Mild pain that is predictable and/or is associated with certain activities of daily living; pain and other symptoms do not have an impact on the provision of care. | Requires the administration of medication (by a registered nurse, carer or care worker) due to:<br>• non-concordance or noncompliance, or<br>• type of medication (for example insulin); or<br>• route of medication (for example PEG).<br>**OR**<br>Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care. | Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of sideeffects. However, with such monitoring the condition is usually non-problematic to manage.<br>**OR**<br>Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care. | |

| *LEVEL→ CATEGORY↓* | **C** | **B** | **A** | **Recorded evidence to support level** |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **11 Altered states of consciousness** | No evidence of altered states of consciousness (ASC).<br>**OR**<br>History of ASC but effectively managed and there is a low risk of harm. | Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. | Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.<br>**OR**<br>Occasional ASCs that require skilled intervention to reduce the risk of harm. | |

| | | | | |
|---|---|---|---|---|
| **Name of patient** | | **Date of completion** | | |
| **TOTAL FROM ALL PAGES** | **C** | **B** | **A** | |
| ADDITIONAL COMMENTS | | | | |

| SIGNED AND POSITION OF SIGNATORY |
|---|
| |

## EQUALITY MONITORING FORM

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

*Please circle or highlight only one box in each category.*

| **1. SEX** | |
|---|---|
| Male | |
| Female | |
| Transgender | |

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

| * Any other, write here |
|---|

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

## 4. DISABILITY

| Do you have a disability, as defined by the *Equality Act 2010?* | The Equality Act defines a person with a disability as someone who 'A physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities. https://www.gov.uk/definition-of-disability-under-equality-actHttps://www.gov.uk/definition-of-disability-under-equality-act-20102010 |
|---|---|

| Yes | No |
|---|---|
| | |

## 5. ETHNIC GROUP –

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

| White | | Mixed | | Asian *or* Asian British | | Black *or* Black British | | Chinese or other group | |
|---|---|---|---|---|---|---|---|---|---|
| British | | White and Black Caribbean | | Indian | | Caribbean | | Chinese | |
| Irish | | White and Black African | | Pakistani | | African | | Other* | |
| Other* | | White and Asian | | Banglades hi | | Other* | | | |
| | | Other* | | Other* | | | | | |

* Any other, write here

## 6. RELIGION

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

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

| Christian | Buddhist | Hindu | Jewish | Muslim | Sikh |
|---|---|---|---|---|---|
| | | | | | |

Any other, write here

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

## Fast Track Assessment

**Appendix 4** September 2023

**For the Terminal Phase of Palliative Care**

| **Please identify the level of assessment below to enable the NHS Long Term Care Team to prioritise urgent cases.** | **Please indicate** |
|---|---|
| **1. End of Life Care Pathway (48-72 hours)**<br><br>Please submit a copy of the completed **Care Decisions for the last days of life document** together with<br><br>a complex care plan request **or** submit a **Fast Track Assessment** (completing all sections of pages 1-9 only) if an individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase and has a **life expectancy of between 48–72 hours.** | |
| **2. Less that 7 days Life Expectancy**<br><br>Please complete all sections of pages **1-9 only** of this **Fast Track assessment** if an individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase and has a life expectancy of **seven days or less**. | |
| **3. All Other Individuals Entering a Terminal Phase**<br><br>Please complete all sections of the **Fast Track assessment** if an individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase. | |

Please forward completed assessment to:

| | |
|---|---|
| NHS Long Term Care Team | Email to<br><br>NHS.LongTermCare@wales.nhs.uk |

## Statement of Consent

In accordance with Section 3 of The Continuing NHS Healthcare National Framework for Implementation in Wales, informed consent should be obtained before the start of the assessment process to determine eligibility for Continuing NHS Healthcare funding (CHC). Consent should encompass:

- Permission to undertake the CHC assessment and subsequent reviews as stated in framework guidelines.
- Sharing and processing of relevant personal information (both in the assessment process and for audit and monitoring purposes. This information may also be shared with other professionals as part of the multi-disciplinary process)

The Mental Capacity Act 2005 states a person has capacity unless proved otherwise

Name: _____ NHS number:_____

DOB: _____

Address:_____

Please complete questions below

1. Has the individual been provided with a copy of the Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers? Yes/No

2. Are there any doubts regarding the individual's ability to consent to the Continuing NHS Health Care Process? Yes/ No

3. Have practicable steps been taken to support the individual to make a decision and if yes what were these? Yes/No

4. Is the individual's ability to make a decision likely to return or considered a temporary loss? Yes/ No

5. Following an assessment of capacity is the person able to consent to the process? Yes/No

Any concerns/comments:_____

If able to consent please ask individual to sign Statement 1.

If deemed to lack capacity and individual has representation, please proceed to statement 2.

If deemed to lack capacity and individual does not have representation proceed to statement 3.

2) Please confirm if the individual has an appointed Lasting Power of Attorney (LPA) for Health and Welfare / Finance and property or Court Appointed Representative, or Independent Mental Capacity Advocate?

Please specify: _____

*Care Coordinator confirms that they have had sight of a certified copy of the original Deputyship Order or registered LPA and confirmed person has relevant authority stated* Y/N

Statement of representative:

I confirm that the reason for the assessment and submission has been explained to me, I have received the Continuing NHS Health care for Adults in Wales Public information leaflet and the sharing and processing of information to relevant organisations involved for the purpose of the assessment and where appropriate audit and monitoring of decisions has been explained.

I am / am not in agreement that the submission should be made for consideration.

Name of Representative: _____

Signature of Representative: _____

Date:_____

Name of Lead Health Professional: _____

Signature of Lead Health Professional: _____

Date:_____

3) If there is no nominated individual a Best Interests discussion will need to take place which should include the views of relevant third-party members including family, friends and advocates where reasonable and practicable. Overall responsibility for the decision is with the decision maker and those consulted do not have authority to consent or refuse consent.

I can confirm that the multi professional team involved in the care, assessment and submission of the identified individual are satisfied that the application is in the individual's best interest. This decision has been made in consultation with the individuals NOK/Family:

Name of Lead Health Professional: _____

Signature of Lead Health Processional: _____

Date:_____

Does person want relatives informed of assessment/condition/treatment? Yes / No

If yes, person authorised to receive information:

Name: Relationship:

Name: Relationship:

Signature of person Date

Name of Person

Name and Address Mr / Mrs / Miss / Ms / Other:

Wishes to be called:

DOB: Age:

Tel No.:

Mobile No.:

Sex: Male / Female

NHS Number

Marital Status: Single/Married/Partner/Civil Partner/Divorced/Separated/Widow/ Widower

GP Surgery: GP Practice Name:

Tel No:

Is patient currently in hospital? Yes / No

If No, where is the patient currently? Please give the address where care will be delivered. State if this is at address above, home, nursing home or other location:

**Assessment Co-ordinator:**

Name: Designation:

Address:

Tel No: Bleep:

Email:

Alternative contact:

Date of Assessment:

**Contacts:**

Name: Relationship:

NOK / Emergency Contact / Main Carer

Address:

Tel No: Mobile No:

**Patient's/Individual's Perspective:** Include wishes, preferences, beliefs, values and spirituality.

Has prognosis been discussed with the patient? Yes / No

Has individual an Advance Decision/Advanced Statement/Living Will? Yes / No

If Yes, evidence will be required.

Is there a Lasting Power of Attorney for personal welfare/Deputy/IMCA? Yes / No

If Yes, appropriate paperwork or registration details will be required.

**Family/Carer's Perspective:**

Has prognosis been discussed with the relative / NOK / main carer? Yes / No

Has a carer's assessment been offered & completed &/or declined?

What assistance has the family stated they will provide?

What support is required to support them in their role as carer?



**Medical Opinion:** This section must be completed by the relevant Doctor

Primary Health Need Approach

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

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

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

- Unpredictability: This describes the degree to which needs fluctuate, creating challenges in managing them. It also relates to the level of risk to the individual's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, or unstable or rapidly deteriorating condition. Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered when completing the DST

| Diagnosis**:** |
| --- |
| |

| Prognosis: |
| --- |
| |

| |
|---|
| |
| Treatment: |
| **Is there a Do Not Attempt Resuscitation (DNAR) Order? Yes / No**<br><br>**If yes, for our records please attach a copy to this assessment.** |
| Summary of Medical Opinion: **Please tick appropriate box** |

| | |
|---|---|
| The individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase and is on the End of Life Priorities (48 – 72 hours) | |
| The individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase and has a life expectancy of less the 7 days. | |
| The individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase | |

Has the patient's GP been informed of prognosis and discharge? Yes / No

**Name:**

**Signature:**

**Designation:** **Date:**

**List Medication & Route:** e.g. morphine through syringe driver, I.M. oral medication etc.

**Risks:** please list whether there are safeguarding issues, or any health and safety risks to individual and others.

**Equipment Required:** please list whether there is a need to commission a hoist, hospital bed, airflow mattress etc.

Can this be obtained from Equipment Store? Yes / No

Has this been ordered? Yes / No

When is delivery expected?

**Total Care Package Required:**

**Care Co-ordinator in the Community Details:**

Name: Designation:

Tel. No: Email:

Base:

Base Tel. No:

Involved in MDT / Discharge Planning? Yes / No

## Assessment of Needs

**1. Breathing**:

| Description | Level of need |
|---|---|

| | |
|---|---|
| | |
| Normal breathing, no issues with shortness of breath. | No needs |
| Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities. | Low |
| Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities.<br>**OR**<br>Episodes of breathlessness that do not respond to management and limit some daily living activities.<br>**OR**<br>Requires any of the following:<br>• low level oxygen therapy (24%).<br>• room air ventilators via a facial or nasal mask.<br>• other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep. | Moderate |
| Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to treatment and limits all daily living activities. | High |
| Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway.<br>**OR**<br>Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy<br>**OR**<br>A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bi-level positive airway pressure, or non-invasive ventilation) | Severe |
| Unable to breathe independently, requires invasive mechanical ventilation. | Priority |
| **Please provide brief details** | |

*2. Nutrition*

| **Description** | **Level of need** |
|---|---|
| | |

| | |
|---|---|
| Able to take adequate food and drink by mouth to meet all nutritional requirements. | No needs |
| Needs supervision, prompting with meals, or may need feeding and/or a special diet.<br>**OR**<br>Able to take food and drink by mouth but additional risk assessment indicates additional/supplementary feeding is required. | Low |
| Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed.<br>**OR**<br>Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG. | Moderate |
| Requires skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway.<br>**OR**<br>Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR**<br>Nutritional status "at risk" and may be associated with unintended, significant weight loss.<br>**OR**<br>Problems relating to a feeding device (for example PEG) that require skilled assessment and review. | High |
| Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled competent intervention and clinical decision making over a 24 hour period to ensure nutrition/hydration, for example I.V. fluids.<br>**OR**<br>Unable to take food and drink by mouth, intervention inappropriate or impossible. | Severe |

Please provide brief details

*3. Continence*

| **Description** | **Level of need** |
|---|---|
| | |

| | |
|---|---|
| Continent of urine and faeces. | No needs |
| Continence care is routine on a day-to-day basis;<br>Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc.<br>**AND**<br>is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation. | Low |
| Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation. | Moderate |
| Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation). | High |

Please provide brief details



## 4. Skin Integrity

| Description | Level of need |
|---|---|
| No risk of pressure damage or skin condition. | No needs |

| | |
|---|---|
| Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down.<br><br>**OR**<br>Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound(s).<br><br>**OR**<br>A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment. | Low |
| Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down.<br><br>**OR**<br>Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment.<br><br>**OR**<br>An identified skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment. | Moderate |
| Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment<br><br>**OR**<br>Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is/are responding to treatment.<br><br>**OR**<br>Specialist dressing regime in place; responding to treatment | High |
| Open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule' which are not responding to treatment and require regular monitoring/reassessment. **OR**<br><br>Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule.<br><br>**OR** Multiple wounds which are not responding to treatment. | Severe |

Please provide brief details

*5. Mobility*

| Description | Level of need |
|---|---|
| Independently mobile | No needs |
| Able to weight bear but needs some assistance and/or requires mobility equipment for daily living. | Low |
| Not able to consistently weight bear.<br>**OR**<br>Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning.<br>**OR**<br>In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers.<br>**OR**<br>At moderate risk of falls (as evidenced in a falls history or risk assessment) | Moderate |
| Completely unable to bear weight and is unable to assist or cooperate with transfers and/or repositioning.<br>**OR**<br>Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate.<br>**OR**<br>At a high risk of falls (as evidenced in a recent falls history and risk assessment).<br>**OR**<br>Involuntary spasms or contractures placing the individual or others at risk. | High |
| Has a clinical condition such that, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical. | Severe |

Please provide brief details

## 6. Communication

| Description | Level of need |
|---|---|
| Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language. | No needs |
| Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing. | Low |
| Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual. | Moderate |
| Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The individual has to have most of their needs anticipated because of their inability to communicate them. | High |

Please provide brief details

*7. Psychological and Emotional* Needs

| Description | Level of need |
|---|---|
| Psychological and emotional needs are not having an impact on their health and well-being. | No needs |
| Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts, distraction and/or reassurance.<br>**OR**<br>Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities. | Low |
| Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or well-being.<br>**OR**<br>Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities. | Moderate |
| Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being.<br>**OR**<br>Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities. | High |

Please provide brief details

*8. Cognition*

| Description | Level of need |
|---|---|
| No evidence of impairment, confusion or disorientation. | No needs |
| Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident.<br>**OR**<br>Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment. | Low |
| Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration. | Moderate |
| Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues they are unable to consistently do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration. | High |
| Cognitive impairment that may, for example, include, marked short-term memory issues, problems with long-term memory or severe disorientation to time, place or individual.<br>The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration. | Severe |

Please provide brief details

## 9. Behaviour

| Description | Level of need |
|---|---|
| No evidence of 'challenging' behaviour. | No needs |
| Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The individual is compliant with all aspects of their care. | Low |
| 'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The individual is nearly always compliant with care. | Moderate |
| 'Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions. | High |
| 'Challenging' behaviour of severity and/or frequency that poses a significant risk to self, others or property. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions. | Severe |
| 'Challenging' behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care. | Priority |

Please provide brief details

## 10. Drug Therapies and Medication

| Description | Level of need |
|---|---|
| Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects. | No needs |
| Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care. | Low |
| Requires the administration of medication (by a registered nurse, carer or care worker) due to:<br>Non-concordance or non-compliance of medication, or type of medication (for example insulin), or route of medication (for example PEG).<br>**OR**<br>Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care. | Moderate |
| Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually nonproblematic to manage.<br>**OR**<br>Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care. | High |
| Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is usually problematic to manage. **OR** Severe recurrent or constant pain which is not responding to treatment. **OR** Risk of non-concordance with medication, placing them at risk of relapse | Severe |
| Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition **OR** Unremitting and overwhelming pain despite all efforts to control pain effectively. | Priority |

Please provide brief details

## 11. Altered States of Consciousness (ASC)

| Description | Level of need |
|---|---|
| No evidence of altered states of consciousness (ASC). | No needs |
| History of ASC but it is effectively managed and there is a low risk of harm. | Low |
| Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. | Moderate |
| Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.<br>**OR**<br>Occasional ASCs that require skilled intervention to reduce the risk of harm. | High |
| Coma.<br>**OR**<br>ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm. | Priority |

Please provide brief details

*Other significant care needs*

| Description | Level of need |
|---|---|
| | Low |
| | Moderate |
| | High |
| | Severe |

**MDT Recommendation in regard to a Primary Health Need (Please consider the four key indicators)**



Date of MDT if applicable:

List who was present / involved in the MDT:

Appendix 5

**HYWEL DDA UNIVERSITY HEALTH BOARD LTC NURSING NEEDS ASSESSMENT**

| **BASIC PERSONAL INFORMATION for NURSING NEEDS ASSESSMENT** | |
|---|---|
| **NAME OF RESIDENT:** | **KNOWN AS:** |
| **DATE OF BIRTH** | |
| **PREVIOUS ADDRESS:** (include postcode) | **NAME OF CARE HOME:**<br><br>**DATE OF ADMISSION:** |
| **MAIN CONTACT / NEXT OF KIN**:<br><br>Name:<br>Address: (including postcode)<br><br>Telephone No:<br>Relationship: | **EMERGENCY CONTACT / OTHER CONTACTS / POA** (If Required)<br>Name:<br>Address:<br><br>Telephone No: |

| | |
|---|---|
| | Relationship to individual: |
| **CONTACT DETAILS WHERE INDIVIDUAL WOULD LIKE CORRESPONDANCE SENT TO (Including telephone contact)** | Name:<br>Address: (including postcode)<br><br>Telephone No:<br>Relationship: |

| |
|---|
| **ADMISSION HISTORY**: |
| **SERVICE USERS' PERSPECTIVE**: |
| **CARERS PERSPECTIVE:** |
| **SOCIAL HISTORY**: |

| | |
|---|---|
| **NAME OF CARE HOME REGISTERED NURSE INVOLVED IN THE ASSESSMENT:** | |
| **INFORMATION SOURCES**: | Able to Consent: Yes / No |

| | |
|---|---|
| Nursing notes: Yes/No | NOK/Representative: Yes/No |
| GP notes: Yes/No | Prescription Chart: Yes/No |
| Nursing Staff/ Care Staff: Yes/No | Hospital Notes: Yes/No |

**NAME AND ADDRESS OF GP**

**PROFESSIONALS INVOLVED IN CARE**

- Social Worker:
- CPN:
- Speech & Language Therapist:
- Dietician:
- Specialist Nurse:
- Physiotherapist / Occupational Therapist:
- Other:

**MEDICAL/NURSING HISTORY**:

**LATEST HOSPITAL ADMISSIONS**:

**GP/OTHER DISCIPLINE VISITS**:

**BREATHING**

Is there a care plan in place - yes / no

Is the care plan appropriate - yes / no

**NUTRITION – FOOD AND DRINK**

Height –

Weight –

BMI -

Home Nutritional Risk Score -

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

**ORAL CARE**

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

**CONTINENCE**

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

**SKIN (INCLUDING TISSUE VIABILITY)**

Home risk assessment score –

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

**MOBILITY:**

Falls risk score -at risk

Is there a care plan in place – yes/no

Is the care plan appropriate - yes/ no

Has the individual suffered a fall since the admission? (if yes please give details below)

| **Date and time of fall** | **Description** | **Were Physical Observations Completed** | **Accident book completed**<br>**(delete as appropriate)** |
|---|---|---|---|
| | | Yes / No | Yes / No |
| | | Yes / No | Yes / No |
| | | Yes / No | Yes / No |
| | | Yes / No | Yes / No |

**COMMUNICATION:**

Is there a care plan in place – yes/ no

Is the care plan appropriate - yes/ no

**MENTAL HEALTH (PSYCHOLOGICAL AND EMOTIONALNEEDS)**

Is the individual subject to the 1983 mental health act –

Is a referral to the CMHT indicated? - yes / no

Is there a care plan in place - yes/ no

Is the care plan appropriate – yes/ no

**COGNITION**

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

**DoLS**

| | | |
|---|---|---|
| DoLS Authorisation in Place from hospital or previous setting – yes/no | DoLS Renewal Date - | DoLS Referral Made – yes/no |
| DoLS Referral Date - | Reason to believe person lacks capacity – yes/no<br>(*see Cognition above*) | Care Home/Provider informed of potential need for DoLS Referral – yes/no |
| **Comments** | | |

Is there a care plan in place - yes / no

Is the care plan appropriate - yes / no

**BEHAVIOUR**

Is a referral to the CMHT indicated? yes / no

Is there a care plan in place - yes / no

Is the care plan appropriate - yes / no

**DRUG THERAPIES AND MEDICATION (Including pain / symptom control)**

**Able to self medicate:** yes / no

**Compliant with medication:** yes / no (if not give details)

**Allergies:**

| Medication | Dose | Frequency | Comments |
|---|---|---|---|
| | | | |
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Is a pain tool being used? (Please provide details)

Is there a care plan in place - yes / no

Is the care plan appropriate - yes / no

**PERSONAL CARE**

| |
|---|
| Is there a care plan in place - yes / no<br>Is the care plan appropriate - yes / no |
| **ALTERED STATE OF CONSCIOUSNESS (ASC)**<br><br>Is there a care plan in place - yes / no<br>Is the care plan appropriate - yes / no |
| **OTHER SIGNIFICANT CARE NEEDS** (e.g. Parkinson's disease, epilepsy, rapid deterioration)<br><br>Is there a care plan in place - yes / no<br>Is the care plan appropriate - yes / no |
| **FREESPACE** |

| **Unpaid carers information** | |
|---|---|
| Are you an unpaid carer? | Would you like further information? Yes/No |

| **Dates of previous assessments in last 12 months** | |
|---|---|

| | |
|---|---|



| **COMPLETE THE 4 KEY INDICATORS OF THE INDIVIDUALS CARE NEEDS** |
|---|

**NATURE**

**INTENSITY**

**COMPLEXITY**

**UNPREDICTABILITY**

**NAME OF LONG TERM CARE SPECIALIST NURSE**:

**DATE OF COMPLETION:**

**SIGNATURE**:

Assessment Reviewed by: Long Term Care Specialist Nurse Team Leader

(Division)

**ISSUES IDENTIFIED**:

**Details:**

*Please provide full details of the issue raised, including dates where necessary and name of service user(s) affected, if applicable*

Name and Position of Individual (s) issues discussed with:

Date of Discussion:

Summary of Discussion:

**Plan**

**Issues identified at assessment**

| | | |
|---|---|---|
| Discussed with home manager | Yes / No | Date |
| Issues emailed to home | Yes / No | Date |
| Issues emailed to CIW | Yes / No | Date |
| Issues copied into care home folder | Yes / No | Date |

**Safeguarding**

| | | |
|---|---|---|
| Safeguarding issues identified at assessment | Yes / No | |
| Referral made | Yes / No | Date |

**Pressure Damage**

| | | |
|---|---|---|
| Pressure damage noted at assessment | Yes / No | |
| Datix completed | Yes / No | Date |



## OUTCOME OF ASSESSMENT

| | |
|---|---|
| **Eligible for NHS Funded Nursing Care** | |

| | |
|---|---|
| | |
| **No Nursing needs identified which are unable to be managed by Community services – no longer eligible for NHS Funded Nursing Care** | |
| **Multidisciplinary Team meeting to be arranged to consider Continuing NHS Healthcare eligibility** | |
| **Continues to meet eligibility for Continuing NHS Healthcare** | |
| **Remains subject to Section 117** | |
| **Remains eligible for a joint Health and Social Care package** | |

| | |
|---|---|
| **Date of next Assessment /Review** | |

**Copies to (delete as appropriate)**

Social Services Yes

File Yes

If you have any questions or comments regarding the outcome of this assessment, please do not hesitate to contact at:



## BASIC PERSONAL INFORMATION for NURSING NEEDS ASSESSMENT

| | |
|---|---|
| **NAME OF INDIVIDUAL:** | **KNOWN AS:** |
| **DATE OF BIRTH** | |
| **ADDRESS:** (include postcode) | **MAIN CONTACT / NEXT OF KIN**:<br><br>Name:<br>Address: (including postcode)<br><br>Telephone No:<br>Relationship: |
| **Name of Care Coordinator** | |
| **Contact Details of Care Coordinator** | |



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

## Appendix 6

### HYWEL DDA UNIVERSITY HEALTH BOARD COMMUNITY NURSING NEEDS ASSESSMENT

| BASIC PERSONAL INFORMATION for NURSING NEEDS ASSESSMENT | |
|---|---|
| **NAME OF INDIVIDUAL:** | **KNOWN AS:** |
| **ADDRESS:** (include postcode) | **MAIN CONTACT / NEXT OF KIN**:<br><br>Name:<br>Address: (including postcode)<br><br>Telephone No:<br>Relationship: |
| **Name of Care Coordinator** | |
| **Contact Details of Care Coordinator** | |
| **Unpaid carers information** | |
| Are you an unpaid carer? Yes/No | Would you like further information? Yes/No |

| | |
|---|---|
| **Dates of previous assessments in last 12 months** | |

**SOCIAL HISTORY**:

| | |
|---|---|
| **INFORMATION SOURCES**: | Individual: Yes / No |
| District Nursing notes: Yes/No | NOK/Representative: Yes/No |
| GP notes: Yes/No | Prescription Chart: Yes/No |
| Care Staff: Yes/No | Hospital Notes: Yes/No |

**NAME AND CONTACT DETAILS OF GP**

**NAME OF PROFESSIONALS INVOLVED IN CARE**

- Social Worker:
- CPN:
- Speech & Language Therapist:
- Dietician:
- Specialist Nurse:
- Physiotherapist / Occupational Therapist:
- Other:

**MEDICAL/NURSING HISTORY**:

| |
|---|
| |
| **LATEST HOSPITAL ADMISSIONS**: |
| **GP/OTHER DISCIPLINE VISITS**: |

**BREATHING**

**NUTRITION – FOOD AND DRINK**

Height -

Weight -

BMI -

**ORAL CARE**

**CONTINENCE**

| |
|---|
| **SKIN (INCLUDING TISSUE VIABILITY)** |
| **MOBILITY:** |
| **COMMUNICATION:** |

**MENTAL HEALTH (PSYCHOLOGICAL AND EMOTIONALNEEDS)**

Is the individual experiencing any signs or symptoms of low mood? If yes, has the individual been informed to contact their GP or consented to referral to GP?

Is the individual subject to the 1983 Mental Health Act - (if YES please specify which section)

Is a referral to the CMHT indicated? - yes / no (if Yes liaise with GP)

**COGNITION**

**BEHAVIOUR**

Is a referral to the CMHT indicated? yes / no (if yes liaise with GP)

**DRUG THERAPIES AND MEDICATION (Including pain / symptom control)**

**Able to self medicate:** yes / no

**Compliant with medication:** yes / no (if not give details )

**Allergies:**

| Medication | Dose | Frequency | Comments |
|---|---|---|---|
| | | | |
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| | | | | |

**PERSONAL CARE**

**ALTERED STATE OF CONSCIOUSNESS (ASC)**

**OTHER SIGNIFICANT CARE NEEDS** (e.g. Parkinson's disease, epilepsy, rapid deterioration)

**LIST OF EQUIPMENT IN PLACE**

| Equipment | Requires Electricity? | Battery Back Up? |
|---|---|---|
| | Yes/No | Yes/No |
| | Yes/No | Yes/No |
| | Yes/No | Yes/No |
| | Yes/No | Yes/No |
| | Yes/No | Yes/No |
| | Yes/No | Yes/No |
| | Yes/No | Yes/No |

| | |
|---|---|
| Registered on Energy Suppliers Priority Services Register? | Yes/No |
| Registered on Network Operators Priority Services Register? | Yes/No |

**CONTIGENCY PLAN IN THE EVENT OF CARER BREAK DOWN/INCLEMENT WEATHER/DETERIORATION IN CONDITION**

| |
|---|
| **PREFERRED PLACE OF CARE TO INCLUDE END OF LIFE CARE** |
| **WHAT IS CURRENT CARE PACKAGE (name of agency / time and length of calls)** |
| **INFORMAL CARE SUPPORT (Family /Friends/Neighbours etc)** |
| **IS CURRENT CARE PACKAGE APPROPRIATE TO MEET NEEDS (If not recommend appropriate care package)** |

**COMPLETE THE 4 KEY INDICATORS OF THE INDIVIDUALS CARE NEEDS**

**NATURE**

**INTENSITY**

**COMPLEXITY**

**UNPREDICTABILITY**

**NAME OF PROFESSIONAL COMPLETING REVIEW**:

**DESIGNATION**

**DATE OF COMPLETION:**

**SIGNATURE**:

## PLEASE IDENTIFY OUTCOME OF ASSESSMENT

| | |
|---|---|
| **Multidisciplinary Team meeting to be arranged to consider Continuing NHS Healthcare eligibility** | |
| **Continues to meet eligibility for Continuing NHS Healthcare** | |
| **Remains eligible for a joint Health and Social Care package** | |
| | |

For Long Term Care use Only:

Assessment Reviewed by:

Name:

Designation:

Signature:

Date:

Appendix 7

## Impact Assessment and Contingency Plan

| | |
|---|---|
| **NAME OF INDIVIDUAL:** | **KNOWN AS:** |
| **ADDRESS:** (include postcode) | **MAIN CONTACT / NEXT OF KIN**:<br><br>Name:<br>Address: (including postcode)<br><br><br>Telephone No:<br>Relationship: |
| **Name of Care Coordinator** | |
| **Contact Details of Care Coordinator** | |

| | |
|---|---|
| **Current Care Provider and Package** | |

**Assessment of Critical Functions**

| | |
|---|---|
| **Minimum level of service?** | *The minimum level of service is the basic function which needs to be delivered.* |
| **Is there any specific training requirement?**<br><br>**How long would training / competencies of new staff / carers take?** | *I.e. suctioning, PEG etc.* |
| **What is the maximum amount of time that formal care could remain undelivered?** | *Please specify number of hours, days, weeks etc.* |
| **Is care provision critical at specific times?** | *Please specify time/day etc.* |

**Contingency Plan**

| | |
|---|---|
| **1. If formal care package was unable to provide care, could the individual remain in the community** | *Please specify what informal support the individual would have (if no please refer to Q2)* |
| **2. What contingency plan has been discussed with the individual?** | *Please note the option of remaining in the community may not be an option in the event of care / carer breakdown*<br><br>*Please consider Short term placement in a Nursing home and possible options (if this is not a sustainable option please refer to Q3)* |
| **3. Is Hospital admission required?** | *Please specify why the above options would not be appropriate* |



**Risk Scoring – Likelihood x Impact = Risk Rating**

| Likelihood Score | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost Certain** |
| Frequency - How often might it/does it happen?<br>(*how many times will the adverse consequence being assessed actually be realised?)* | This will probably never happen/recur (except in very exceptional circumstances).<br>Not expected to occur for years.* | Do not expect it to happen/recur but it is possible that it may do so.<br>Expected to occur at least annually.* | It might happen or recur occasionally.<br>Expected to occur at least monthly.* | It might happen or recur occasionally.<br>Expected to occur at least monthly.* | It will undoubtedly happen/recur, possibly frequently.<br>Expected to occur at least daily.* |
| * time-framed descriptors of frequency | | | | | |
| Probability - Will it happen or not?<br>*(what is the chance the adverse consequence will occur in a given reference period?)* | (0-5%*) | (5-25%*) | (25-75%*) | (75-95%*) | (>95%*) |
| *used to assign a probability score for risks related to time-limited or one off projects or business objectives. | | | | | |

## Risk Impact (Domains)

| Domains | Negligible - 1 | Minor - 2 | Moderate - 3 | Major - 4 | Catastrophic - 5 |
|---|---|---|---|---|---|
| **Safety of Patients, Staff or Public** | Minimal injury requiring no/minimal intervention or treatment.<br><br>No time off work. | Minor injury or illness, requiring minor intervention.<br><br>Requiring time off work for >3 days<br><br>Increase in length of hospital stay by 1-3 days. | Moderate injury requiring professional intervention.<br><br>Requiring time off work for 4-14 days.<br><br>Increase in length of hospital stay by 4-15 days.<br><br>Agency reportable incident.<br><br>An event which impacts on a small number of patients. | Major injury leading to long-term incapacity/disability.<br><br>Requiring time off work for >14 days.<br><br>Increase in length of hospital stay by >15 days.<br><br>Mismanagement of patient care with long-term effects. | Incident leading to death.<br><br>Multiple permanent injuries or irreversible health effects.<br><br>An event which impacts on a large number of patients. |
| **Quality, Complaints or Audit** | Peripheral element of treatment or service suboptimal.<br><br>Informal complaint/inquiry. | Overall treatment or service suboptimal.<br><br>Formal complaint.<br><br>Local resolution.<br><br>Single failure to meet internal standards.<br><br>Minor implications for patient safety if unresolved.<br><br>Reduced performance if unresolved. | Treatment or service has significantly reduced effectiveness.<br><br>Formal complaint -<br><br>Escalation.<br><br>Repeated failure to meet internal standards.<br><br>Major patient safety implications if findings are not acted on. | Non-compliance with national standards with significant risk to patients if unresolved.<br><br>Multiple complaints/ independent review.<br><br>Low achievement of performance/delivery requirements.<br><br>Critical report. | Totally unacceptable level or quality of treatment/service.<br><br>Gross failure of patient safety if findings not acted on.<br><br>Inquest/ombudsman inquiry.<br><br>Gross failure to meet national standards / performance requirements. |

| RISK MATRIX | | | | | |
|---|---|---|---|---|---|
| | LIKELIHOOD → | | | | |
| IMPACT ↓ | RARE 1 | UNLIKELY 2 | POSSIBLE 3 | LIKELY 4 | ALMOST CERTAIN 5 |
| CATASTROPHIC 5 | 5 | 10 | 15 | 20 | 25 |
| MAJOR 4 | 4 | 8 | 12 | 16 | 20 |
| MODERATE 3 | 3 | 6 | 9 | 12 | 15 |
| MINOR 2 | 2 | 4 | 6 | 8 | 10 |
| RARE 1 | 1 | 2 | 3 | 4 | 5 |

| Risk Scored | Action Timetable - Frequency of review |
|---|---|
| 15-25 | Action plan should include immediate action to reduce the risk. Reviewed by Directorate level Group at every meeting. |
| 8-12 | Action plan should include urgent action to reduce the risk. Reviewed by Directorate level Group at every meeting. |
| 4-6 | Service/Department manager to monitor risk and deliver action plan.<br>Monitored by Directorate at least 6 monthly. |
| 1-3 | Service/Department manager to monitor risk and deliver action plan.Reviewed by manager, at least quarterly & local review group level, e.g. service team meeting. Monitored by Directorate at least 6-12 monthly. |

Appendix 8


## Transition Pathway Referral Form from Children Services to Adult Continuing NHS Healthcare

### Personal Details:

| | |
|---|---|
| Name | |
| D.O.B | |
| Home Address | |
| Legal Guardian Name | |

### Referral Details:

| | |
|---|---|
| Transition Coordinator | |
| Service | |
| Referral Date | |
| Current Location | |
| Diagnosis | |
| Reason for Referral | |
| **PROFESSIONALS INVOLVED IN CARE** | |
| **MEDICAL HISTORY**: | |

| | |
|---|---|
| Is this person a looked after child | Yes / No |
| If yes please indicate placing authority | |

| Date Placed | |
|---|---|

**Identified Needs**

| |
|---|
| **BREATHING** |
| **NUTRITION – FOOD AND DRINK** |
| **CONTINENCE** |
| **SKIN (INCLUDING TISSUE VIABILITY)** |
| **MOBILITY:** |
| **COMMUNICATION:** |
| **PSYCHOLOGICAL AND EMOTIONALNEEDS** |
| **COGNITION** |
| **BEHAVIOUR** |
| **DRUG THERAPIES AND MEDICATION (Including pain / symptom control)** |

**Compliant with medication:** yes / no (if not give details)

**Allergies:**

| Medication | Dose | Frequency / Route | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**ALTERED STATE OF CONSCIOUSNESS (ASC)**

**OTHER SIGNIFICANT HEALTH CARE NEEDS**

**ARE NEEDS LIKELY TO CHANGE IN THE NEXT 12 MONTHS YES / NO**

**IF YES PLEASE PROVIDE REASON**

| | |
|---|---|
| **Name of referrer** | |
| **Designation** | |
| **Signature** | |
| **Contact Details** | |
| **Date** | |



For Shared Patient Pathway to complete (LTC & MH/LD Commissioning)

| | |
|---|---|
| Date referral received | |
| Date of SPP | |
| Outcome of SPP | |
| Initial Pathway identified | LTC ☐<br>MH ☐<br>LD ☐ |
| Transition Nurse informed | |



Appendix 9

**NHS Long Term Care Discharge to Assess Pathway Referral Form (D2A) for individuals who have the requirement for 24hr Nursing Care**

| | |
|---|---|
| **Date of Referral** | |
| **Name of Patient** | |
| **DOB** | |
| **NHS Number** | |
| **Date of Admission** | |
| **Hospital / Ward** | |
| **Name of Referrer** | |
| **Speciality** | |
| **Email Address** | |

| | Yes | No |
|---|---|---|
| Confirmation Patient / NOK / representative is aware of referral to Long Term Care | ☐ | ☐ |
| **Is there reason to doubt Mental Capacity to make decisions regarding care and residency. Copy of MCA to be provided if applicable** | ☐ | ☐ |
| **Is a best interest meeting required. Copy of BIM to be provided if applicable** | ☐ | ☐ |
| **Known discharge plan:** | | |
| **Out of county placement – Y/N** | ☐ | ☐ |
| **Care Home Placement – Y/N** | ☐ | ☐ |
| **Package of Care in own Home – Y/N** | ☐ | ☐ |

| **Reason for Referral with Identification of needs** |
|---|
| |

On receipt of this **COMPLETED** referral form, a return email will be sent from Long Term Care acknowledging the referral form has been accepted .**Failure to provide all required information will result in it being returned which will delay the process.** Please complete and return to: NHS.LongTermCare@wales.nhs.u

References and Links

Continuing NHS Health Care (gov.wales)

Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)

Written Statement - Developing a Strategic Framework for Welsh Language Services in Health and Social Services (9 March 2011) | GOV.WALES

Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers (gov.wales)

Responsible Authority Guidance (gov.wales)

Who-Pays-final-24082020-v2.pdf (england.nhs.uk)

NHS Wales complaints and concerns: Putting Things Right | GOV.WALES

Safeguarding (sharepoint.com)

**Hywel Dda University Health Board**
**Equality Impact Assessment (EqIA)**

**Please note:**

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:

Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

**Form 1: Overview**

| | | |
|---|---|---|
| **1.** | **What are you Equality Impact assessing?** | Long Term Care Operational Policy |
| **2.** | **Brief Aims and Description** | The aim of this document is to :<br>• Ensure standardised procedures are followed across the Health Board in line with the CHC Framework<br>• The service provision runs smoothly and efficiently<br>• Education and training of staff groups is maintained<br>• The audit and MDT processes are maintained<br>• Ensuring pathways are robust and managed in line with the CHC Framework<br>• Providing standardised processes for the service to follow |
| **3.** | **Who is involved in undertaking this EqIA?** | Tracy Devantier Performance and Service Improvement Manager |
| **4.** | **Is the Policy related to other policies/areas of work?** | No |
| **5.** | **Who will be affected by the strategy / policy / plan / procedure / service?**<br>(Consider staff as well as the population that the project / change may affect to different degrees) | Long Term Care nursing and administration team. Independent contractors that run the Nursing Care homes.<br>Local authority Teams and other third parties<br>All managers non clinical and Clinical as well as corporate services in the Health board. |
| **6.** | **What might help/hinder the success of the Policy?** | Implementing the operational Policy will ensure that we as a service are adhering to the National Framework as we have based this policy around this framework. What will hinder this policy is external influences outside of our control such as what happens in the Local Health Authorities. |

**Form 2: Human Rights**

**Human Rights**: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

| **Consider, is the Policy relevant to:** | **Yes** | **No** |
|---|---|---|
| **Article 2: The right to life**<br><br>**Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control | Yes | |
| **Article 3: The right not to be tortured or treated in an inhuman or degrading way**<br><br>**Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control | Yes | |
| **Article 5: The right to liberty**<br><br>**Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control | Yes | |
| **Article 6: The right to a fair trial**<br><br>**Example**: issues of patient choice, control, empowerment and independence | Yes | |
| **Article 8: The right to respect for private and family life, home and correspondence; Issues of patient restraint and control**<br><br>**Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life | Yes | |
| **Article 11: The right to freedom of thought, conscience and religion**<br><br>**Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers | Yes | |

| How will the strategy, policy, plan, procedure and/or service impact on: | Positive | Negative | No impact | Potential positive and / or negative impacts<br><br>Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data. | Opportunities for improvement / mitigation<br><br>If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan. |
|---|---|---|---|---|---|
| **Age**<br>Is it likely to affect older and younger people in different ways or affect one age group and not another? | √ | | | The Welsh Assembly Government has produced a 2021 Framework for Continuing NHS Healthcare (CHC). It sets out the Welsh Assembly Government's policy for eligibility for CHC and the Responsibilities of NHS organisations and local authorities under the framework and related matters.<br>Hywel Dda University Health Board's (HDdUHB) Operational Policy is based on this National Framework.<br>The policy outlines the approach to be taken by practitioners to the assessment and decision making process and indicates the governance arrangements surrounding the application and process. It is only intended for adults over 18 years of age | Children under 18 years of age come under a different CHC process and does not sit with LTC, but Children's services should identify those children with potential eligibility for NHS Continuing Healthcare and should notify the appropriate adult complex care teams. Ideally when the child reaches the age of 14 years, especially if the young person's needs are likely to remain at a similar level into adulthood. Once the young person reaches 16 years of age there should be a formal referral for screening to the appropriate adult NHS Continuing Healthcare team |
| **Disability**<br>Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes | √ | | | As above, The service is already offered to those with a disability. No impact is foreseen. However, this will be reviewed and any new or additional information will be considered | However, the decision letter may also include, where applicable and appropriate, information regarding FNC or a joint package of care **& also**, Someone with long term mental health is not eligible but will be under section 117 |
| **Gender Reassignment**<br>Consider the potential impact on individuals who either:<br><br>•Have undergone, intend to undergo or are currently undergoing gender reassignment.<br>•Do not intend to undergo medical treatment but wish to live in a | | | √ | No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered | |

| | | | | | |
|---|---|---|---|---|---|
| different gender from their gender at birth. | | | | | |
| **Marriage and Civil Partnership**<br>This also covers those who are not married or in a civil partnership. | | | √ | No impact is foreseen. However, this will be reviewed and any new or additional information will be considered | |

| | | | | | |
|---|---|---|---|---|---|
| **Pregnancy and Maternity**<br>Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave. | | | √ | No impact is foreseen. However, this will be reviewed and any new or additional information will be considered | |
| **Race/Ethnicity or Nationality**<br>People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers. | | | √ | No impact is foreseen. However, this will be reviewed and any new or additional information will be considered | |
| **Religion or Belief (or non-belief)**<br>The term 'religion' includes a religious or philosophical belief. | | | √ | No impact is foreseen. However, this will be reviewed and any new or additional information will be considered | |
| **Sex**<br>Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other? | | | √ | No impact is foreseen. However, this will be reviewed and any new or additional information will be considered | |
| **Sexual Orientation**<br>Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes. | | | √ | No impact is foreseen. However, this will be reviewed and any new or additional information will be considered | |
| **Armed Forces**<br>Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'<br><br>For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: | | | √ | No impact is foreseen. However, this will be reviewed and any new or additional information will be considered | |

| | | | | | |
|---|---|---|---|---|---|
| **Armed-Forces-Covenant-duty-statutory-guidance** | | | | | |
| **Socio-economic Deprivation**<br>Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.<br><br>For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty** | √ | | | It is recognised that we serve a diverse population, however if a person is eligible for continuing Health Care then this is based on a needs based assessment and is not a means tested service. | If a patient is eligible for CHC, then all costs will be funded.<br>It means that the cost of the care home is fully covered by the NHS, including room and board. Although it is less common, CHC packages can also be provided to care for someone in their own home. |
| **Welsh Language**<br>Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language. | √ | | | | |

**Form 4: Examine the Information Gathered So Far**

| | | |
|---|---|---|
| **1.** | **Do you have adequate information to make a fully informed decision on any potential impact?** | Yes the policy gives a through understanding of the CHC process and its pathways |
| **2.** | **Should you proceed with the Policy whilst the EqIA is ongoing?** | Yes |
| **3.** | **Does the information collected relate to all protected characteristics?** | Yes |
| **4.** | **What additional information (if any) is required?** | None |
| **5.** | **How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).** | There is no further information needed at this time. |

## Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

| Protected Characteristic | Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below) | Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below) | Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below) |
|---|---|---|---|
| **Age** | **3** | **+2** | **6** |
| **Disability** | **2** | **+1** | **2** |
| **Gender Reassignment** | **2** | **0** | **0** |
| **Marriage and Civil Partnership** | **2** | **0** | **0** |
| **Pregnancy and Maternity** | **2** | **0** | **0** |
| **Race/Ethnicity or Nationality** | **2** | **0** | **0** |
| **Religion or Belief** | **2** | **0** | **0** |
| **Sex** | **2** | **0** | **0** |
| **Sexual Orientation** | **2** | **0** | **0** |
| **Armed Forces** | **2** | **0** | **0** |
| **Socio-Economic Deprivation** | **2** | **+2** | **4** |
| **Welsh Language** | **2** | **+2** | **4** |

| Scoring Chart A: Evidence Available | |
|---|---|
| 3 | Existing data/research |
| 2 | Anecdotal/awareness data only |
| 1 | No evidence or suggestion |
| | |
| | |
| | |
| | |

| Scoring Chart B: Potential Impact | |
|---|---|
| -3 | High negative |
| -2 | Medium negative |
| -1 | Low negative |
| 0 | No impact |
| +1 | Low positive |
| +2 | Medium positive |
| +3 | High positive |

| Scoring Chart C: Impact | |
|---|---|
| -6 to -9 | High Impact (H) |
| -3 to -5 | Medium Impact (M) |
| -1 to -2 | Low Impact (L) |
| 0 | No Impact (N) |
| 1 to 9 | Positive Impact (P) |
| | |
| | |

**Form 6 Outcome**

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You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

| | |
|---|---|
| **Will the Policy be adopted?** | Yes |
| **If No please give reasons and any alternative action(s) agreed.** | |
| **Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?** | No |

| | |
|---|---|
| **What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?** | The Operational policy will be reviewed yearly and any deviations from this impact assessment will be reviewed and added into the policy at renewal date |
| **When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?** | Yearly. The Performance and Service Improvement Manager will be responsible |
| **Where positive impact has been identified for one or more groups please explain how this will be maximised?** | The data range will not change and where positive impact has been assessed this will always remain fairly static until WG make any changes that may affect the CHC process. To ensure we are maximising impacts, we need to make sure all our processes in the service are clear such as our reporting mechanisms and time lines on getting back to relevant parties/ stakeholders.<br><br>However with appeals – We recognise that not all individuals are happy with some decisions so we have a appeal process in place where the service can review.<br>If an individual or their representative disagrees with the eligibility decision for either CHC or NHS Funded Nursing Care, and intend to appeal that decision, they must inform the relevant LHB of their intention to appeal within 28 days of receipt of the decision letter.<br>Written notification of intention to appeal a decision outside of the 28 days period will only be accepted in exceptional circumstances.<br>The individual must submit their written appeal to the relevant LHB within 6 months of the individual /or their representative being informed of that decision. Requests made after this time period will only be considered in exceptional circumstances. |
| **Where the potential for negative impact on one of more group has been** | No Negative impacts |

| | |
|---|---|
| **identified please explain what mitigating action has been planned to address this.**<br><br>**If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.** | |

**Form 7 Action Plan**

| **Actions**<br>(required to address any potential negative impact identified or any gaps in data) | **Assigned to** | **Target Review Date** | **Completion Date** | **Comments / Update** |
|---|---|---|---|---|
| The EqIA will be reviewed annually and reassessed and any complaints will be actioned accordingly | Performance Manager | October 2024 | October 2023 | |
| | | | | |
| | | | | |

| | | |
|---|---|---|
| **EqIA Completed by:** | **Name** | Tracy Devantier |
| | **Title** | Performance and Service Improvement Manager |
| | **Team / Division** | Long Term Care |

| | | |
|---|---|---|
| | **Contact details** | Tracy.devantier@wales.nhs.uk |
| | **Date** | 18/09/2023 |
| **EqIA Authorised by:** | **Name** | Tracy Devantier |
| | **Title** | Performance and Improvement Manager |
| | **Team / Division** | Long Term Care |
| | **Contact details** | Tracy.devantier@wales.co.uk |
| | **Date** | 18/09/2023 |
| **Seen by Diversity & Inclusion Team:** | **Name** | Alan Winter |
| | **Title** | Senior Diversity & Inclusion Officer |
| | **Team / Division** | SPD&I |
| | **Contact details** | Alan.winter@wales.nhs.uk |
| | **Date** | 21/12/2023 |