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Llywodraeth Cymru
Welsh Government

Welsh Government
Consultation Document

Continuing NHS Healthcare

The National Framework for Wales

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Action required: 21 August 2019

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Overview

Continuing NHS Healthcare in Wales (CHC) is a package of care and support for people who have complex care issues which are primarily health based. The NHS in Wales, through local health boards, is responsible for the delivery of CHC, though there are roles for others, including local authorities, in this process. Existing arrangements for the provision of CHC are set out in the National Framework for Continuing NHS Healthcare in Wales which was published in 2014. This consultation seeks your views on amendments to the 2014 Framework.

How to respond

You can respond to this consultation by completing and returning, by midnight on the closing date, the consultation response form at the back of this document. The response should be sent to:

Complex, Unscheduled Care and Disability Branch
Partnership and Cooperation Division
Welsh Government
4th Floor, North
Cathays Park
Cardiff
CF10 3NQ

Further information and related documents

Alternatively the consultation response form is available on our website <http://wales.gov.uk/consultations/?lang=en> and can be returned to us, by midnight on the closing date, via e-mail to:

(English) CHCFramework.Consultation@gov.wales
(Welsh) FframwaithGIP.Ymgynghoriad@llyw.cymru

Large print, Braille and alternative language versions of this document are available on request.

Contact details

For further information, please contact:

Complex, Unscheduled Care and Disability Branch
Partnership and Cooperation Division
Welsh Government
4th Floor, North
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(English) CHCFramework.Consultation@gov.wales
(Welsh) FframwaithGIP.Ymgynghoriad@llyw.cymru

General Data Protection Regulations

The Welsh Government will be the data controller for any personal data you provide as part of your response to the consultation. Welsh Ministers have statutory powers they will rely on to process this personal data, which will enable them to make informed decisions about how they exercise their public functions. Any response you send us will be seen in full by Welsh Government staff dealing with the issues covered by this consultation. Where the Welsh Government undertakes further analysis of consultation responses then this work may be commissioned from an accredited third party (e.g. a research organisation or a consultancy company). Any such work will only be undertaken under contract. Welsh Government's standard terms and conditions for such contracts set out strict requirements for the processing and safekeeping of personal data.

In order to show that the consultation was carried out properly, the Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. If you do not want your name or address published, please tell us this in writing when you send your response. We will then redact them before publishing.

Any respondents to the consultation will need to be aware of the Welsh Government's responsibilities under Freedom of Information legislation. If your details are published as part of the consultation response, these published reports will be retained indefinitely. Any of your data held otherwise by Welsh Government will be kept for no more than three years.

Your rights

Under the data protection legislation, you have the right:

- to be informed of the personal data holds about you and to access it
- to require us to rectify inaccuracies in that data
- to (in certain circumstances) object to or restrict processing
- for (in certain circumstances) your data to be 'erased'
- to (in certain circumstances) data portability
- to lodge a complaint with the Information Commissioner's Office (ICO) who is our independent regulator for data protection.

For further details about the information the Welsh Government holds and its use, or if you want to exercise your rights under the GDPR, please see contact details below:

Data Protection Officer:
Welsh Government
Cathays Park
Cardiff. CF10 3NQ

e-mail:
Data.ProtectionOfficer@gov.wales

Information Commissioner's Office:
Wycliffe House
Water Lane
Wilmslow
Cheshire. SK9 5AF
Tel: 01625 545 745 / 0303 123 1113
Website: <https://ico.org.uk>

Introduction

Continuing NHS Healthcare (“CHC”) is the name given to a package of care and support given by the NHS, through local health boards (LHBs), to people whose needs are mainly health-based. Around 5,000 people in Wales are receiving CHC at any point and it accounts for £360 million of the annual NHS budget.

Arrangements for CHC are set out in the 2014 National Framework for Continuing NHS Healthcare in Wales (the Framework). The Framework covers adults aged 18 and over, and sets out the Welsh Government’s revised policy for eligibility for CHC and the responsibilities of LHBs and local authorities (LAs). It sets out a process for the NHS, working with LA partners, to assess health needs, decide on eligibility for CHC and provide appropriate care. All LHBs and LAs in Wales will be required to follow it.

The Framework was last revised in 2014 and made a number of significant changes at that time. These included; strengthening of governance issues; stronger provisions for the Welsh Language; the assessment process and how information is recorded (through a Decision Support Tool); a strengthened role for carers; reviews of decisions and enhanced arrangements regarding retrospective claims. It also identified and set out linkages with wider policy areas outside CHC, such as mental health, learning disability and Direct Payments.

The Framework is designed to provide consistency in practice across Wales and to ensure that adults with complex care issues can receive the appropriate level of care and support for their needs.

Scope of the review of the Framework

The scope of this review has been set by the National Complex Care Board which provides strategic oversight for CHC and comprises senior representatives from each of the seven health boards in Wales, alongside Welsh Government officials. The Board’s view was that the principles supporting the existing Framework are sound and that the review should therefore aim to clarify, refine or add to the existing Framework as appropriate.

The Welsh Government established a small working group to assist in the review. The group met on a number of occasions during 2017 and 2018 to discuss potential changes to the Framework.

Membership included representatives of:

- local health boards
- local authorities
- the Public Services Ombudsman for Wales
- third sector representatives

Summary of changes

- presentational changes - a more logical structure and flow to the document, greater clarity in some areas and general updating to reflect policy and legal changes since 2014.
- the assessment of eligibility for CHC, including:
 - planning an assessment of need
 - the use of a screening tool ('the Checklist')
 - the assessment process
 - guidance on the Decision Support Tool, including its usage and definitions
 - guidance for pandemic and emergency situations
- making a decision on eligibility
 - the relationship between an individual and the multi-disciplinary team (MDT)
 - reaching and recording eligibility decisions
 - communicating the recommendation
 - communicating the final eligibility decision
- service provision and review
 - supporting an individual in their own home
 - clarification on the relationship between Direct Payments and CHC
 - reviews of eligibility decisions for CHC
- links between CHC and wider policy areas
 - mental health
 - Deprivation of Liberty
 - transitional arrangements for children and young people entering adult CHC
- ensuring a clear and consistent approach to the handling of disputes and appeals and that these are dealt with in a timely manner
- refining the process for handling retrospective claims.

Implementation

Once the revised Framework is published, there will be a short period before any new arrangements take effect. We will be using that time to focus and build on the existing support, guidance and performance arrangements to ensure changes are implemented effectively. This will include refining and developing:

- communication tools
- an online 'CHC toolkit' to assist staff, including template documentation for LHBs on contracts, policies and protocols
- structured opportunities for shared learning, through learning events, newsletters and an online forum
- a national performance framework

Q1. In addition to revising the Framework, we are placing a strong emphasis on its effective implementation. Are there particular areas you would wish to see addressed in materials developed to support implementation?

Q2. The Framework as it stands is a technical document aimed at specialist professionals who oversee assessment and care provision. We would welcome your thoughts on the potential publication of a simplified Framework aimed at both practitioners and service users. Comments on its appropriateness, including suggested format, content and style are welcome.

Q3. Does the proposed Framework provide sufficient assurance about the responsibility, ownership and governance of CHC by Welsh Government, LHBs and their partners?

Q4. What approaches could be put in place nationally, regionally and locally to further develop partnership working between local health boards, local authorities and other partners in relation to CHC?

Overview of Changes

1. Greater clarity and presentational style.

Issue

The 2014 Framework was felt to be very detailed but there was opportunity to provide further clarity in some areas and to re-order the sections to better reflect the CHC process.

Proposal

We have retained the core principles of the existing Framework; namely, to put people first, involve and engage with them and their representatives throughout the process and ensure decisions affecting them are informed by evidence. There is a continued emphasis on care and support that is focused on need and that is co-ordinated and avoids any unnecessary upheaval to an individual's way of life.

Given the size and amount of detail within the Framework, it is important to convey the requirements, responsibilities and expectations as effectively as possible. We have therefore redesigned the layout and ordering of sections so that there is a natural 'flow' which mirrors the CHC process itself from start to finish:

- key principles
- clarifying roles and responsibilities
- areas for consideration prior to any assessment
- undertaking an assessment
- eligibility considerations
- service provision and review
- links to wider policy areas
- disputes and appeals
- retrospective reviews

All annexes have been moved to the end of the document and references to policy and legislation have also been updated, notably aligning requirements to the provisions within the Social Services and Well-being (Wales) Act 2014.

Q5. It was felt that some aspects of the Framework lacked clarity. Do you agree with this? If so, have we identified and addressed the right areas in the Framework to improve clarity?

2. The assessment process

Issue

We want to ensure any assessments for CHC are necessary, professional, timely and involve the individual or their representatives. Our analysis has shown a number of factors which are necessary for the successful completion of an assessment. These factors include proper planning, the involvement of the correct people and engagement and communication with the individual and/or any chosen representatives.

Proposals

The 2014 Framework set out the process of planning for and undertaking an assessment for CHC in one section. We felt this could create confusion and have clarified those areas, separating them into two distinct sections (Sections 3 and 4 respectively).

i) Planning an assessment

Under Section 3 we retain the principles set out in the 2014 Framework, while further emphasising the need for professional and clear communications to the individual. We have also provided greater clarity regarding the specific people involved in the process. Changes include:

- how the commissioning team who provide the service assess an individual's needs
- the workings of the Multi-disciplinary Team (MDT), which makes recommendations on an individual's eligibility for CHC. Specifically membership of the team, individual roles and engagement between local health boards, local authorities, the individual and their representatives.
- the responsibilities of local health boards and local authorities in supporting carers

The requirements around seeking consent have been expanded, taking best practice introduced in the English CHC Framework. We have, for example, included additional wording which sets out the requirements necessary to seek valid consent. There are also extra provisions regarding an individual's capacity to consent, particularly where an individual may have difficulty expressing their views. The expectation is set out that those involved with any assessment are familiar with the principles of the Mental Capacity Act 2005.

Our new provisions ensure individuals have access to advocacy services and set out how any information is shared, particularly for those individuals without capacity. We have, for example, clarified the Powers of Attorney and enhanced the wording around decisions taken in the 'best interests' of an individual, which are in line with those in the English CHC Framework. These include added guidance on responsibility for making the decision, the role of third parties (including families, advocates and carers) and wider issues to consider when making the decision and the recording of that decision.

ii) The use of a checklist ('the Checklist')

Although it is used for backdated, or retrospective, claims for CHC, the use of a screening tool or checklist is not mandated for contemporary assessments. It can however, be useful in specific circumstances to identify 'triggers' for CHC which need further consideration. For example, care home residents whose condition has changed and require an earlier than planned review. 'The Checklist' is referred to in the 2014 Framework, and is attached in Annex 4.

We have provided further detail on its use in this section of the new Framework and Annex 4. Its is designed to the checklist used in England and we have added detailed guidance on its use for contemporary and retrospective cases. This guidance includes when it should be used; who may complete it how it should be completed; next steps following its completion when eligibility or no eligibility has been found.

iii) The assessment of eligibility for CHC

There is no intention for policy changes made through this process to impact on the eligibility threshold for CHC, which is well-established and based on the consideration of a 'primary health need'.

In terms of the assessment process itself, additional wording has been included to ensure screening and assessments of eligibility for CHC should be undertaken at the right time and location for the individual, when any ongoing needs are known and ideally within a community setting. New wording, which aligns to provisions for CHC in England, recognises that any consideration for CHC should only happen after an individual is discharged from hospital, should not delay the discharge process and a range of alternative care and support such as reablement or interim services should help a timely discharge.

We have also included a new section on identifying a person's eligibility for CHC based on the totality of their needs and requiring a clear, reasoned decision which requires LHBs and LAs to consider, regardless of the outcome, whether a multi-disciplinary assessment has identified issues to be addressed.

We have also clarified and incorporated wording in the existing Decision Support Tool around conditions that are effectively controlled (“well-managed needs”), based in part on new provisions introduced in England. This notes that care and due regard should be given to such conditions, noting for example that needs may appear to be exacerbated if an individual is in an inappropriate environment because they require a particular type of care and support. Our proposals promote a joint approach between the NHS and local authorities to the assessment of need, where appropriate and for it to take into account any wider care and support needs of the individual. This would be regardless of the eventual outcome.

In line with the duties on local authorities under the Social Services and Well-being (Wales) Act 2014, there is now a strong emphasis that there should be no gap in the provision of care and consideration of eligibility.

iv) The Use of a Decision Support Tool (“DST”)

We want to further clarify the use of the DST and ensure it is used appropriately as part of any assessment for eligibility.

In terms of the Framework itself, there are a number of minor changes regarding provisions that were already in the 2014 Framework. These have been reordered and re-worded slightly for greater clarification and prominence.

Examples include how the DST should not be used as a ‘scoring mechanism’ and that a multi-disciplinary assessment of needs must be carried out before the DST is used.

There is also additional wording to reflect enhanced provisions on the use of the DST in the draft Framework. Whilst we wish to avoid unnecessary duplication, replicating the wording of the Framework in the DST reinforces the principles set out in the Framework and ensures they are not overlooked when put into practice. For example, in both the draft Framework and draft DST we now say the following, whereas previously messages were spread across the two documents:

- any decision on eligibility must be clearly and professionally explained to an individual.
- consent should be obtained from an individual with capacity before the completion of the DST.
- the individual should be invited to be present or represented wherever practicable and given reasonable notice of completion of the DST to enable them to arrange for a family member or other person to be present, if necessary.
- the MDTs role in completing the DST.
- how the decision should be communicated.

The 12 “Domains”

Aside from wider narrative changes the 12 domains of identified need are broadly unchanged, with a few minor amendments proposed as follows:

- Behaviour – add reference to self-harm as an example.
- Mobility – revise notes. For example, replacing the reference to the 2001 National Service Framework for Older People with a more general emphasis on assessment.
- Nutrition – revise wording and examples in the low, moderate, high and severe categories.
- Psychological and Emotional Needs – clarify wording around the individual’s engagement in the care process.
- Cognition - replace the previous highest level of identified need of ‘severe’ with ‘high’.
- Drug Therapies or Medication – replace references to ‘non-concordance’ with ‘refusal or misuse of medication’.
- Other Significant Care Needs – remove the levels of need in order to better reflect its purpose to capture areas for wider consideration.

We have revisited the 2014 Decision Support Tool to reflect the change in the domains. We propose to reorder these more logically - into an order in which a person’s needs would normally be considered. There is additional wording under many of the domains to support effective completion of the DST.

iv) Pandemic and other emergency situations

We have included wording in line with UK Government policy about completing assessments in the event of the above. Where these situations occur, our proposals place priority on the safety of the patient, ensuring they receive the care they need. This would mean that LHBs should be able to choose not to undertake a CHC assessment until after the emergency period but they will retain the responsibility for the individual’s care and should work with local authorities as necessary.

Q6. The following aspects have been considerably revised:

- assessment process
- consideration of eligibility
- use of toolkits, notably the Checklist and the Decision Support Tool

Do you agree these areas, as they are proposed, are fit for purpose?

Q7. Do you think that individuals and their families are involved enough in the updated assessment process? If not, in which additional ways would you like to see the process improved?

3. Making a recommendation on eligibility

Issue

As part of the decision-making process, the MDT is required to make a recommendation to the LHB as to whether or not the individual has a primary health need. The LHB takes this recommendation into account when deciding on an individual's eligibility for CHC. This decision must be clearly communicated to the individual.

Evidence from previous cases suggests these principles have not always been applied consistently. This can lead to confusion, frustration and potentially challenge to the eventual decision.

Proposals

We are proposing to strengthen the provisions in Section 5 around how eligibility decisions are reached, recorded and ultimately conveyed to the individual. The changes proposed here are in line with some of the "Key Principles" of communication and involvement, which are set out at the front of the Framework, and which promote effective communication and involvement with the individual.

- i) The relationship between the individual (and/or their representatives) and the MDT

We have introduced new wording to explicitly set out how the MDT should involve the individual and their representatives. This confirms the individual and/or their representatives cannot be members of the MDT. However, they should be fully involved in the process and be given every opportunity to contribute and attend the MDT discussions which will inform the recommendation to the LHB.

- ii) Reaching and recording eligibility decisions

We have proposed stronger arrangements around the responsibilities on the MDT as part of this process.

We are reinforcing in the Framework and the DST that in cases where the LHB does not accept the MDT's recommendation, they may request and accept additional evidence and ask the MDT to reconsider its decision. By contrast, the 2014 Framework, simply stated that "Only in exceptional circumstances and for clearly articulated reasons should the LHB not accept the multidisciplinary team's expert advice on CHC eligibility".

We are proposing that where the MDT is unable to reach agreement on the recommendation this should be clearly recorded and evidenced. Although this was referred to in the DST guidance, we are now explicitly stating within the Framework that where agreement cannot be reached, practitioners should consider the higher level of a domain but with clear reasoned evidence to support this. Where additional evidence may be sought, this should not prolong the eligibility process unduly.

iii) Communicating the recommendation (to the LHB and the individual)

We have also stipulated how the MDT's recommendations should be conveyed to the LHB and the individual. Our proposed format provides clear, concise but sufficient detail to enable the LHB and the individual to understand the underlying rationale for the recommendation. Where individuals and/or their representatives are not present, then the recommendation should be communicated to them as soon as possible.

iv) Communicating the eligibility decision

We have provided a new section, setting out precisely how the final decision on eligibility should be conveyed to the individual and/or their representatives.

This information should be conveyed to the individual in writing, as soon as the final decision has been reached by the LHB. This should include a clear decision and rationale for eligibility (based on a primary health need) and be accompanied by a copy of the DST. It should also include contact details of those who can help provide any further clarification; and also set out how to request a review of any decision.

Where someone is eligible for CHC there should be an indication of the likely package of care and support they will receive to meet their needs. If they are ineligible then the letter may set out an alternative package of care appropriate to their needs.

4. Service provision and review

Issue

LHBs are responsible for the planning and provision of CHC. Any consideration cannot be taken in isolation to other services, however, and a full assessment and consideration of care and support needs will require them to work in partnership with other bodies, including local authorities.

This area presents specific challenges, not least how CHC relates to the provision of other care packages, which it is felt were not adequately covered in the previous Framework. An example of this is the use of Direct Payments (where an individual receives money and arranges for their own care). This is a popular service for those that use it but is incompatible with CHC.

Proposal

- i) Supporting individuals eligible for CHC in their own home

The 2014 Framework recognises there are a number of complex packages of care being delivered in an individual's own home. This is recognised in our draft Framework where we reiterate the NHS is responsible for meeting health and social care needs of those eligible to receive CHC and wish to live at home. We have introduced new wording to clarify some of the limits of those responsibilities. For example, the NHS is not responsible for rent, food, normal utility bills and matters covered by personal income. It also stipulates LHBs cannot set arbitrary limits on care at home based on costs.

Our new wording also makes clear that whilst LHBs can take comparative costs and value for money into account, they cannot set arbitrary limits on care at home packages.

Where joint packages of care are required, LAs are reminded of their duty to meet and assess any needs they are responsible for under the Social Services and Well-being (Wales) Act.

- ii) Direct Payments

In line with the principles in the previous version of the Framework, it is currently unlawful for Direct Payments to be used to purchase health care which the NHS is responsible for providing. It is not unlawful, however, 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. This includes the pooling of budgets and other mechanisms to ensure people experience seamless care.

We have introduced some further clarifications in this area. We have made it clear that every effort should be made by partner organisations to ensure that individuals are made aware that Direct Payments will no longer apply if they become eligible for CHC Funding. We have also clarified that there can be no assumption that LAs will continue to provide Direct Payments, where a CHC assessment is refused.

iii) Reviews of CHC Eligibility

An individual's eligibility for CHC is subject to review. Reviews should follow the format of an assessment, consider all the services received and be tailored to the individual.

These are not new arrangements within the Framework but we have clarified the focus of these reviews, namely to ensure the care plans remain appropriate for the persons needs. They should be proportionate to the situation in question in order to ensure that time and resources are used effectively.

To ensure reviews are relevant, evidence-based and considered appropriately, we have included new provisions. These state that any reviews of a person's need must be informed by the most recent DST. Any evidence of a change in those needs will require a full reassessment including a new DST by the MDT. We have placed new expectations on LHBs to consult with LAs before making any decisions on eligibility and to ensure an individual's needs continue to be met during this reassessment of eligibility process. There should also be no unilateral withdrawal of a funding package.

We have also enhanced wording in the 2014 Framework into a separate section which sets out the expected outcomes of a review (namely meeting needs, considering eligibility for CHC and determining whether any change in needs requires a change in a care package). The new provisions stipulate the need for due consideration of a change in an individual's location or funding of their care as part of that review.

5. Links to wider policy areas

Issue

We have retained links to other policies and areas in our draft Framework, though these have been pulled into a separate section. Given the existing Framework was written in 2014 there is a need to update and reflect any changes in these areas.

Proposals

i) Mental health

Where appropriate, we have clarified and strengthened the wording around aftercare services for Mental Health (Section 117 of the Mental Health Act 1983). The draft Framework recognises that the provision of Section 117 is shared between LAs and the NHS, 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.

ii) Deprivation of Liberty

There are additional provisions in relation to Deprivation of Liberty (DoL). 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.

iii) Transition from children and young person to adult services

There are minor additions within this section, in order to align with proposed amendments to the Children and Young People's Continuing Care Guidance to be published later this year. We have strengthened the emphasis that the aim of transition planning is to ensure a consistent package of support, jointly designed and agreed by the young person and their carers. This should start, not just at 14, but as soon as possible where the need is already identified or as soon as possible, if problems emerge that will require ongoing care, after this age. We are aligning with their new proposals, which require a formal referral for assessment to be completed by the time a child is 16 years of age.

iv) Applying the CHC Framework to adults with a learning disability

We have amended the first paragraph in this section in line with the Welsh Government's desired outcomes.

Q8. In your view, does the proposed Framework link well with, other health and social services policy and guidance? Are there any other linkages to good guidance or innovative practice we should be making?

6. Disputes and appeals

Issue

The Welsh Government expects local health boards and their partners to work together to deliver the best possible outcomes for the citizens of Wales. Effective partnership working and integration, together with implementation of this Framework should minimise the need to proceed to formal dispute procedures.

Where disputes arise, we want to ensure there is a clear, consistent approach across LHBs in Wales in how disputes and appeals are managed. This will avoid distress being caused to individuals and their families or carers as a result.

Proposals

i) Disputes

We have now added a requirement that where there is an unresolved dispute within the MDT on a recommendation, then this should be escalated within 48 hours to ensure quick consideration of the individual's needs.

Whilst it is preferable for any disputes to be settled informally, the 2014 Framework contained provisions for LHBs and LAs to establish a protocol to resolve disputes. Our new proposals now set out various elements these protocols should contain. These include various timescales, stages, escalation procedures and a final stage, including independent arbitration.

Where disputes relate to local authorities and LHBs in different geographical areas, the dispute resolution process of the responsible LHB should normally be used in order to ensure resolution in a robust and timely manner.

ii) Appeals

In terms of appeals, LHBs are now expected to explain to individuals the arrangements and timescales for dealing with a review of the eligibility decision.

A new stipulation has been added that a request to review a decision about eligibility for either CHC or NHS Funded Nursing Care must be made within 28 days of the individual and/or their representative being informed of that decision. We propose to recognise exceptional circumstances outside this period. This deadline is designed to ensure that individuals receive the right care, at the right time and in the right place. It is felt that 28 days is appropriate - if an individual were to appeal a decision after that time it is

probable that their needs have changed and a fresh assessment would be required.

Retrospective reviews

Issue

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 been eligible for CHC. A retrospective review claim is different from an appeal against a current CHC assessment and decision on eligibility.

There is a historic backlog of retrospective claims, which have been managed by the National All-Wales Project Team as well as individual LHBs. From April 2019, all claims will be managed by individual LHBs and there is a need to make processes as clear and effective as possible to ensure the timely and correct resolution of those claims.

Proposals

We have previously announced exercises to 'close down' (or 'cut-off') the periods within which claims could be considered for eligibility for CHC. This is because as time passes, it becomes more difficult to access an individual's care records, which is essential in order to understand their care needs for the period in question and their eligibility for CHC. Previous cut-off exercises have proven to be complex to manage. In some cases, for example, they have resulted in a sudden influx of claims to LHBs once any public announcement is made. We have therefore moved to a rolling cut-off of 12 months from the date of the claim.

At the start of the process for considering the eligibility of a retrospective claim, evidence of the claimants legal and authority and proof of payment of care fees are obtained by the LHB. Section 9 in the draft Framework proposes a new protocol for requesting records from health and social care providers. Under this, all agencies will be asked by LHBs to provide the necessary supporting records within 3 months or to confirm that they have been destroyed, lost or are unavailable for any other reason. Examples of circumstances where the LHB may consider exceptions to this practice are contained within the draft Framework.

From this point, we have provided a new two-stage process for considering a retrospective claim, developing the necessary chronology of need from the records available and the claimant's views. This is to manage the large volume of claims and make the system more manageable. The requirements employ a checklist to identify triggers for eligibility, albeit this would not replace professional judgement in this matter.

The proposed two-stage process is as follows:

- Stage 1 - A checklist, ('the Checklist'), based on the Decision Support Tool, is applied to an individual's chronology or history of care and support needs to identify triggers for full consideration of eligibility for CHC. A trigger date may be identified at the start of the claim period or part way through to identify when the individual became eligible for CHC. If there are no triggers for consideration of eligibility, the case is closed at this point. Claimants should be sent a written explanation of the outcome.
- Stage 2 - Where triggers are found, the information in the chronology will be reviewed and assessed against the 4 primary health need indicators (nature, intensity, complexity and unpredictability).
- Once all information has been analysed, it is compiled into a document detailing the recommendation. This document is peer reviewed by a different clinician to ensure the recommendation and supporting evidence is robust and that the criteria have been consistently applied. To further ensure the timely resolution of claims, we are proposing that cases with no eligibility are peer-reviewed by "*at least one different clinician*". The existing arrangements require two such individuals and it can prove a challenge to find mutual availability of individuals in a short space of time, and does not enhance the outcome of the review itself.

Q9. Is the proposed two-stage process for retrospective reviews appropriate and sufficiently comprehensive?

Independent Review Panel

require all cases presented to an IRP to be decided unanimously by all panel members.

Furthermore, in cases where no eligibility was found, we have introduced two new provisions to avoid any unnecessary delays in the process where no eligibility or partial eligibility was found by the IRP. In cases of no eligibility, if a claimant does not wish to attend a negotiation meeting in person, the recommendation should be discussed over the telephone or in writing as far as possible. In cases of partial eligibility, where a claimant does not wish to attend the negotiation they should also be able to discuss the recommendation over the phone, then an IRP should be convened.

Consultation response form

Your name:

Organisation (if applicable):

email / telephone number:

Your address:

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here:

Consultation questions

Question 1

In addition to revising the Framework we are placing a strong emphasis on its effective implementation.

Are there particular areas you would wish to see addressed in materials developed to support implementation?

YES

PARTLY

NO

if you have answered partly or no could you please tell us what additional information is needed?

Question 2

The Framework as it stands is a technical document aimed at specialist professionals who oversee assessment and care provision. We would welcome your thoughts on the potential publication of a simplified Framework aimed at both practitioners and service users. Comments on its appropriateness, including suggested format, content and style are welcome.

Question 3

Does the proposed Framework provide sufficient assurance about the responsibility, ownership and governance of CHC by Welsh Government, LHBs and their partners?

YES	PARTLY	NO
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If you have answered partly or no can you tell us what you recommend we change/ add?

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Question 4

What approaches could be put in place nationally, regionally and locally to further develop partnership working between local health boards, local authorities and other partners in relation to CHC?

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Question 5

It was felt that some aspects of the Framework lacked clarity. Have we identified and addressed the right areas in the Framework and improved clarity?

YES

PARTLY

NO

If you have answered partly or no, can you please tell us what area is unclear?

Question 6

The proposed key areas of the framework are:

The following aspects have been considerably revised

- assessment process,
- consideration of eligibility
- use of toolkits, notably the Checklist and the Decision Support Tool

Do you agree these areas, as they are proposed, are fit for purpose?

YES

PARTLY

NO

If you have answered partly or no could you please tell us what additional key areas or changes you would wish to see?

Question 7

Do you think that individuals and their families are involved enough in the updated assessment process?

YES

PARTLY

NO

If you have answered partly or no can you give us details of what you would recommend to be added?

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Question 8

In your view, does the proposed Framework link well with other health and social services policy and guidance?

YES

PARTLY

NO

If you have answered partly or no can you tell us what feel is missing and what you recommend we add?

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Question 9

Is the proposed two-stage process for retrospective reviews appropriate and sufficiently comprehensive?

YES

PARTLY

NO

If you have answered partly or no can you tell us what feel is missing and what you recommend we add?

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Question 10: We would like to know your views on the effects that the new Framework would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.

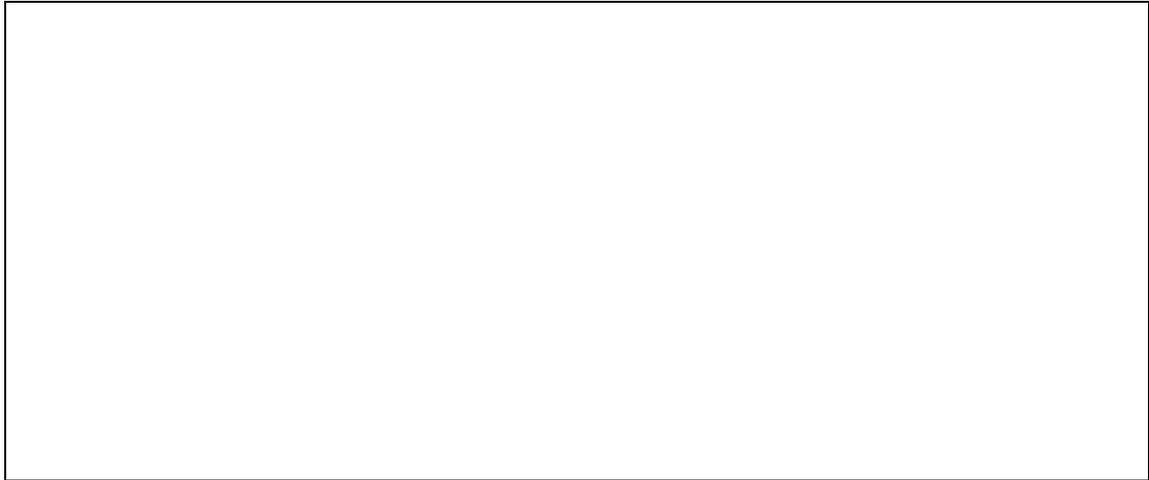
What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

Comments

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Question 11: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Please enter here:

A large, empty rectangular box with a thin black border, intended for the user to enter their response to Question 11.