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Cabinet
Thursday, 24 March 2022, 10.00 am, County Hall

Membership
Councillors:
Cllr Simon Geraghty (Chairman), Cllr Alan Amos, Cllr Marc Bayliss, Cllr Matt Dormer, Cllr Adrian Hardman (Vice Chairman), Cllr Marcus Hart, Cllr Adam Kent, Cllr Karen May, Cllr Tony Miller and Cllr Andy Roberts

Appendices Supplement

Agenda produced and published by the Assistant Director for Legal and Governance, County Hall, Spetchley Road, Worcester WR5 2NP. To obtain further information or hard copies of this agenda, please contact Sheena Jones 01905 846011 email: sjones19@worcestershire.gov.uk

All the above reports and supporting information can be accessed via the Council's website here

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WORCESTERSHIRE CHILDREN FIRST

Worcestershire Children First Business Plan

April 2022 - March 2023

Contents

Foreword

Chairman's Foreword

As we enter our third year of operation as Worcestershire Children First, I think it is appropriate to reflect on our journey to date.

As outlined in the DCS/CEO's foreword we have undertaken a considerable workload under challenging conditions last year and continued to improve. I echo the statement that we will continue to be a learning organisation and alongside our own comprehensive quality assurance programme, we will contribute to a local safeguarding review to consider what lessons can be learnt and what we need to do differently.

I would like to put on record my thanks on behalf of the Board to all staff for their hard work in achieving this milestone and to the Council for their support. I would also like to thank my Board colleagues for their valued input during the year in providing challenge and support to develop services.

Looking forward to the Business Plan for 2022-23, we have an ambitious programme of work, and I am pleased to support the move to developing more innovative ways of working. One of the strengths of WCF is that we deliver on behalf of the Council, services for all children and young people which enables us to develop working methods that combine different disciplines.

The focus on an accelerated improvement plan for our SEND offer is to be welcomed and I look forward to substantive progress in this area and the further development of our trading activities in Learning and Achievement Services.

The County Council continues to operate in a very challenging financial environment, and we await the outcome of the consultation on local government finance reforms, due for consultation in Spring 2022 and the impact on Children's services. WCF is experiencing financial pressures on placements and Home to School and College Transport in particular, however, our close working relationship with the Council has enabled us to not only invest in key services, but to also challenge all budgets to meet our goal of delivering value for money and cost-effective services.

Demand for services continues to increase and this places further financial pressure on the Company and the Council. Our strong governance arrangements have enabled the company to closely monitor budgets and regular reporting to the Board and Council has been maintained. Our financial risk has increased but we are confident that our operating and reporting arrangements will greatly assist in managing the risks of controlling a company with an anticipated annual turnover of £135M. The financial environment and our cost pressures pose risks to the company, however, our commitment to delivering our key goals remains firm.

In conclusion, WCF is in my opinion in a strong position to deliver the plan as outlined, given we have strong leadership, a positive learning culture and a hardworking loyal workforce, complimented by sound corporate governance arrangements to hold the Executive to account. I look forward to all we will sustain and achieve in the forthcoming year.

Rob Morrison
Chair of Worcestershire Children First

Chief Executive Worcestershire Children First and Director of Children's Services for Worcestershire County Council Foreword

The year of 2022-23 will be my second year as Director of Children's Services and Chief Executive of Worcestershire Children First. Whilst on one hand I think "where did that year go" I also look back on what a phenomenal amount of work has been undertaken. I would again like to recognise and thank the children, young people, their parents and carers, the staff of Worcestershire Children First and our partners who during the year have helped us in our mission to make children happier, healthier and safer.

Our work often means working with families at times of challenge and crisis and it requires the identification and management of risk. Using our strength-based approach we work in partnership with families and our partner agencies to provide the support and services needed to promote the health, education and welfare of children.

Throughout 2021-22 we have undertaken approximately 14,000 assessments at the Family Front Door to identify needs, worked with over 13,000 children providing early help and provided support to over 1,000 children on Children in Need plans. We have worked with over 400 children assessed as at risk of "significant harm" where we work with partners to manage risk and implement their child protection plans and we have cared for over 900 children in our care.

The challenges of child focused social work never go away, and I want to acknowledge that the mistreatment or death of any child is unacceptable. I recognise that, whether this happens locally or further afield, there is an understandable public outcry of sadness, anger, and frustration that is often reflected by the news media, as happened during the second half of the year.

Will Quince MP Parliamentary Under-Secretary of State for Children and Families wrote to all Directors of Children's Services on 7th January 2022. This letter was particularly helpful, communicating support and direction for us and our partners in the work we do. It strongly reflects our approach in Worcestershire to prioritise early help and prevention and in taking a child outcome focused approach to risk management when working with families.

It is however with great personal and professional sadness that we have worked with some families where children have suffered serious significant harm in this past year and one child has died. In this and other cases we will contribute to local safeguarding reviews where we will explore what lessons we can learn and we will reflect on the way we work with partners and parents to deliver our services to best promote the welfare of children and protect them from harm.

Turning to the year ahead, we have developed our business plan into three key areas. **Sustain & Improve**, **Innovate** and **Invest**. Knowing ourselves, listening to the experiences of children and families of our services and understanding the impact we are making to the lives of children and young people is our highest company priority.

I am proud and excited to be in a position where we can talk about "sustaining" all we have achieved in the quality and timeliness of social care services, and we continue to commit to being open to learning. In 2022-23 our SEND and Fostering service improvement plans will be a priority and this alongside "investing" in our services we aim to be "innovative" as we continue our journey to deliver the very best Children's Services to the children, young people and families of Worcestershire.

Tina Russell
Chief Executive of Worcestershire Children First & Director of Children's Services for Worcestershire County Council

Executive Summary

You will see in the **Foreword messages** from our Chair and myself, a reminder of the vision and mission we have set ourselves as a company to achieve within the challenging and changing world in which we continue to work, to deliver the best services we can.

We remain committed to our company values; to keep **children at the heart of everything we do, value family life, provide good education for all, protect children from harm and embrace diversity.**

This year we have welcomed two new Directors to our board, to deliver our social care and safeguarding work, and as we develop our 0-25 all age disability services, we will add another new Director of All Age Disability, whilst maintaining a focus on education improvement, inclusion and planning through the Director for Education. These senior management developments have had one focus: to ensure **we have the right leadership in the right place, with the skills and capacity to take us into our next phase of service development and delivery.**

The plan re-sets out our **Strategic Goals** detailed in our five-year plan 2019–2024.

Knowing ourselves, listening to the experiences of children and families of our services and understanding the impact we are making to the lives of children and young people is our highest company priority. Our section on the Quality Assurance Framework sets out how we will continue to use this three-dimensional approach to all our services through 2022-23.

2022-23 will be our 3rd full year in operation and our plan sets out our priorities for **Sustain & Improve** services, to be **Innovative** and to **Invest** to save and ensure best value.

Sustain and Improve

Our foremost priority is to sustain the significant improvements that we have achieved since we were first rated as an inadequate Children's Service in October 2016. What has been achieved is evidenced through our key performance indicators, our Quality Assurance Programme and our inspection outcomes over the past three years, ultimately reflected in September 2021 with the removal of the statutory direction.

Sustain and Improve
■ WCF Fostering Improvement Plan ■ WCF Adoption Business Plan ■ Permanency in care proceedings ■ SEND Accelerated Progress Plan ■ WCF Quality Assurance programme ■ Review Education and Skills Strategy ■ Service Reviews – Resources at Best value ■ Care Leavers – Education/Housing and Support

Sustaining such good levels of performance is not something that's achieved at any one point in time, it requires a continuation of hard work, commitment, and dedication of the whole workforce to be achieved and re-achieved every day, every month, and every year. Our quality assurance and business management processes are in place as "business as usual" to ensure we monitor all our activity and the impact and outcomes being achieved for children and young people. We will continue to be a learning and improving organisation and our priorities for improvement are set out above.

Innovate

We are proud to be in a place where we can build on the foundations of good practice and start to innovate.

Innovation means taking that brave step to do something new and different.

As part of our innovations, we will join with regional and national activities to reflect and share our own learning to achieve best practice

Our priority innovations for 2022/23 are set out here.

Innovate
■ Development of community and overnight short breaks for independent living ■ Evaluation and delivery of Family Safeguarding ■ Supporting Families First - Children in Need ■ Development of the Virtual Head role ■ Empower & inform parents in Child Safeguarding processes ■ Promote the Emotional Health & Wellbeing of Children in Need and those in Care ■ Early Help: Family Hub & Holiday Activity and Food Strategy ■ Get Safe / Get There: Reducing exploitation of children ■ Create an All Age Disability 0-25 service

Invest

"Money makes the world go around"

We know though it is often in short supply, so taking every possible opportunity for national, regional and local funding opportunities alongside making savings in order to invest and re-invest in our front-line services is our third priority for 2022/23. Our priorities for investment are set out here.

Invest
■ Development of WCF Residential Services ■ Family Group Conferencing - contingency for care & protection ■ Early Years Strategy - improve children's readiness for school ■ Deliver school Capital Programme ■ Develop provision and specialist resource for Unaccompanied Asylum-Seeking Children ■ Commissioning Strategy – best value ■ Worcester City secondary school

Our plan outlines our **Three Pillars of Success: Working in Partnership.**

In Partnership with WCC (Worcestershire County Council)

This partnership continues to be one of the foundations of our company we recognise in our plan, not just our own priorities and vision for what we want to achieve for children and families, but how important it is for people to see those children and families as members of the Worcestershire community.

The WCC priorities: **Open for Business**, **Children and Families**, **The Environment** and **Health and Wellbeing** are our priorities too for the children and families who are part of the Worcestershire community.

To thrive our children and their families need to have access to economic opportunity, accessible education and employment, to live in an environment that is a good place to live and grow up as a family and the physical and mental health of this younger generation is what is key to reducing need and demand in any long-term plan.

We will be working alongside WCC in the key developments of **All Age Disability Experience and School Place Planning.**

In partnership with our Workforce

Working in partnership with our Workforce is our second foundation to the success of our services. 2021-22 continued to be a "response and reset" as the pandemic continued to sweep through the nation. We saw a continued increase in workload and pressures as we experienced a rise in the demand for help and support. There was an increase in the number of serious harm cases in young children and a rising demand for support and assistance for children with additional needs.

Despite these pressures our workforce overall has remained remarkably stable and committed to Worcestershire Children First; with over 93% permanency in staffing overall, 88% permanency in front line social worker posts and 99% in managerial posts. This stability is an important part of sustaining our continued quality. (All figures are as at quarter 3 2021-22.)

However, "change and turn over" is an inevitable part of an organisation and as such positive and timely recruitment, bringing new people into our services and supporting internal career development of others, also adds a valuable mix of experiences, knowledge, skills and diversity to our workforce which we welcome. This year 2022-23 we have added a fifth value to our vision, which is to recognise and value diversity in our workforce and in our community of children, young people, and families.

In partnership with our stakeholders

The third pillar of success is working in partnership with our stakeholders. This is key to the success to our company and to achieving our aims and aspirations. Whether it is children and young people themselves, their parents and carers or the wide ranging statutory and voluntary professional partnerships, we know how essential it is for us to work together, to share experiences, learning and best practice.

We remain committed and fully engaged at all levels to ensure the voice and experiences of Worcestershire children, young people and families and that of our workforce is heard, taken into account and influences service development.

Starting from our strong stable leadership position in 2022-23 we will invest in **Local, Regional and National Partnerships** to ensure we are at the forefront of sharing best practice and continuing in our own reflection and learning.

Each front facing service area within WCF has its own "business as usual" and a "Priorities Plan on a Page".

Early Help, Children in Need and Family Front Door:

- Supporting Families First Children in Need: prevention/managing risk in the family and in the community
- Emotional Health and Wellbeing for children in need
- Early Help in the community, targeted vulnerable children and enabling Covid recovery
- Get Safe and Get There – keeping children safe from exploitation

Child Protection and Through Care:

- WCF Fostering Improvement plan – improving quality and sufficiency in Foster Care
- WCF Adoption Agency Business Plan – supporting timely permanency for children in care
- Care Leavers – improving services and ensuring corporate parents and partners priorities
- Family Safeguarding – evaluation and service expansion, working directly with parents to reduce risk of harm and need for care
- Working with parents – helping parents understand thresholds of interventions, impact and outcomes
- Emotional Health of children in care – ensuring children in care and care leavers have timely access to EHWB services
- Residential Care – development of quality and sufficiency in children's homes and supported living
- UASC – developing our specialist knowledge and services to unaccompanied asylum seeker children and young people
- Family Group Conferencing – supporting families to use their wider family network for support

Education, Early Years: Improvement, Inclusion and Planning:

- Extension of the role of the virtual head to vulnerable children
- Develop an Early Years strategy to drive forward access and quality in provision to young children preparing them for school
- Development of a new secondary school in Worcester
- Deliver against the school capital planning programme – ensuring sufficiency in school places
- Education and Skills Strategy – ensure the ESS identify care leavers and vulnerable people who are not in education, employment of training (NEET)
- Development of the Integrated Care System – ensuring WCF and Health partners work in collaboration in providing services to children and vulnerable learners

Children with SEND and Disabilities: (All Age Disability)

- Implementation of the SEND Accelerated Progress Plan
- Development of the All Age Disability Services
- Development of community short breaks offer
- Development of shared care/independent living

These are all set out with level 1 and level 2 plans that include milestone activities and outcome measures to be monitored throughout the year.

Finance and Risk Management

The business plan concludes with the company's financial information and our risk management approach.

Introduction

Worcestershire Children First Business Plan

2022-23 will be the third year of Worcestershire Children First (WCF) delivering children's services across the county of Worcestershire. These services include Early Help and Support to Children in Need, Children's Social Care and Safeguarding, Through Care Services for Looked After Children and Care Leavers, Services for Children with a Disability, SEND services and Education Improvement, Learning and Achievement services.

WCF has an independently registered Fostering Agency providing foster care placements to children in care and we have an independently registered Adoption and Permanency service that works alongside our regional adoption agency "Adoption Central England" whose focus is to ensure we achieve timely permanency for children who have entered the care system.

The company is 100% owned by Worcestershire County Council and delivers its children's services on behalf of the local authority, working with partners across the county to ensure children, young people and families receive the best possible services.

The business plan sets out how we plan to sustain and improve, innovate, and invest during 2022-23.

Vision, Mission and Values

During 2021-22 we extended our values to include a fifth value, 'embrace diversity' to reflect our Company wide focus on Workforce and Culture and our commitment to diversity and inclusion.

Our Vision

Worcestershire to be a wonderful place for all children and young people to grow up.

WORCESTERSHIRE CHILDREN FIRST

Our Mission

Supporting children and young people to be happy, healthy and safe.

Our Values

Children at our heart

We will keep children and young people at the heart of everything we do.

Value family life

We will support and empower parents to care for their own children.

Good education for all

We will value education as the best start in life for all children and young people.

Protection from harm

We will act in a professional and timely way to protect children from harm.

Embrace diversity

A progressive culture of championing equality, diversity and inclusion.

WCF Company Governance

WCF Board Structure and External Governance

As a wholly owned Council Company, WCF has a contractual relationship with Worcestershire County Council to provide statutory children's services. WCF have a 'buy back' arrangement of 14 corporate support services, delivered by the Council with legal agreements.

These contractual arrangements, between Council and Company, are overseen by a Quarterly Review Board and a Performance and Commissioning Group to ensure contract compliance, within the terms of reference of the Company Board (**appendix 1**).

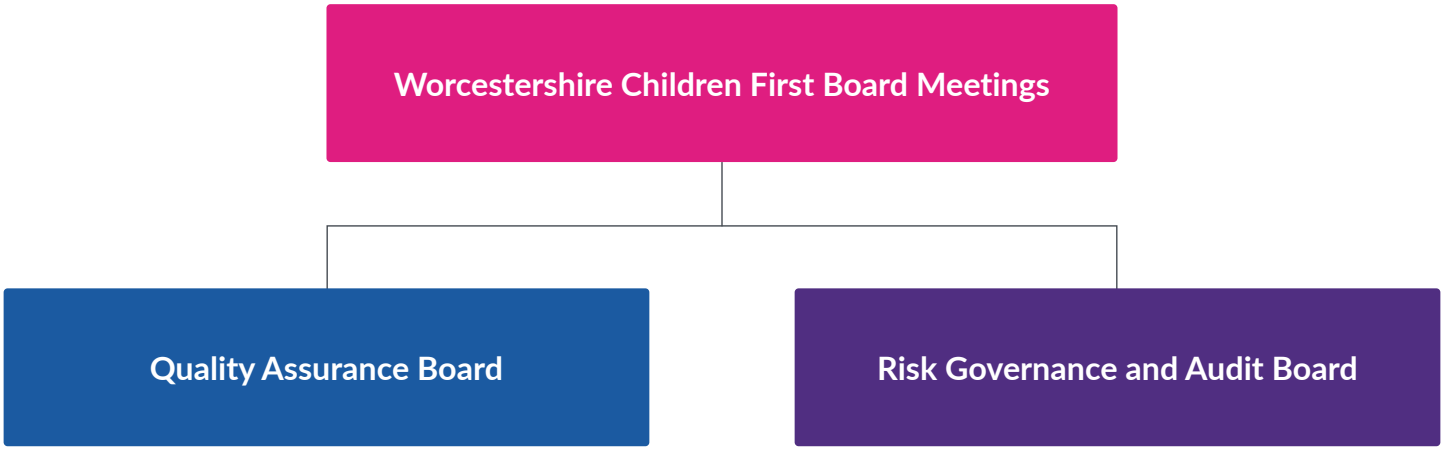
Our contractual Key Performance Indicators (KPIs) as shown in **appendix 2** hold WCF to account for delivering social care, early help and education services. Similarly, we monitor support from 'buy back' services through Support Service Agreements (SSAs). The formalities are managed day to day by WCC's Commissioning and Partnership Management function, working positively and proactively with WCF's Resources Directorate. The relationship is based on partnership, support, challenge, evidence, and achievement of outcomes. There has been a continued, strong, effective working relationship between WCC and WCF which goes far beyond the formal contractual monitoring arrangements, and these add the most value to improving outcomes for children and young people.

During 2021, WCF saw the appointment of Tina Russell to the joint position of Chief Executive and Director of Children's Services. The Directorship of Sarah Wilkins changed to Director of Education & Early Years: Improvement, Inclusion and Planning. There has been the addition of two new Executive Directors, Emma Brittain, Director of Early Help, Children in Need and Family Front Door and Adam Johnston, Director of Child Protection and Through Care and creation of a further position, Director of 0-25 All Age Disability Services, which is currently vacant. The board currently consists of 12 Executive and Non-Executive Directors with a wealth of public sector expertise in supporting families and communities. Executive Directors are those employed by WCF to lead and manage delivery functions and teams, whilst Non-Executive Directors do not have responsibility for day-to-day operations but provide input and challenge via Board meetings and sub-board meetings throughout the year.

Rob Morrison Chairman (DfE appointment)		**Tina Russell** Chief Executive and Director of Children's Services		
Phil Rook Director of Resources	**Sarah Wilkins** Director of Education and Early Years: Improvement, Inclusion and Planning	**Emma Brittain** Director of Early Help, Children in Need and Family Front Door	**Adam Johnston** Director of Child Protection and Through Care	**(Vacancy)** Director of 0-25 All Age Disability Service
Cllr Marcus Hart Non-Executive Director (WCC)	**Cllr Karen May** Non-Executive Director (WCC)	**Andrew Spice** Non-Executive Director (WCC)		
Sally Taylor Non-Executive Director (Independent)	**Claire Burgess** Non-Executive Director (Independent)	**Gareth Moss** Non-Executive Director (Independent)		

(■ (Pink) denotes Non-Executive Director; ■ (Dark Blue) represents Executive Director.
The Chairman of the Board is a DfE appointment ■ (Purple))

To maintain rigour, WCF's internal governance takes the form of monthly WCF Board meetings (with **an Annual General Meeting** and every third Board meeting held in public when conditions allow). Additionally, there are two subgroups reporting into the Board of Directors focusing on improvement of services; The governance structure for the Board of Worcestershire Children First can be seen in the diagram below:



The Quality Assurance Board

The Quality Assurance Board typically meets four times a year and oversees the quality and performance of our front-line Safeguarding and Education services in improving outcomes for children. This includes actively seeking the views and opinions of children and young people on the impact of our interventions and how we continuously learn and improve to be even better.

The Risk Governance and Audit Board

The Risk Governance and Audit Board typically meets three times a year and maintains an oversight of our governance, risk management, internal control and value for money framework. This Board ensures strategic compliance, management and performance of WCF as a whole with an unwavering focus on children and young people at the heart of our Company's purpose.

Internally, the Executive Leadership Team (ELT), who are responsible on a day-to-day basis for running the business, meet regularly to ensure service improvement continues with momentum, and to ensure all areas of WCF have strategic oversight. Regular reporting and monitoring impacts positively on outcomes for children and young people and is the core and demonstrable Company purpose. Their ambition for Worcestershire Children First is to be rated as 'Good' in provision of services.

Each year we will share our company achievement and challenges through our public meetings. This will be an opportunity for our stakeholders, young people, staff and the public to feedback on company performance and inform services.

Strategic Goals - Five Year Plan

Our ambition is to make a positive and sustained difference to the lives of children young people and families and to be able to provide a wide range of evidence to support this achievement. The diagram on this page provides a visual representation of how we plan to develop and improve our services for children, young people and their families over the next five years, and will guide our work in 2022/23 (our third full year in operation):

Years 1 and 2

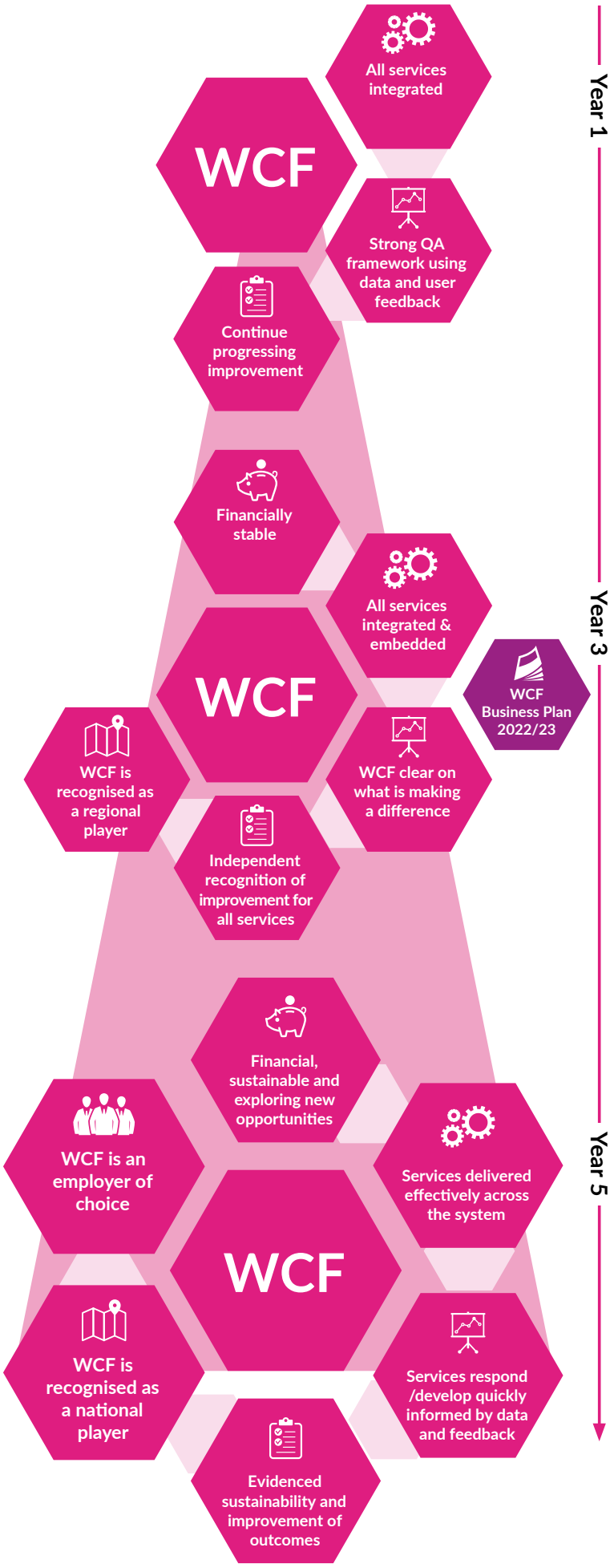
- Service user feedback indicates WCF is making a positive difference to CYPF
- Working under WCF Brand
- Building stable and productive teams, culture and behaviours
- Social care rated Requires Improvement (at point of transfer)
- Commissioner/Provider separation
- Support services tested and operational
- Demonstrate credentials with existing parties and children, young people and families

Years 3 and 4

- Increasing co-creation with children, young people and families
- Work effectively and efficiently within financial envelope
- Evidence of improved outcomes
- Embedding new culture
- Review opportunities for growth within existing services
- Wider strategic relationships developed
- Gain independent recognition of improvement and performance

Year 5

- Achieve sustainability and potentially explore new commercial opportunities
- Improved and evidenced outcomes
- Effective and responsive development
- Council and community are proud of WCF
- Begin review of commissioning intentions
- Integrated, effective partnership working across the system
- Support services sourced effectively



Internal Organisational Structure

Under the Chief Executive of Worcestershire Children First, sit five specific service areas:

Early Help, Children in Need and Family Front Door

- Family Front Door and Partnerships (Contact / Referral and Assessment: MASH)
- Targeted Family Support
- Get Safe Exploitation Team
- Emergency Duty Team
- Supporting Families First Children in Need

Child Protection and Through Care

- Locality Safeguarding (planning for children in need of support and protection)
- Through Care & Sufficiency (care and placement planning for children who are looked after)
- Supervised Family Time Service for children in care
- Residential, Supported Living and Outreach Services
- Children and Young People Participation
- Worcestershire Family Safeguarding
- Case Progression and Permanency Team

Education and Early Years

- Forecasting and planning to ensure enough good education places for children
- Admissions, Governor Services and supporting School Improvement
- Supporting schools, education and early years settings to promote welfare and safeguard children
- Vulnerable Learners – virtual school for looked after children and inclusion services to support and prevent children from missing education

0-25 All Age Disability Service including SEND

- Special Educational Needs & Disability (SEND) assessment, planning, review and support services
- Children with Disability services children's social care
- Young Adult services for children with disabilities and additional needs (subject to cabinet and consultation outcome at the time of writing)

Quality Assurance

- WCF Head of Quality Assurance (monitoring the effectiveness, quality and timeliness of services through audit, key performance measures and service user feedback)
- Principal Social Worker
- Independent Chairs for Looked After Children and Child Protection

Resources

- Human Resources & Organisational Design
- Funding and policy for Worcestershire Schools and management of Schools Forum
- Financial Management for WCF and Schools
- Commissioning Hub
- IT and management information
- Strategic Business, Transformation and Commissioning
- Traded Services for Education

Business Plan Improvement & Development 2022/23

Business Plan Improvement and Development

As set out in our vision statement the ultimate aim of our company is to provide children and families with quality services and support to enable them to receive a good education and to be safe in their care arrangements and community.

That means working with Education and Early Years providers to ensure children access high quality provision to give them the best start and education opportunity, to enable them to reach their full potential.

In safeguarding terms, it means supporting families with early help and support to reduce risk and harm, ultimately resulting in fewer children being in need of a child protection plan or care. **Appendix 4: Worcestershire Children First overarching business plan 2022-23**

Sustain and Improve

Our foremost priority is to sustain the significant improvements that we have achieved since we were first rated as an inadequate Children's Service in October 2016. What has been achieved is evidenced through our key performance indicators, our Quality Assurance Programme, and our inspection outcomes over the past three years, ultimately reflected in September 2021 with the removal of the statutory direction.

Sustaining such good levels of performance is not something that's achieved at any one point in time, it requires a continuation of hard work, commitment, and dedication of the whole workforce to be achieved and re-achieved every day, every month, and every year. Our quality assurance and business management processes are in place to ensure we monitor all our activity and the impact and outcomes being achieved for children and young people. We will continue to be a learning and improving organisation, our priorities for improvement are set out below.

Sustain and Improve
■ WCF Fostering Improvement Plan ■ WCF Adoption Business Plan ■ Permanency in care proceedings ■ SEND Accelerated Progress Plan ■ WCF Quality Assurance programme ■ Review Education and Skills Strategy ■ Service Reviews – Resources at Best value ■ Care Leavers – Education/Housing and Support

Innovate

We are proud to be in a place where we can build on the foundations of good practice and start to innovate. Innovation means taking that brave step to do something new and different. This can be a challenge when a natural response to having made such improvement can be to "stay the same" holding on to the stability of that improvement. WCF want to do even better. As part of our innovations, we will join with regional and national activities to both learn and share our own learning and best practice. Our priority innovations for 2022-23 are set out below.

Innovate
■ Development of community and overnight short breaks for independent living ■ Evaluation and delivery of Family Safeguarding ■ Supporting Families First - Children in Need ■ Development of the Virtual Head role ■ Empower & inform parents in Child Safeguarding processes ■ Promote the Emotional Health & Wellbeing of Children in Need and those in Care ■ Early Help: Family Hub & HAF Strategy ■ Get Safe / Get There: Reducing exploitation of children ■ Create an All Age Disability 0-25 service

Invest

"Money makes the world go around"

We know though it is often in short supply so we will take every possible opportunity for national, regional and local funding, alongside making savings in order to invest and re-invest in our front-line services. Our priorities for investment are set out below.

Invest
■ Development of WCF Residential Services ■ Family Group Conferencing - contingency for care & protection ■ Early Years Strategy - improve children's readiness for school ■ Deliver school Capital Programme ■ Develop provision and specialist resource for Unaccompanied Asylum-Seeking Children ■ Commissioning Strategy – best value ■ Worcester City secondary school

Three Pillars of Success

1. Working in Partnership with WCC

Working in Partnership with WCC (Worcestershire County Council) continues to be one of the pillars to success of our company we recognise in our plan, not just our own priorities and vision for what we want to achieve for children and families, but how important it is for people to see those children and families as members of the Worcestershire community.

The WCC priorities: **Open for Business**, **Children and Families**, **The Environment** and **Health and Wellbeing** are as important for the children and families that we work with as they are part of the whole Worcestershire community.

To thrive our children and their families need to have access to economic opportunity, accessible education and employment, to live in an environment that is a good place to live and grow up as a family and the physical and mental health of this younger generation is what is key to reducing need and demand in any long-term plan.

As a Council wholly owned company WCF and WCC have an interdependent relationship through the contractual delivery of children's services by the company and 'bought back services from the Council. We acknowledge WCC Priorities in our Business Planning to ensure we align with core areas of focus and access opportunities available for collaboration with our key stakeholder. WCF also have service delivery links with the People Directorate in terms of adult social care, community development and public health.

We demonstrate our wider commitment to multi-agency working via membership at other strategic partnership groups including:

- Worcestershire Safeguarding Children Partnership
- Health and Wellbeing Board and its Children and Young People Strategic Partnership
- Safer Communities Partnership
- Worcestershire County Domestic Abuse Forum
- All Age Disability Partnership
- Education Partnerships

We will be working alongside WCC in the key developments of WCC priorities.

All Age Disability

WCF are working with WCC to develop an improved all age disability experience, through provision of a joined-up offer of support and coordination of services for those children and young people with disabilities and special educational needs. This is underpinned by the new SEND Strategy and Action Plan and our joint commissioning and partnerships with health through the Integrated Care System.

We will be bringing the services of SEND for children together along with our social care disability team and young adults services to work under a single leadership and a coordinated geographical footprint across the County.

Our aim is to offer longer term life and independence planning for children and young people into adulthood without a sharp change in their support at transitional ages of 18 (social care) or 25 (education). Support will be planned early, with young people and their families/carers to ensure ongoing achievement and sustainment of their independence.

Our work will seek to embed arrangements for 'preparing for adulthood' from the earliest years, supporting young people with SEND to feel included in the community, achieve employment, experience independent living and have housing options, good health, friendships and relationships.

The corresponding benefit for both WCF and WCC is to ensure a better predictive understanding of plans for young people and assurance of ongoing costs and effective support and services of what they need when they get older.

Customer Service access to Council Services and Communications

We will work in partnership with the Council in reviewing our customer service experience and making improvements to meet the needs of Worcestershire's residents. Focusing on the digital accessibility, we will adopt effective customer service and utilise digital technology to ensure greater access and enhancement to our services.

Integrated Well-Being – Community Development

WCC continue to develop the Here2Help service. It has supported thousands of people in Worcestershire with emergency food parcels, medication collections, food collections and delivery. It has also grown the volunteering offer and strengthened relationships with districts, partners and the Voluntary Community Service, who have worked together to provide a One Worcestershire response.

Following the success of the service, WCC is now building on the opportunity to evolve the service into an Integrated Wellbeing Offer with a vision to offer all residents that are in need, early intervention and prevention, empowering and enabling people to find their own solutions within their community-led services to reduce the impact on statutory services.

The progression of this is looking at how we provide a partnership approach to the delivery of both virtual and community location-based advice, support and services for both adults and children. The delivery of Early Help and support in our communities to children and young people is a key priority for the Early Help Partnership and this includes being part of the regional work looking at the role and delivery of the Family Hub model.

Digital Strategy - Worcestershire is a place where staff members, people, communities and businesses can flourish digitally

WCF recognise the opportunities that present in WCC's Digital Strategy 2021-23 and fully support the digital vision to use modern technologies to fundamentally improve how we support our staff, communities, businesses, and visitors. Digitalisation can enable the streamlining of delivery of our services so they can be provided in the most efficient and cost-effective way possible to our children, young people and families. The installation of video conferencing units in our meeting rooms at County Hall and off-site locations supports our hybrid model of face to face and remote working for all teams. We will continue to maximise technology to develop self-service systems for parents and carers, with the introduction in 2022 of a free school meals eligibility checking service, and an automated system for in-year school admissions, and a new e-store for traded services for schools and settings.

Development of our Commissioning Strategy

The WCF Commissioning Hub was launched in October 2021. Our company-wide consistent approach using the hub model ensures we are:

- meeting the needs of children and young people
- maximising value for money when we make placement decisions
- securing savings or avoiding additional costs through effective procurement
- quality assuring the services and provision we commission
- seeking continuous improvement in the way services are delivered
- meeting statutory timescales
- reporting within forecasted budget
- Managing within our financial agreed budget

School Place Planning

WCF works in partnership with WCC and other partners to forecast, plan and deliver to the right level of school places in education planning areas, as population levels grow and contract. We also work together to monitor and maintain the corporate estate of schools, prioritising programmes of work to keep our school properties maintained and safe. Key to this is securing funding for expansion via government, council and housing growth sources. Work this year includes the expansion of places in some schools, creation of permanent accommodation to replace temporary accommodation, progress a coordinated approach to the organisation of schools in the Pershore area, improve our sufficiency of the right specialist provision for children with SEND and secure the next steps towards a new secondary school for Worcester.

2. Working in Partnership with our Workforce

Our Workforce continues to be a second pillar to the success of our services.

Our workforce is our most valuable asset to successfully deliver services that make a positive difference for our families in Worcestershire. We strive to be the 'employer of choice' for children's services staff, and we approach this through a culture that values the impact that our staff have in improving children's lives. We have high expectations and have created the conditions where professional expertise is valued and can flourish, where everyone is empowered to act and supported to succeed.

2021-22 continued to be a response and reset as the pandemic continued to sweep through the nation. We saw a continued increase in workload and pressures as we experienced a rise in the demand for help and support. There was an increase in the number of serious harm cases in young children and a rising demand for support and assistance for children with additional needs.

Despite these pressures and national challenges on recruitment, our workforce overall has remained remarkably stable and committed to Worcestershire Children First; with over 93% permanency in staffing overall, 88% permanency in front line social worker posts and 99% in managerial posts. This stability is an important part of sustaining our continued quality. (All figures are as at quarter 3 2021-22.)

However, "change and turn over" is an inevitable part of an organisation and as such positive and timely recruitment, bringing new people into our services and supporting internal career development of others, also adds a valuable mix of experiences, knowledge, skills and diversity to our workforce which we welcome. This year 2022-23 we have added a fifth value to our vision, which is to recognise and value diversity in our workforce and in our community of children, young people and families.

In July 2021 we launched our Workforce Strategy, which sets us out as an organisation of high challenge and high support. The strategy focuses on the following workforce foundations:

- Health and Well-being
- Recruitment and Retention
- Diversity and Culture
- Leadership and Management
- Building Skills for our Future Workforce

Our staff conference was held in November 2021, and we launched our 5th Company Value – Embrace Diversity, to reinforce our commitment to continue to develop a progressive culture in which we champion equality, diversity and inclusion. Our Diversity and Inclusion Collective invites all staff to participate in a monthly forum of discussion, learning and development.

In 2021 we introduced our annual Voice of the Workforce (VOW) survey; a system health check and a barometer of our services that enables staff to share their views and feedback on the strengths and areas for development to support continuous improvement. The survey was completed by 61% of the workforce and its findings support the key priorities of our quarterly Workforce Board.

We structure our service planning using an End-to-End approach; this ensures we think whole service, ensuring all staff across our teams and service areas are included and outcomes for children are prioritised, wherever they are in their journey through our services.

Our Workforce Strategy is underpinned by our robust Quality Assurance programme. Using the Key Performance Indicators, Audit and feedback from children, young people and families we will improve our understanding of how the strategy is supporting us to deliver good quality services in relation to:

- Staffing stability – permanency and sickness
- Voice of the child – quality of practice through audit
- Participation and inclusion – recruitment and service development
- Compliments and Complaint - outcomes and learning

Quotes from the workforce

91% of staff said that the new smart ways of working, such as virtual technology/blended office & home working have supported them to undertake their job effectively.

92% of staff said they felt Worcestershire Children First was an inclusive organisation and was proactive in promoting anti-discriminatory practice.

93% said that their direct line managers were visible, approachable, and responsive, and 92% said they received dedicated supervision and review of their performance.

99% of our Social Work Workforce said that they use a strength & relationship approach in their practice with children and families.

3. Working in Partnership with Stakeholders

This is the third pillar key to our company achieving success. Whether it is partnership with children and young people themselves, their parents and carers, or the wide-ranging agency partnerships we know how valuable and essential it is for us to work together, to share experiences, learning and best practice.

The following are the priority formal partnerships led or attended by Worcestershire Children First:

Local Partnerships

- **WSCP** – DCS is member of the Executive Board with Get Safe and QAPP subgroups led by WCF
- **HWBB and all associated ICS partnership forums** – DCS and Director membership at all groups
- **Children & Young People Partnership – subgroups Early Help Partnership / All Age Disability (previously SEND) and Emotional Health and Wellbeing Collaborative** – WCF Executive leadership representation at all groups
- **Local Family Justice Board (LFJB)** – DCS and AD for Care Proceedings and Permanency
- **Sharing practice learning and what works: Models of success** - The Supporting Families First team is a WCF multi-disciplinary team that has built a new model of working directly and intensively with both adults and children to bring about changes within families facing multiple and complex challenges, often in crisis. The positive outcomes achieved by this approach are significant and therefore Dudley has asked us to work with them intensively on developing and implementing this model of working within their Local Authority's work with families. WCF have seconded a Practice Manager to Dudley to support this regionally.

Regional Partnerships

Worcestershire Children First is a fully engaged member of the regional DCS group with committed membership through the range of subgroups and the regional improvement alliance.

- **Early Help** – Co-Chair WCF Director of CIN, Early Help and Family Front Door
- **ADCS, link to family hub and troubled families** - Co-Chair WCF Director of CIN, Early Help and Family Front Door. The regional ADCS group which has both the Family Hub model and Supporting Families agenda as its key priorities. This forum looks at service delivery and models of practice across the West Midlands region; how these influence and shape the services that our children and young people receive, developing best practice delivery across the region but also here in Worcestershire.
- **Quality and Practice** – WCF Directors of CIN and Through care
- **Education and SEND** – WCF Director of Education
- **Principal Social Work Network** – WCF Principal Social Worker
- **Strategic Performance Network** – WCF DCS sponsor and WCF Senior Data analyst
- **Safe Centre** – Worcestershire tri member representative LA
- **Dudley Supporting Families First** - intensive work with Dudley on developing and implementing the WCF Supporting Families First model of working
- **Quality Assurance Practice & Procedures Group (QAPP)** - Multi-Agency Quality Assurance is also a key area of our work, where regular multi-agency auditing, feedback and KPI analysis is undertaken, to learn about the effectiveness of our multi-agency safeguarding arrangements, this work is driven through the Safeguarding Partnership and the Quality Assurance Practice & Procedures Group (QAPP).

National Partnerships

- **National Improvement Alliance** – WCF DCS lead for West Midlands
- **MASH – National working group (lead by ACC Jones West Mercia Police)** – DCS and Director membership on working group and subgroups
- **Research regarding supporting families and care prevention (Newton Europe)** – WCF one of six LA/Trust engaged for deep dive
- **Research into structural change in children's services (LGA Research)** – WCF one of six selected ADMs

- **Introducing greater transparency in, including media access to, the work of the family courts (ADCS led by Justice McFarlane)** – WCF Assistant Director for Care Proceedings and Permanency
- **LGA – early years strategy work** - Worcestershire is one of 12 local authorities working with the Local Government Association (LGA) to develop an Early Years Strategy. The support involves mapping current supply of services for pre-birth to five, alongside current childcare provision and identifying what our gaps and challenges are. The key strategic outcomes will be identified alongside priorities. The LGA will then support with consultation to create the most effective design for the services to meet the priorities. The Strategy development will include the diverse childcare sector of the County, health commissioners and providers and partners.
- **Secretary of State for Education's Attendance Action Alliance** – the Children's Commissioner's Office is carrying out an attendance audit of local authorities. Following on from the SEND inspection report noting the effectiveness of the Missing Monday's forum, WCF has been invited to take part in a 'deep dive' exercise to understand how multiple agencies can work together in local areas to identify children who have dropped out of education and deliver interventions to support them.

WCF Quality Assurance Framework

Worcestershire Children First have developed and appointed to a new post of Head of Quality Assurance, this role oversees the Quality Assurance work of Social Care & Safeguarding, Early Help and SEND Services. Our Quality Assurance Framework has three dimensions:

- **Key Performance Indicators:** Analysis of our business and performance information on a daily, weekly, monthly, quarterly, and annual basis – this enables us to understand how much we are doing and how timely we manage this work
- **Feedback from Children, Young People and Families:** We are committed to understanding the experiences of our work and services directly from children and families; we strive to learn from these experiences and build it into our future practice. We bring this learning together from Compliments and Complaints, but we also have a programme of quarterly feedback mechanisms to hear about children and families' experiences – this supports us to understand the impact of our work and the difference we are making
- **Audit Activity:** Completion of case file audits (using a peer and moderation approach) and targeted audits; each area of the service has a programme of quarterly audits – this supports us to know the quality of our practice

Multi-Agency Quality Assurance is also a key area of our work, where regular multi-agency auditing, feedback and KPI analysis is undertaken, to learn about the effectiveness of our multi-agency safeguarding arrangements, this work is driven through the Safeguarding Partnership and the Quality Assurance Practice & Procedures Group (QAPP).

Throughout 2021-22 we have developed our Quality Assurance approach for SEND with the introduction of a new case file audit programme and feedback mechanisms, a focus of 2022-23 will be consolidating this work. Each service area will have a report on the key learning from both qualitative and quantitative findings and enables us to learn as a service and to continue to improve services for children.

Quality Assurance and Scrutiny

We promote and engage with rigorous internal and external scrutiny and quality assurance (QA) mechanisms, to ensure we deliver high-quality service provision through:

- WCC Corporate Parenting Board
- WCC Children and Families Overview and Scrutiny Panel
- Worcestershire Safeguarding Children Partnership
- SEND Improvement Board

In 2022-23 WCF will be pro-actively preparing for Ofsted and DfE Regulatory inspections for children's local services. This includes:

- Inspection of Local Authority Children's Services (ILACS)
- Residential Children's Homes
- Independent Fostering Agency (IFA)
- Joint Targeted Area Inspection (JTAI)
- Regulatory Inspections of Schools
- Local Area SEND
- Adoption Service

In 2021 Ofsted undertook a focused Inspection Visit to Children's Social Care evidencing independent validation of our work, in respect of our quality assurance framework they said:

"The quality assurance framework is a strong area of practice, well embedded internally and across the safeguarding partnership. In particular, the audit approach is very effective. Children's case file audits are well moderated and identified actions followed through to completion, making a real time difference to improving interventions in case work. Collective learning from quality assurance activity, including extensive child and family feedback, is used well to inform service improvement"

Feedback from Children, Young People and Families include:

"I love living with my dad, my care order is now discharged, and I am no longer looked after. I am pleased about this" (child)

"Talked to me making me understand that some of my choices were not great but she also told me she was proud of me for knowing my future and securing a place at college, she never talked down to me I felt listened to" (young person)

"Asked the questions that were needed rather than asking irrelevant questions. She reassured me and made me feel comfortable. Conversations were recorded accurately" (young person)

"The worker has been both nurturing and direct when it has been needed, her knowledge in so many areas are astounding but most of all her understanding and compassion at a time when I felt like giving up will never be forgotten. Outstandingly supportive, deeply knowledgeable and one of the most beautiful natured people I have had the privilege to get to know" (Foster Carer)

"You have made an impact on my life all the time we have met up, you were and always will be someone I trust and remember for the rest of my life" (Child)

"I just wanted to say a massive THANK YOU for your positive communication and patience re all the documentation for the EHCPs and SEN questions. There was much. It was so reassuring being understood, to be listened to and dealt with positively" (Parent)

"I just wanted to pass on my gratitude with regards to the work the Social Worker has completed with myself and the boys. She's a credit to the social care sector. She's so kind, empathetic, and sincere. She's always gone above and beyond for my boys; they have benefited from all of her hard work. I'll always be grateful for her coming into our lives, as she's been an integral part of our journey as a family. She has managed to renew my trust in social care! I just wanted to pass this on to you as her manager" (Parent)

"Oh, my goodness, yes yes yes! The school rang me before I saw your email and since then I have spoken to them. We are thrilled about it, so much that I cried!! Thank you for doing more for us than any other caseworker has ever done for us. Not just for this but your lovely caring attitude" (parent)

Between 1st April – 31st December 2021, 272 families gave us direct feedback on the experiences of their services, what families told us evidences to us that how they have experienced our services has been sustained from the previous year. They told us:

- 97% of families felt that they were given opportunities to share their views and opinions.
- 95% of families said that their worker (Social Worker, Early Help Family Support Worker, Personal Advisor) listened to their child's views.
- 95% of families said that they felt included within the assessment and/or plan for their child.

The next section of this business plan sets out how each individual service area within WCF has its own business as usual plan of activity and "Priority Plan on a Page" to ensure we deliver against our 2022-23 business plan.

Early Help, Children in Need and Family Front Door Priorities

Our Values  Children at our heart  Value family life  Good education for all  Protection from harm  Embrace diversity	
Area of priority	**Milestones**
Supporting Families First - Children in Need	■ Development of new Autism parenting support worker to support families in the community. ■ Webstar: demonstrating impact and outcomes for children, young people and their families. ■ Prevention of escalating risk into child protection and needing to become Looked After where safe and appropriate to do so. ■ Development of the Family Group Conferencing model for WCF families.
Emotional Health & Wellbeing – for children in need through to those in care.	■ Development and expansion of the emotional health and wellbeing offer in Supporting Families First to include 2 FTE higher intensity emotional health and wellbeing workers. ■ Joint initiative between WCF and health delivering an emotional health and wellbeing workshop to FSW in schools across the six districts.
Early Help in the community	■ Develop and implement the Worcestershire Holiday, Activity and Food strategy. Engaging hard to reach children and young people and supporting community connection via providers. ■ Launch the virtual Worcestershire Family Hub page on WCC website and register this. ■ Work with partners, Here 2 Help and regional Local Authorities on the development of Worcestershire's Family hub model. ■ Continue to demonstrate impact and outcomes for the Supporting Families agenda reaching our Worcestershire target, increasing the engagement of partners. ■ Further develop the evidence base of partnership community based early help delivery.
Get Safe – Get There	■ Effective use of intelligence and profiling of the GET SAFE / Get There cohort. ■ Ensure the GET SAFE approach adapts and develops to meet the challenges of this abuse.

Measures

- Communication to parents in the medium of animated film to engage and aid their understanding of what we do.
- Strong positioning of WCF to submit business cases to future DfE grants to support innovation and service development.

Child Protection and Through Care Priorities

Our Values  Children at our heart  Value family life  Good education for all  Protection from harm  Embrace diversity	
Area of priority	**Milestones**
WCF Fostering Improvement Plan	See the fostering improvement plan – **appendix 4** ■ Safer caring plans and risk assessments ■ Notifiable events ■ Quality Assurance and performance ■ Safer recruitment/foster carer – workforce development ■ Voice of the child and views and experiences of parents ■ Foster carer recruitment, assessment and support and the voice of foster carers ■ Approval/matching foster carers
WCF Adoption Agency Business Plan	WCF VAA Workstreams are: ■ Permanency Plans and development of Post Adoption Contact ■ Early Permanence/Foster for Adopt ■ Quality Assurance/Improving Child Permanency Reports/Role of Adoption Panel, Feedback and Performance ■ Safer Recruitment & Workforce development ■ Voice of child & voice of Adoptive parents/Birth Parents/ & Adoptive Birth Children ■ Adoptive Parents Recruitment, Assessment & Support ■ Adoption Decision Making Process & Matching
Permanency in care proceedings	■ Refresh the Family & Friends Policy ■ Conversion of 38 cases form Kinship to Special Guardianship Order (SGO) ■ Discharge of 18 Care Orders (12 families) and placement with parents' placements ■ Complete care proceedings with SGO permanency outcome

Our Values  Children at our heart  Value family life  Good education for all  Protection from harm  Embrace diversity	
Area of priority	**Milestones**
Care Leavers – Education/ Housing and Support	■ Implementation of DfE Mark Riddel's Peer Review recommendations ■ Development of a IRO transition protocol from care to pathway plans ■ Appointment of a dedicated IRO for complex pathway planning transitions ■ Corporate Parenting Board sub-groups to be developed to deliver on Pledges to include young person and elected member representation ■ Business conference events to be held for each district to address EET ■ Develop and launch district housing pilot to increase housing provision and employment support ■ Review the House Project support to Care Leavers transitioning to independence and build a Worcestershire model ■ Evaluate outcomes of Complex Care Leavers Project alongside District Housing and social landlords to expand tenancy offer
Evaluation and delivery of Family Safeguarding	■ Secure investment for expansion of WFS ■ Recruit to new posts ■ Revise working protocol to reflect expansion and working within locality teams ■ Quarterly evaluation reports ■ Identify data (reduction in LPLO and Care) on which to base future base funding ■ Launch of Domestic Abuse Strategy & newly re-commissioned DASS, IDVA & DRIVE services – April 2022 ■ Launch of newly re-commissioned Domestic Abuse Training – April 2022 ■ Joint Adult Activity with West Mercia Police focused on timely receipt of Domestic Abuse Notifications
Empower and engage parents understanding in the Child Safeguarding processes	■ Produce video for parents to enable an understanding of safeguarding processes from Section 47 through to care proceedings ■ Develop cultural safeguarding practice to effectively risk manage alongside families and partners and avoid successive placement breakdowns for CYP

Our Values	 Children at our heart	 Value family life	 Good education for all	 Protection from harm	 Embrace diversity

Area of priority	Milestones
Emotional Health & Wellbeing – for children in need through to those in care.	■ Audit focused on EHWB element of Health Assessments with health partners ■ Section 117 step down process for CYP to be embedded ■ Review and amalgamation of EHWB/MH boards and working groups to inform ICS and collaborative approach (see Developing an Integrated Care System below)
Development of WCF Residential Services	■ Develop 1 bed children's home with DFE capital bid funding ■ Review renumeration for residential staff to address recruitment and retention difficulties ■ Live action plans to be maintained, shared and reviewed between WCF homes (to include triangulation of care plans with behavioural/safety plans and risk assessments) ■ Standards and SOP's for each WCF semi-independent provision to be implemented and impact measured ■ Develop partnership(s) with external provider(s)
Develop provision and specialist resource for Unaccompanied Asylum Seeking Children	■ Regional NTS development around exodus of UASC from 'shire counties to metropolitan centres ■ Consideration around specialist development of vacant provision ■ Explore UASC offer in Redditch to encompass accommodation, education and community links
Family Group Conferencing	■ Secure investment for the development of a FGC ■ Launch of FGC

Measures

- Evidence of best value in commissioning placements for residential education and children in care
- % of children in care in foster care
- % of children in foster care placed in an internal foster care provision
- Completion of residential new build and refurbishments to increase in house residential provision for mainstream and unaccompanied children and young people
- % of children homes judged to be good or outstanding
- % of health assessments completed in time scales with the quality of improved quality of assessment of emotional health and well-being needs supporting timely access to appropriate services for looked after children
- Increase the % of children exiting care with SGO

- Reduced the number of children placed with Parents
- % of children who achieve permanency out of the care system within 12 months of being received into care
- Stabilising of the high needs deficit and reduction in high needs spend associated with placements
- % of care leavers who are in EET and living in suitable accommodation
- Launch of the family group conferencing service

Education, Early Years Improvement, Inclusion and Planning

Our Values  Children at our heart  Value family life  Good education for all  Protection from harm  Embrace diversity	
Area of priority	**Milestones**
Extension of the role of Virtual Head Teacher	■ Develop and share outcome data profile for children with a social worker ■ Completion and findings of the joint project Virtual School and Supporting Families First ■ Toolkit, good practice, and training involvement for target schools
Early Years Strategy - improve children's readiness for school	■ Completion of the Early Needs Assessment findings and analysis ■ Findings of the Early Needs Assessment applied to the Strategy outline ■ Co-production of the priorities with stakeholders ■ Creation of the action plan ■ Collection and analysis of Foundation Stage attainment data (2022) ■ Completion of LGA project
Worcester City Secondary School	■ Complete land purchase for site ■ Appointment of construction design and build contractor ■ Successful completion of competition process for Academy sponsor ■ Plan for further CYP engagement and involvement in scheme for design and build

Our Values	 CHILDREN AT OUR HEART	 VALUE FAMILY LIFE	 GOOD EDUCATION FOR ALL	 PROTECTION FROM HARM	 EMBRACE DIVERSITY

Area of priority	Milestones
Deliver against the school planning Capital Programme	■ Confirmed and prioritised funded capital maintenance programme ■ Wolverley CE Secondary School – permanent accommodation scheme ■ Confirm and share recommendations for Pershore Pyramid and progress ■ Confirm plan and agree timescales for Bromsgrove expansions ■ Confirm and agree special provision plan to respond to SEND Accelerated Progress Plan
Review Education and Skills Strategy	■ Alignment of strategy document to other WCC/WCF current strategies and plans ■ Alignment of strategy ethos and actions to the SEND Accelerated Progress Plan ■ Completion of audit of each objective against current practice to identify gaps ■ Consultation with stakeholders of actions needed to close identified gaps. ■ Complete Strategy review with response and plans following publication of Education White Paper (2022 tbc) ■ Review and implement year 2 plan of Exclusion and Alternative Provision review
Developing an Integrated Care System	■ WCF representation on relevant levels of governance and programme boards ■ Development of outcome-based commissioning activity ■ Confirm workplan/intentions for CYP joint commissioning group

Measures

- Baseline and improvements in the foundation stage attainment for early years children
- Increased take up of funded places for 2-year-olds to above England averages
- 4/5 schools judged to be good or outstanding by Ofsted standards
- % of vulnerable children (i.e. they are subject to a social work plan) who are excluded or missing in education being less than national averages
- Increase in joint commissioning arrangements
- Communication for families in mixed media form completed for accessibility and understanding of education actions and processes e.g., exclusion, managed moves

0-25 All Age Disability Service and SEND

Our Values	 Children at our heart	 Value family life	 Good education for all	 Protection from harm	 Embrace diversity

Area of priority	Milestones
SEND Accelerated Progress Plan	■ Address the variation in the skills and commitment of some mainstream schools to provide effective support for children who have SEND ■ Increase the range of suitable specialist provision to meet the identified needs of children and young people ■ Improve relationships with parents and carers and the level of engagement, co-production, and collaboration ■ Improve the quality of EHCPs and contributions from health and social care along with the process to check and review the quality of EHCP plans
All Age Disability	■ Transformation to SEND 0-25 Partnership Board to drive leadership and developments ■ Recruit to Director position ■ Complete formal consultation with staff (subject to Cabinet recommendations) ■ Implement reorganisation to new operating model ■ Implement evaluation recommendations from Year 9 onwards review toolkit ■ Launch and monitor impact of travel training approach
Development of Community short breaks offer	■ Re-commissioning of community short breaks to extended reach and availability
Development of shared care independent living preparation offer	■ Complete and progress business case for the recommissioning of Greenhill Lodge for community support, overnight breaks, respite, and independence provision

Measures

- Development of community and overnight short breaks for independent living
- Delivery of the accelerated action plan for SEND services receiving favourable reports in relation to progress made against the four priority areas
- Launch of the 0-25 All Age Disability structure and staff transfer to WCF
- Reduction in the percentage of children with disabilities received into care in an unplanned way
- Communication to parents in the medium of animated film completed and available for all parents accessing 0-25 all age disability services

Quality Assurance Priorities

Our Values	 Children at our heart	 Value family life	 Good education for all	 Protection from harm	 Embrace diversity

Area of priority	Milestones
Children's Social Care & Safeguarding (inc. Early Help, FFD & Child in Need and Child Protection & Through Care)	■ Sustain all managers and group managers undertaking a quarterly programme of case file audits, moderations, and targeted audit activity ■ Sustain our feedback mechanisms to hear about children & families experiences ■ Continue to strive to improve services and quality of practice from our learning to improve outcomes for children & families ■ Learning presented through newsletters and reports evidencing our sustained and improving practice – outcomes for children ■ Innovate a new virtual tool for children and young people to share their views and feedback on their experience of our work called "Have Your Say!" – this is in replace of Mind of My Own and will go live in April 2022 ■ Innovating our audits to include the development of 'Embracing Diversity into Audits and Feedback' – go live January 2022 and we will see the outcomes and learning from this from April 2022 onwards ■ Independent validation through focused visit or ILACs Inspection and our annual conversation with Ofsted
Worcestershire Children First Fostering	■ Milestones and measures connected to the WCF Fostering Improvement Plan ■ Independent validation through Ofsted reinspection visit on progress of our improvement plan ■ Establish a programme of lead/peer and moderated audits on the quality of interventions, support & supervision of foster carers – audit areas will be connected to key areas of Fostering Improvement Plan ■ Establish opportunities for children, young people, birth parents and foster carers to share their experiences of our services through audits and targeted feedback ■ Learning presented through newsletters and reports evidencing our learning both quantitative and qualitative, share this learning to close the learning loop and evidence impact & improved outcomes for children
Residential Services	■ A programme of quarterly case file audits, to include visits to children's homes by Registered Managers and moderated by Group Managers to evidence the experiences of children within our care settings ■ Opportunities for children & young people in our care to share their experiences of living in our residential settings ■ Monthly independent visitor visits to our residential settings with reports on strengths and areas for focus by the RI and RM ■ Independent validation through Ofsted Inspections of our residential & short-breaks settings

Area of priority	Milestones
Safeguarding Quality Assurance (IROs, CP Chairs & LADO Service)	■ Sustain a programme of monthly mid-way audits by IROs & Chairs for children on CP Plans and Care Plans ■ A programme of quarterly targeted audits, annual practice observations and annual diagnostic interviews with IROs/Chairs to quality assure the work of SQA, our impact and learning ■ Opportunities for children & young people and their families to share their experiences of our services through mid-way audits and targeted feedback surveys ■ Opportunities for partner agencies to share with us their experiences of conferences, reviews, and the MOA Service through targeted surveys ■ Feedback mechanisms will also include 'End of Placement Feedback' and 'Learning from Disruptions'
SEND / All Age Disability	■ Milestones and measures connected to the SEND APP ■ Consolidation of the audit programme piloted in 2021 – new Education, Health & Care Plans ■ Development of the audit programme to include annual reviews & Year 9 reviews – April 2022 onwards ■ Development of wider Service User feedback mechanisms to hear about children & families experiences of our services – quarterly programme of targeted feedback opportunities ■ Development and appointment of a SEND Complaints Officer, the role will centralise complaints tracking in SEND Service, they will also investigate and respond to Stage 1 complaints as well as identifying learning and supporting practice development. ■ Development of learning briefings/newsletters and presentations to share learning across the services ■ Development of learning guides/seven-step briefings on learning from Quality Assurance for partner agencies ■ Independent Validation through DFE and NHS England Monitoring Visits
Workforce	■ Opportunities for all staff to share their views through the annual 'Voice of the Workforce Survey' ■ Engagement with the annual 'LGA Social Work Survey' and undertaking our own Social Work health check ■ All staff engagement with the WCF Staff Conference ■ Development of specialist leadership and management training, resources, and information ■ Development of workforce plans and career pathways, including apprenticeships and succession plans for service areas across WCF

Measures

- Quality assurance analysis reports evidencing:
  - » Children and young people tell us they feel listened to, safe in their care placements and that interventions make a difference to their lives
  - » Audits evidence sustained good practice and continuous improvement
  - » KPIs remain stable and or above England averages
- Outcomes of the workforce strategy staff tell us:
  - » they feel valued, supported and developed as a workforce
  - » workloads and caseloads are manageable
- % Of staff permanently employed
- % Of social work staff permanently employed

Finance

This section describes the resources to run Worcestershire Children First (WCF), agreed funding arrangements for 2022/23 with indicative contract sums for 2023/24 and 2024/25 reflective of current forecast demand. The figures are indicative at this stage as the Council is currently reviewing its Medium-Term Financial Plan and is awaiting the outcome from consultation on local government finance reforms, due for consultation in Spring 2022.

The key driver for WCF is to sustain and improve our services to ensure the best outcomes for children, not cost reduction or income generation. However, given the current challenging financial context and to mitigate future cost pressures the company focuses on trading with schools through our Learning and Achievement Services and efficient use of resources to ensure value for money. The budget for 2022/23 is in full alignment with the Council's Budget setting process and this was considered and agreed by the Worcestershire Children First Board on 20 January 2022 and Worcestershire County Council's Cabinet on 3 February 2022.

Summary of Financial Information

The agreed contract sums are shown as two separate elements, net funding from WCC base budget and grants passed through to the company to arrive at the gross contract price, and with Sales, Fees and Changes to arrive at the total company turnover. These are shown in Table 1 below.

Contract Sum	Original Budget 2021/22	Original Budget 2022/23
	£000	**£000**
Net Budget funded by WCC	106,583	109,143
Other Funding passed through:		
Funding added to contract (Grants / Income / Reserves)	18,865	25,778
Total Gross Cost funded by WCC Contract	**125,448**	**132,462**
Sales, Fees and Charges	1,995	2,459
Total Gross Cost	**127,443**	**134,921**

The contract sum includes external funding that would be required to be transferred to the Company, on top of the Council 'Net Budget', to fund the gross expenditure requirements of Worcestershire Children First. The net budget includes the cost of Support Services that are purchased from the County Council £7.5m in 2022/23.

Service Budgets

The total gross expenditure budget 2022/23 financial year is **£135m**. In development of the financial model and as part of the development of the business plan for WCF, a detailed review, analysis, challenge, and scrutiny has been completed by finance staff, the WCF Board and as part of the agreed governance arrangements in the contract and agreed by both the Chief Financial Officer of the council and the Director of Resources for WCF.

2022/23 Service Gross Expenditure Budgets

In November Will Quince MP, Parliamentary Under Secretary of State for Children and Families confirmed that the Statutory Direction placed on Worcestershire County Council has been lifted and we have formally moved to the "support and supervision" period. This is a key milestone in our improvement journey and demonstrates the significant progress made in safeguarding and the services for vulnerable children in the County despite huge financial pressures in Children's Services.

The budget for 2022/23 includes a continued commitment by the council to invest £7.9m to improve outcomes for children and young people (up to the age of 25) in Worcestershire.

	2022/23 £m	Comments
Funding ongoing children's social care placement pressures	5.9	Reflects gross increases in potential demand for numbers of cases and inflation for cost placements
Pay inflation	1.3	Staff inflation 3% across 2021/22 and 2022/23 noting the pay award for 2021/22 offer has been made but not agreed.
Prices Inflation	0.7	Contract inflation, including SEND and Home to School Transport costs
Total Gross	**7.9**	
New Funding		
WCF will in part be funded for 2022/23 by use of Social Care Grant plus the one-off Services Grant	(5.6)	The 2022/23 budget funds the agreed potential costs faced by WCF for the coming year. The in-year budget will be monitored carefully to assess any recurrent pressure. The net budget will be uplifted in 2023/24 if the one-off grant is removed and the demand remains. This is expected to be revised base budget starting position of at least £4.1 million.
Net base budget change	**2.3**	

A further £1.9 million of one-off funding has already been set aside as an earmarked reserve for potential placement pressures that could arise following recovery from the pandemic to mitigate an increase in demand.

A draw down has not been required in the last three financial years due to the strong leadership, good practice in the service and careful financial management. However, during the past year, the associated impact of the pandemic has resulted in increased demand and costs for support, protection, and care services, including for children with special educational needs which has risen locally in line with the national picture. Therefore, the financial risk has increased.

It should be noted that in these tables, certain assumptions have been made in respect of growth, savings, and inflation. For inflation, assumptions are in line with WCC MTFP. Utilities such as gas and electricity have also been inflated over the period, by amounts that again are in line with the WCC MTFP.

In terms of demand growth, the budget reflects the latest agreed monitoring position, which incorporates trend analysis and a revised monthly forecast which is reviewed in detail. This means that the budget includes the most recent estimate of increases/decreases across all placement types over the period.

Table 2: Recurrent operating costs WCF (2022/23)

Ref.	Service	Staffing	Premises	Transport	Other Non-staffing	Total Gross Expenditure
		£000's	£000's	£000's	£000's	£000's
A	Resources Directorate	4,356	1	21	9,069	13,447
B	Social Care Directorate	29,359	444	717	60,581	91,101
C	Education and Early Year Directorate	8,664	214	644	2,055	11,577
D	Home to School Transport	216	0	17,990	83	18,289
E	Youth Offending Services	0	0	0	507	507
F	**Total Gross Expenditure**	**42,595**	**659**	**19,372**	**72,295**	**134,921**

Note - £2,459k of Sales, Fees and Charges income outside of the main WCC contract gives WCF a net budget of £132.462m (the contract sum in Table 3)

Table 3: Contract Price for WCF, over- time

Ref.	Service	2021/22 Current	2022/23 Original	2023/24 Indicative	2024/25 Indicative
		£000's	£000's	£000's	£000's
A	Resources Directorate	12,075	13,159	13,422	13,690
B	Social Care Directorate	81,480	90,718	96,533	102,463
C	Education and Early Year Directorate*	13,196	9,789	9,984	10,184
D	Home to School Transport	18,190	18,289	19,455	20,644
E	Youth Offending Services	507	507	507	507
F	**WCF Contract Sum**	**125,448**	**132,462**	**139,901**	**147,488**

* Early Help transferred to Social Care from Education and Early Years (EEY) in 2022/23 and CWD budgets expected to transfer from Social Care to EEY in 2022/23 which is not reflected in above table.

2022/23 Funding Sources and Contract Funding Reconciliation

Latest 2022/23 Contract Funding Reconcilliation		Funding	
2022/23 Gross Expenditure Budget			**134,921**
Non-WCC Sales, Fees and Charges		2,459	
WCC Gross Contract Sum			**132,462**
Funded By:	Dedicated Schools Grant	6,437	
	One-off Services Grant 2022/2023	5,600	
	Public Health Ring-Fenced Grant	850	
	Other Grants	7,440	
	Other Income	316	
	HTST Income	1,497	
	Capitalised Revenue	608	
	Funding from Reserves	571	
Total non-base budget funding passed through Council		23,319	
Total External Funding			**25,778**
Council Base Budget 2022/23			**109,143**

The service element of the contract value is the 'gross budget' shown above, less the Sales, Fees and Charges income which could be recovered directly by the Company.

The 2022/23 budget is challenging and broadly sufficient in terms of meeting current service demands, however there are ongoing demand pressures in both the Placements and Provision budget, and Home to School and College Transport. Budget monitoring and variance analysis is reported monthly by the Company and will be used to regularly update the 3-year projection of Company budget. This model of forecasting has been used for two years and has proved to be accurate and reliable.

Transfer of Reserves

The company budget has an element of funding from reserves which will be passported as income, however Children's Services specific reserves will be held on the Council's balance sheet. The use of the reserves to fund activity will be agreed annually through the annual budget setting process or in year through the agreed change request process.

Transfer of Assets and Capital

There is no physical transfer of assets to WCF, and the Company will not hold a capital budget. The Company will lease all buildings, including furnishings and fittings, from the Council. The rental charge for property will be for a peppercorn rent.

Where the Company identifies a desired use of capital funds for investment, the Director of Resources will submit a business case requesting funds to the Council.

If the Council agrees the capital funding through its normal Capital Processes, any asset created as a result will be an asset owned by the Council.

VAT

As part of company set up, we scoped requirements for PS Tax VAT/Tax advisors for advice to WCC and WCF. The conclusion following a review of the business case and contractual documentation by our advisors was the contract between WCF and Worcestershire County Council will result in a single supply of taxable services by WFC to the Council.

Further Tax Implications for the Company

We reviewed our tax status, and this has been confirmed by HMRC that confirmation that the provision of services from Worcestershire Children First to Worcestershire County Council does not constitute a trade for corporation tax purposes. Any surplus on other activities within an accounting period is subject to UK Corporation Tax which is currently 19%. The Treasury announced in March 2021 that the intention of the current Government is to increase the Corporation Tax rate to 25% by April 2023. This will have a future impact on the tax charges for Worcestershire Children First.

Cashflow

WCF cashflow remains healthy and is spread relatively evenly from month to month. A cashflow forecast has been carried out during implementation and been reviewed constantly since go-live. Working capital has been steady (with an average balance of £27M in 2021/22). Cashflow will be managed carefully by the company to ensure it can meet its financial obligations.

Risk Management

Risk Management and Business Continuity Planning are a vital part of the Company's success to consider and mitigate (where possible) inherent (unmanaged) and residual (managed) risk. This involves an informed understanding of the effectiveness of controls and actions in place subject to ORCT principles (Objective, Risks, Controls, Tests). WCF are representatives at Worcestershire County Council's (WCC) Corporate Risk Management Group (CRMG) who implement Corporate Risk Management and Business Continuity arrangements for critical services across all aspects of the Council's activities.

WCF maintains the Company risk register, which will be scrutinised at the Risk, Governance and Audit Board:

- Serious harm or death of a child/young person
- Reputational risk as a result of receiving a poor Ofsted inspection rating
- Failure to act in the interests of children and young people - keeping them safe or planning for permanence
- Financial pressure on resources due to increased demand on Children's Placements
- Uncertainty of future funding arrangements (2022- 23 onwards) for local government which impacts financial strategy for the company
- Business continuity failure in critical services
- Insufficient staff capacity, capability and productivity - recruitment and retention
- Education for all children in Worcestershire including school financial pressures, home to school transport costs, management of the Dedicated Schools Grant on behalf of the Council, changes to school organisation and SEND
- Future government strategy around SEND and High Needs Funding arrangements (managed on behalf of council)
- Additionally, risks are captured as part of transformational projects.

Our risk management and business continuity framework, alongside our performance monitoring and quality assurance mechanisms, support our commitment to provide rigorous quality services, improving outcomes for our children and young people in Worcestershire.

Conclusion

The Business Plan for Worcestershire Children First details our Company information and priorities for the year ahead acknowledging the challenges and how we continue to respond to sustain and improve, innovate and invest in our services in 2022-23.

We are proud of our improvements and acknowledge there is still more to do, we will always strive to understand the voices and experiences of our children and young people and actively welcome feedback via:

YourSay@worcschildrenfirst.org.uk

Appendix 1: Terms of Reference: Worcestershire Children First (WCF) Board

Introduction

The Board of Directors is responsible for exercising all the powers of Worcestershire Children First set out in the Articles of Association, however, may delegate any of those powers to a sub Groups of the Board or to an Executive Director.

The principal role of the Chairman is to manage and provide leadership to the Board of Directors of WCF. The Chairman is accountable to the owner and DfE for the management of WCF, through the Chief Executive for company duties but not the Statutory Director of Children's Services responsibilities.

Membership

The members of the Board shall comprise of the Chairman, the non-executive directors and executive directors.

Attendance

Only members of the Board shall be entitled to attend meetings. Wider representation will be via invitation only.

Quorum

No business shall be transacted at meetings of the Board unless the Chair, two executive directors, two non-executive directors, (one independent non-executive director and one council non-executive director) are in attendance. A duly convened meeting of the Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers or discretions vesting or exercisable by the board.

Meetings of the Board

The Board shall meet on a monthly basis, at a location that will be determined by the Board. Formal Board meetings will be held monthly with every third meeting held in public (Members of the public shall be entitled to attend such Board meetings but, shall not be entitled to speak or vote at such Board meetings). Additional meetings may be called where there is a business requirement to do so to support decision making.

Minutes of Meetings

All formal Board meetings will be minuted together with clear resolutions of the Board. A record of attendees will also be provided together with any apologies received. A higher level record of informal meetings will be held to summarise attendance, apologies and general discussions.

The Chairman shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

Duties

The duties of the Board are to:

i. Determine (within the overall policies and priorities of WCF) and keep under review the company's strategic direction in accordance with the member views of the company
ii. Determine the company's key financial objectives in accordance with the member views
iii. Monitor performance against clear objectives, business plans and budgets in respect of:

- Quality of Services
- Finance
- Operational performance - workforce

- » Risk management
- » Matters that may materially affect the reputation of the Company
- » Income, future growth and development of the company

iv. Ensure appropriate financial stewardship through effective value for money, financial control and financial planning and strategy

v. Approve and keep under review the WCF's annual revenue budget

vi. Approve and keep under review WCF's arrangements for the management of risk

vii. Approve the Annual report and Accounts and other statutory submissions

viii. Approve a Schedule of Matters Reserved to the Board and Scheme of Delegation

ix. Receive and consider reports from Sub Groups

x. Review and, if appropriate, agree changes in the terms of reference for Sub Groups

Sub Groups of the Board

The Board may establish and delegate powers to formally constituted Sub Groups. Sub Groups established by the Board shall include:

- Risk, Governance and Audit Board
- Quality Assurance Board

Appendix 2: Key Performance Indicators (KPIs)

Performance Dashboard: 1 - 31 January 2022

Children Looked After

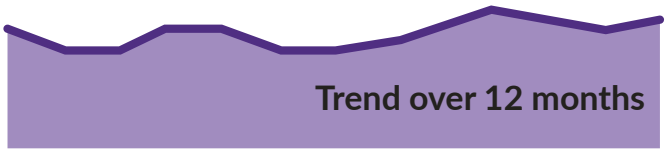
at month end **902**

Subject of Child Protection Plan

at month end **421**

Children in Need

at month end **763**



Children and YP with an EHCP

at month end **4,612**

Indicator	This Month	KPI Status	Min. Target	Stat. Neigh.	Preceeding three months		
					Nov	Oct	Sep
A: (KPI-SC1) Referrals - Level 4 decision within 24 hours	81.3	●	52.30		●	●	●
B: (KPI-SC2) S17 Assessments completed within 45 days	83.9	●	75.60	81.0	●	●	●
C: (KPI-SC3) Proportion of Children Subject to CP Plan with Plan in Place	96.7	●	80.00		●	●	●
D: (KPI-SC4) ICPCs completed within 15 days	88.7	●	67.80	85.0	●	●	●
E: (KPI-SC5) Proportion of children who became the subject of a Child Protection Plan for a second or subsequent time within 2 years	36.7	●	27.30		●	●	●
F: (KPI-SC6) RCPCs completed within timescale	100.0	●	87.90	93.0	●	●	●
G: (KPI-SC7) Proportion of children subject to a Child Protection Plan seen within 20 days	94.5	●	77.00		●	●	●

Indicator	This Month	KPI Status	Min. Target	Stat. Neigh.	Preceeding three months		
					Nov	Oct	Sep
H: (KPI-SC8) % Children Looked After Reviews in timescale	91.1	●	80.90		●	●	●
I: (KPI-SC9) Looked After Children with up to date Care Plan/Pathway Plan	99.3	●	73.00		●	●	●
J: (KPI-SC10) % Looked After Children who had a visit (in person) within timescale (30 days/60 days)	90.4	●	85.00				
K: (KPI-SC11) % Children Open for assessment or plan without an allocated worker for 5 days	0.3	●	1.00		●	●	●
L: (KPI-SC12) % of Care Leavers open to services with an up to date pathway plan (age 18-25)	64.1	●	52.40		●	●	●
M: (KPI-EH1) % of annual target reached for successful claims under the "Troubled Families" programme	87.7	●	66.20		●	●	●
N: (KPI-ED1) Percentage of EHCP requests received where review decisions have been made within 6 weeks	100.0	●	80.00		●	●	●
O: (KPI-ED2) Percentage of Education Health and Care Plan decisions made within 16 weeks	14.3	●	60.00		●	●	●
P: (KPI-ED3) Percentage of Education Health and Care Plans completed within 20 weeks	7.0	●	60.00		●	●	●
Q: (KPI-ED4) Percentage of Statutory Advice Reports (all types) for EHCP Needs Assessment submitted within 6 weeks of request sent	41.0	●	80.00		●	●	●
R: (KPI-ED6) Percentage of looked after children of school age with an up to date Personal Education Plan	100.0	●	80.00		●	●	●

Key to KPI Status

- ● Green - KPI is at or above target
- ● Amber - KPI is below target, but not for three consecutive months, so action plan not triggered
- ● Red - KPI is below target and has been for three consecutive months, triggering action plan

Appendix 3: Worcestershire Children First Overarching Business Plan 2022-23:


CHILDREN AT OUR HEART


VALUE FAMILY LIFE


GOOD EDUCATION FOR ALL


PROTECTION FROM HARM


EMBRACE DIVERSITY

This next year 2022-23 will be our 3rd full year in company. Our foremost priority is to sustain the significant improvements that we have achieved since we were first rated as an inadequate Children's Service in October 2016. What has been achieved is evidenced through our key performance indicators, our Quality Assurance Programme and our inspection outcomes. Ultimately reflected in September 2021 with the removal of the statutory direction.

Sustain and Improve

Sustaining such good levels of performance is not something that's achieved at any one point in time, it requires a continuation of hard work, commitment and dedication of the whole workforce to be achieved and re-achieved every day, every month and every year. Our quality assurance and business management processes are in place as "business as usual" to ensure we monitor all our activity and the impact and outcomes being achieved for children and young people. We will continue to be a learning and improving organisation and our priorities for improvement are set out below.

Innovate

We are proud to be in a place where we can build on the foundations of good practice and start to innovate. Innovation means taking that brave step to do something new and different. This can be particularly challenging when you've been in such a difficult place and have achieved so much, a common and understandable reaction is to hold on to those achievements and stay the same, but we know how important it is to innovate. The below lists the areas of innovation that are our priorities for 2022-23.

Invest

Through 2022-23 we will invest in our own services. Invest means ensuring that we deliver our services at best value, make savings where possible and take up funding opportunities, working alongside WCC to invest in order to improve and develop our frontline services to children and families.

Sustain and Improve	Innovate	Invest
■ WCF Fostering Improvement Plan ■ WCF Adoption Business Plan ■ Permanency in care proceedings ■ SEND Accelerated Progress Plan ■ WCF Quality Assurance programme ■ Review Education and Skills Strategy ■ Service Reviews – Resources at Best value ■ Care Leavers – Education/ Housing and Support	■ Development of community and overnight short breaks for independent living ■ Evaluation and delivery of Family Safeguarding ■ Supporting Families First - Children in Need ■ Development of the Virtual Head role ■ Empower & inform parents in Child Safeguarding processes ■ Promote the Emotional Health & Wellbeing of Children in Need and those in Care ■ Early Help: Family Hub & HAF Strategy ■ Get Safe / Get There: Reducing exploitation of children ■ Create an All Age Disability 0-25 service	■ Development of WCF Residential Services ■ Family Group Conferencing - contingency for care & protection ■ Early Years Strategy - improve children's readiness for school ■ Deliver school Capital Programme ■ Develop provision and specialist resource for Unaccompanied Asylum-Seeking Children ■ Commissioning Strategy – best value ■ Worcester City secondary school

Appendix 4: Worcestershire Children First Fostering Improvement Plan

Worcestershire Children First
Independent Fostering Agency Improvement Level One Plan 2021 -2022

Requirements - Fostering Service Regulations

Regulation 3.1: Statement of purpose and children's guide

Regulation 8.1: Registered person – general requirements

Regulation 11 (a): the welfare of children placed or to be placed with foster parents is safeguarded and promoted at all times.

Regulation 18.4: A written record is made of any complaint or representation, the action taken in response to it, and the outcome of the investigation.

Regulation 20: Safer Recruitment of Staff and Panel Members

Regulation 27: Foster Carer approval and agreement meet regulation.

Regulation 31: Register of Foster Carers

Regulation 35: Review and monitoring of quality of care. Voice of the Child. Consultation with Child about the care they receive.

Regulation 36: Notable events. Notification, management, and updates.

Recommendations - National Minimum Standards

Standard 13: Recruiting and assessing foster carers who can meet the needs of looked after children

Standard 15: Matching the child with a placement that meets their assessed needs

Standard 16: Statement of purpose and children's guide

Standard 21: Supervision and support of foster carers

Fostering Improvement Workstreams
Improvement & Business Sponsor: Maria White | Change Manager: Liz Dutton

Workstream 1	Workstream 2	Workstream 3	Workstream 4	Workstream 5	Workstream 6	Workstream 7
SAFER CARING PLANS & RISK ASSESSMENT (Reg 11, 36 & Std 15)	**NOTIFIABLE EVENTS (Reg 11, 36)**	**QUALITY ASSRANCE AND PERFORMANCE (Reg 3.1, 8.1, 18.4, 31 & Std 16)**	**SAFER RECRUITMENT/ FOSTER CARER -WORKFORCE DEVELOPMENT (Reg 20)**	**VOICE OF THE CHILD & VIEWS AND EXPERIENCE OF PARENTS (Reg 35)**	**FOSTER CARER RECRUITMENT, ASSESSMENT & SUPPORT AND THE VOICE OF FOSTER CARERS (Std 13, 21)**	**APPROVAL / MATCHING FOSTER CARERS (Reg 27 & Std 15)**
LEAD: Geraldine O'Donnell **Manager:** Debbie Carroll **Membership:** Independent Reviewing Officer, Children and Young People, Foster Carers, Learning and Development	**LEAD:** Debbie Carroll **Manager:** Susan Fletcher, Laurie-Mo Gullachsen **Membership:** Local Authority Designated Officer, Emergency Duty Team Manager, Business Analyst	**LEAD:** Susan Fletcher **Manager:** Geraldine O'Donnell/ Debbie Carroll **Membership:** Independent Reviewing Officer, Children and Young People	**LEAD:** Sharon Hurley **Manager:** Doe Goodwin/Serina Hadley/Louise Parker **Membership:** Foster Carer, Through Care Services, Learning and Development Team, Worcestershire Children First Comms Team	**LEAD:** Caroline Sutch **Manager:** Susan Fletcher/Alison Williams/Sharon Hurley/Louise Parker **Membership:** Children and Young People, Independent Reviewing Officer, Foster Carer, Looked After Children Team Manager, Fostering Social Worker	**LEAD:** Alison Williams/ Carol Barker **Manager:** Caroline Sutch **Membership:** Foster Carer, Children and Young People, Worcestershire Children First Comm)	**LEAD:** Carol Barker/ Louise Parker **Manager:** Susan Fletcher **Membership:** APPROVALS: Panel Chair and Vice, Chair, Panel Members, Panel Adviser, Agency Decision Maker, Team Managers **Matching:** Team Managers, Children and Families Social Worker

Workstream Membership

- Children & Young People
- Foster Carers
- Independent Reviewing Officer
- WCF Safeguarding Social Workers
- WCF IFA Social Workers

- WCF Business Team/Liquid Logic
- WCF Management Information
- WCF Communications Team
- WCC Learning & Development

- WCC HR Operational & Delivery Team/Social Work Opportunities
- Virtual School Headteacher
- SEND and Vulnerable Learners
- Fostering Panel Chair & Fostering panel

Cross Cutting Themes

Safeguarding	Quality Assurance	Communication	Performance and Monitoring

Appendix 5: SEND Accelerated Progress Plan (SEND APP) 2022-2023

Worcestershire Local Area SEND Accelerated Progress Plan (SEND APP) 2022-2023

Project Sponsors: DCS and CEO of WCF; Chief Executive, Herefordshire and Worcestershire Clinical Commissioning Group (CCG) | **Business Lead:** Director of All Age Disability (0-25) | **Programme Lead:** Early Help Partnership Development Officer

Worcestershire's Vision for SEND

"In Worcestershire we want all children and young people with special educational needs and / or disabilities to be truly seen and respected as individuals and to be the best they can be." Draft SEND Strategy 2022 -2025

Key Concern Workstreams

Workstream 1

MAINSTREAM SCHOOLS

THE VARIATION IN THE SKILLS AND COMMITMENT OF SOME **MAINSTREAM SCHOOLS** TO PROVIDE EFFECTIVE SUPPORT FOR CHILDREN WHO HAVE SEND

LEAD WCF AND HEALTH: Assistant Director Education Quality (Worcestershire Children First), Lead for Children and Maternity (CCG)

Membership: Parent carer forum (FiP) and WAC and stakeholder groups, School Phases (First and Primary, Middle, Secondary and High – for LA maintained and Academies), Special Schools, Worcestershire Children First, CCG, SENDIASS

Aims:

- CYP's SEND are identified early in educational settings and robust plans are in place to address these. CYP's progress is monitored against clear outcomes and their plans are adapted accordingly
- CYP attend mainstream schools with effective and consistent inclusive practice which ensures their needs are understood by all staff, they access full time educational provision including extracurricular activities and they make good progress across all aspects of their development.
- CYP experience successful transitions between educational placements which result in good attendance, achievement and progress.
- CYP attend schools who have accessed support and embedded training and development learning opportunities to support them to meet their needs

Workstream 2

SPECIALIST PROVISION

THE LACK OF SUITABLE **SPECIALIST PROVISION** TO MEET THE IDENTIFIED NEEDS OF CHILDREN AND YOUNG PEOPLE

LEAD WCF AND HEALTH: SEND Group Manager (Worcestershire Children First), Lead for Children and Maternity (CCG)

Membership: Parent carer forum (FiP) and WAC and stakeholder groups, Special School, Specialist Provision Forum, Worcestershire Children First, CCG, SENDIASS, HWHCT

Aims:

- CYP with SEND receive effective full time educational provision. Where a change of placement is required, this happens without delay
- Parent carers are clear about the outcomes their child's educational placement are working towards and their progress towards these.
- Parent carers understand how we make our decisions about educational placements in SEND
- Parent carers and CYP can say how their preferences have been taken into account in decisions about educational placements and there is regular and timely communication throughout the decision-making process
- Parent carer confidence in the local offer to meet their child's needs is increased so that more early years children with EHCPs transition into mainstream education at statutory school age
- To have an effective Graduated Response including planning and sufficiency for individual long-term needs
- There is a sufficiency of education provision in the Local Area for CYP who's needs should be met in a specialist setting

Workstream 3

PARENTS AND CARERS

FRAGILE RELATIONSHIPS WITH **PARENTS AND CARERS** AND A LACK OF MEANINGFUL ENGAGEMENT AND CO-PRODUCTION AND COLLABORATION

LEAD WCF AND HEALTH: Children with Disabilities Group Manager (Worcestershire Children First), Lead for Children and Maternity (CCG)

Membership: Parent carer forum (FiP) and WAC and stakeholder groups, Service user by experience x2, YP Participation Officer, Worcestershire Children First, Worcestershire County Council, CCG, SENDIASS, HWHCT

Aims:

- Deliver to our co-production charter
- Parent carers understand how CYP's special educational needs are identified and assessed in schools and EY providers and the support available to these settings
- Parent carers have confidence in our mainstream schools being inclusive and all schools delivering the identified provision in the child's plan, and they know how to seek help if they have concerns.
- Parent carers are able to contribute and coproduce the draft EHC Plan
- Parent carers are involved in and understand the SEND improvement work the Local Area is taking and the impact of this work across education services and settings, health and social care.
- Parent carers understand how their views and experiences are being used to improve arrangements for SEND in Worcestershire

Workstream 4

QUALITY OF EHC PLANS

THE POOR QUALITY OF EHCPS AND LIMITED CONTRIBUTIONS FROM HEALTH AND SOCIAL CARE ALONG WITH THE PROCESS TO CHECK AND REVIEW THE **QUALITY OF EHC PLANS**

LEAD WCF AND HEALTH: SEND Group Manager (Worcestershire Children First), Senior Manager for SEND (CCG)

Membership: Parent carer forum (FiP) and WAC and stakeholder groups, CAMHS, SEND case workers, SEND Senior case worker, ASWP Adult SC, FE Partners, Worcestershire Children First, Worcestershire County Council, YP Engagement Officer, CCG, SENDIASS, HWHCT

Aims:

- CYP have EHCPs which accurately reflect their aspirations, needs, the outcomes they are working towards, and the provision required to achieve these across education, health and social care. From Year 9, this includes these EHCPs include a focus on Preparation for Adulthood.
- CYP's and parent carers' views are clear and up to date in EHCPs.
- CYP's EHCPs are reviewed on an annual basis and any amendments agreed are made in a timely way so that plans accurately reflect current needs, provision and outcomes

Worcestershire Children First

County Hall Spetchley Road Worcester WR5 2NP

Website: **www.worcschildrenfirst.org.uk**

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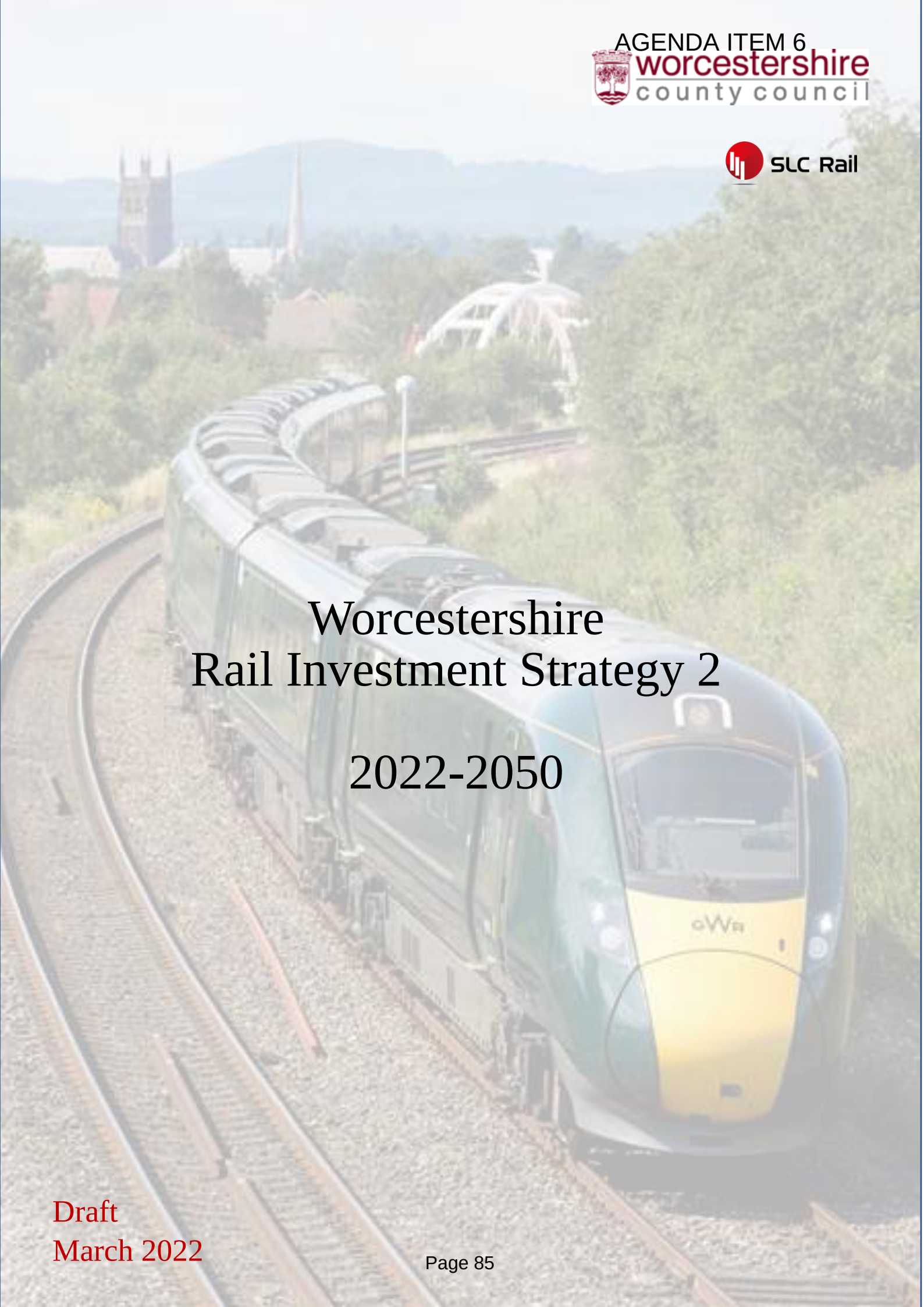
worcestershire county council

SLC Rail



Worcestershire Rail Investment Strategy 2

2022-2050

Draft
March 2022

Executive Summary: Worcestershire Rail Investment Strategy 2 (WRIS-2)

1. In 2017 Worcestershire County Council (WCC) prepared its economically evidenced Rail Investment Strategy (WRIS), measured against Gross Value Added (GVA) and new jobs.
2. This prioritised enhanced local, regional and GB-wide rail connectivity on the basis of its value to the growing economy, population and precious environments of the County.
3. These priorities included transformed connectivity to London, GB-wide services at Worcestershire Parkway and new regional Birmingham-Worcestershire-Bristol services.
4. The WRIS addressed quality, access and car park capacity improvements at County railway stations and supported rail industry schemes such as Worcester Area re-signalling.
5. The strategy has been proactively developed since 2017, with WCC-led Worcestershire Parkway and Kidderminster Station enhancements completed.
6. A compelling London services business case has been prepared by the WCC-led North Cotswold Line Task Force, and station access, car park and key masterplans progressed.

Responding to COVID-19 (CV19)

7. CV19 led to significant rail service reductions, including in Worcestershire, and changed working patterns and passenger demand now challenge industry planning and funding.
8. This WRIS-2 takes direct account of post-CV19 Department for Transport recovery forecasts and uses West Midlands Rail Executive's (WMRE) post-CV19 service demand testing.
9. This provides WCC with comprehensive analysis covering the economic value of the County's rail services and detailed 30-year forecasts of passenger demand by rail corridor.
10. In parallel, preparation with WMRE's own revised 30-year strategy, WRIS-2 benefits from integration of relevant WMRE, Midlands Connect and Network Rail service propositions.
11. WMRE's work shows 'Cross City South' covering Redditch, Bromsgrove, Worcester and South-West services as the second highest regional growth corridor, growing by c. 60% by 2050.

WRIS-2's Conditional Outputs

12. WRIS-2's principal conditional outputs (page 3 over) for further WCC development are:
    - **London/Oxford** - Ongoing preparation of Outline Business Case for faster, Worcester-London 2 trains per hour (tph) and direct 1 tph Kidderminster/Droitwich Spa to London.
    - **GB-wide connectivity** - Exeter-Worcestershire Parkway-Manchester and Midlands Connect Birmingham-Worcestershire Parkway-Bristol/Cardiff services.
    - **Worcestershire-Bristol** - 2023 implementation of Department for Transport (DfT) options for 1 tph Worcester-Tewkesbury-Cheltenham Spa-Gloucester-Bristol service.
    - **Birmingham/HS2** - Earliest restoration of Worcester, Bromsgrove, Redditch and Kidderminster-Birmingham frequencies removed during CV19, and future expansion.
    - **Stations and access** - Worcester Shrub Hill and Redditch masterplans implementation, and ongoing development of car parks and enhanced access to National Rail network.
    - **Industry engagement** - Securing Worcester Area Modernisation/re-signalling, King's Norton capacity (to restore Redditch/Bromsgrove-Birmingham frequency lost via COVID-19/Camp Hill scheme) and electrification of Snow Hill Lines, Birmingham-Bristol and Bromsgrove-Worcester via Network Rail, DfT and the future 'Great British Railways' (GBR).
    - **Funding innovation** – Developing radically innovative Third-Party financing models given limited industry/government monies to facilitate WCC's desired changes.
    - **Key national policy objectives** – Maximising the role Worcestershire's railway plays in the Levelling Up and De-carbonisation agendas.
    - **Fares and ticketing** - Close engagement with GBR in a full review of fares and the means of purchasing tickets, especially as work, tourism and leisure patterns change

Conditional Outputs

Worcestershire Rail Investment Strategy 2 priorities					
		WRIS 1 Economic Model 2017		West Midlands Rail Investment Strategy Demand Model 2022	When
		GVA £m p.a.	New Jobs	Demand uplift % to 2050 (WMRIS)	CP = Rail industry 'Control Periods'
Worcestershire Rail Investment Strategy 1 - 2017 (retained)					
NCL 1	2 trains per hour between Worcester and London Paddington with 1 train per hour having fast journey time of 1 hour 50 minutes or less	19.04	421		CP7 2024-29
NCL 2	1 train per hour between Kidderminster, Droitwich Spa and London Paddington	13.08	273		
NCL 3	Additional infrastructure capacity on the North Cotswold Line to support a 2 trains per hour Worcester to London service				
WAB 2	New direct train service between (Birmingham), Bromsgrove, Worcestershire Parkway, Cheltenham Spa, Gooucester and Bristol Temple Meads	5.66	145	66%	2023
WAB 3	Support for additional infrastructure capacity and re-signalling between Stoke Works, Droitwich Spa, Worcester and Great Malvern-Hereford to support train service growth and development				CP7
WPK 1	Introduction of calls at Worcestershire Parkway in the hourly Exeter-Bristol-Manchester service	4.4	108	+ 66%	CP7
ELC 1	Electrification of Snow Hill Lines, Birmingham-Bristol Line and Cross City Bromsgrove-Worcester to support train service growth and development				CP8 2029-34
ACS 1	Additional car park capacity at existing stations and/or new stations to accommodate forecast passenger growth				CP6 2019-2024 and CP7
WOS 1	Shrub Hill Station Masterplan to support train service growth to London, Birmingham and west of England and Shrub Hill Quarter regeneration			+ 61%-66%	CP6 and CP7
TKT 1	Cross industry review of ticketing and fares structures to match new and developing train services (incl. with Great British Railways when established)				CP7
WRIS 2	**In development**				
ACS 2	Station car parks development assessment at Blakedown, Kidderminster, Alevechurch and Pershore				CP6 and CP7
DTW 1	Droitwich Station Masterplan options and car park expansion				CP6 and CP7
RED 1	Redditch Station Masterplan development and delivery, and engagement with rail indsutry to restore pre-COVID Cross City frequency			+ 39%	CP6 and CP7
RWK 1	Rushwick/West of Worcester New Station development			+ 61%	CP6 and CP7
WOP 1	Worcestershire Parkway access/car park expansion			+ 66%	CP6 and CP7
FND 1	Developing Third Party funding innovation (all schemes) in context of rail industry funding challenges				CP6 and CP7
FND 2	Maximising opportunities for funding bids (all schemes) to developing government sources e.g. Levelling Up				CP6 and CP7
DCB 1	Adopting all rail industry best-practice to support successful application of the decarbonisation agenda.				
WCC support via WMRE & Midlands Connect membership					
WAB 1A	Support for DfT/GWR prospective increase from 1 train/2 hours to 1 train per hour between Worcester FS/SH, Cheltenham Spa, Gloucester and Bristol			+ 66%	2023
WAB 4	Support for NR King's Norton scheme/Cross City frequency restoration			+ 39%	CP7
MRH 1	Support for Midlands Connect 2 trains per hour Birmingham-Bromsgrove-Worcester-Hereford			+ 61%	CP8
MRH 2	Support for Midlands Connect 2 trains per hour Birmingham-Worcestershire Parkway-Bristol/Cardiff			+ 66%	CP8
WMRE 1	Support for West Midlands Rail Executive/West Midlands Trains for 1 train per hour Worcester Shrub Hill-Birmingham restoration			+ 37%	2023
WMRE 2	Support for West Midlands Rail Executive future 2 trains per hour Birmingham-Stratford to support Wythall development options				CP8

ONE – Introduction

In 2017 Worcestershire County Council (WCC) published its ambitious, forward-looking Worcestershire Rail Investment Strategy (WRIS) for the role of the railway over the next 30 years in supporting the County's economy, growing communities and its precious environment.

This drew upon innovative analysis of the benefits for Worcestershire's economy of better rail connectivity, prioritising service improvements, station regeneration, new stations and car park expansion via uplift in 'Gross Value Added' (GVA) and new jobs, setting a clear agenda for engagement with the complex organisations of the railway industry.

Key priorities included faster and more frequent 'North Cotswold Line' services to Oxford and London, preparing for the new opportunities made possible by Worcestershire Parkway, pressing the rail industry for Birmingham-Bristol Corridor service to call in the County, and transforming ease of access to the National Rail network for Worcestershire residents.

Since 2017 – A time of major change

This renewed Worcestershire Rail Investment Strategy 2 (WRIS-2) responds to substantial contextual change between 2017 and 2022 including:

- **Covid-19** and its multiple impacts on ways and places of work, demand for rail travel, government funding of railway services and future enhancements, and some resultant semi-permanent service reductions, including a number affecting Worcestershire.
- **Rail Industry re-organisation** with the government's proposed new integrated lead body '*Great British Railways*' due to become the 'controlling mind' of the industry in c. 2025 and with which Worcestershire will necessarily need to engage closely.
- **Government policy focus** including Levelling-Up and de-carbonisation agendas.
- **Local Plan changes** with expanded housing volumes and spatial changes in the South Worcestershire Development Plan (SWDP), Bromsgrove, Redditch and Wyre Forest Local Plans, at neighbouring authorities, and with Birmingham overspill challenges.
- **Worcestershire County Council-led rail developments** including Worcestershire Parkway and Kidderminster's new station buildings opened in 2020, and evolving business cases for better Worcester-Oxford-London services, Worcester Shrub Hill and Redditch station masterplans, a potential new west-of-Worcester station at Rushwick, and greater car park capacity at stations.
- **Wider rail industry developments** including Midlands Connect's 'Midlands Rail Hub'[1] which offers increased Birmingham-Worcester-Hereford frequencies and new Birmingham-Worcester-Bristol/Cardiff services from the 2030s, Network Rail's parallel support for transformed Worcestershire connectivity on the Birmingham-Bristol Corridor, and West Midlands Rail Executive's own wider regional Rail Investment Strategy post-Covid 19 review which is being concluded in parallel with this Worcestershire plan.

[1] https://www.midlandsconnect.uk/projects/rail/midlands-rail-hub/

TWO – Our approach to Worcestershire Rail Investment Strategy 2

Evolution from the 2017 Rail Investment Strategy

The 2017 Worcestershire Rail Investment Strategy (WRIS)[2] focused on Gross Value Added (GVA) and new jobs as key indicators of the best value to the County of different types of enhanced rail connectivity, including:

- **More frequent, faster services** e.g. sub-2 hour journey times and doubled frequency to London via the North Cotswolds and Oxford.
- **New direct GB-wide services** e.g. from Worcestershire to North-West, North-East, South-West England, the East Midlands and South Wales.
- **Specific new connectivity** related to Local Plan growth supporting major areas of housing development e.g. urban regeneration such as the Shrub Hill Quarter and Redditch, Rushwick, west of Worcester, and the major development proposed around the now-opened Worcestershire Parkway.

This enabled a clear set of priorities for investment to be adopted within the strategy *driven by outputs rather than led by infrastructure limitations* and incorporated in parallel into Worcestershire Local Transport Plan 4[3].

This economically evidenced approach was consistent with Network Rail's Long Term Planning processes and specifically with West Midlands Rail Executive's (WMRE) own 30-year strategy[4] for the wider West Midlands region, published in 2019, which broadly supported the County's specific connectivity ambitions, and used a shared forecasting model developed by SLC Rail and SYSTRA. (Chaired by the Mayor of the West Midlands, WMRE plans strategic development of the region's rail network and co-manages the West Midlands Trains franchise with the Department for Transport; WCC is a full member of WMRE.)

A demand-led post-COVID 19 approach for WRIS-2

The collapse of rail passenger demand during the COVID 19 lockdown from March 23rd 2020, not only required substantial funding support from government for the maintenance of services but challenged industry thinking and evidencing of future network development given its impact upon ways of working, locations of work, commuting and leisure travel, and hence of the nature of train services and connectivity that may be required in a post-COVID 19 future.

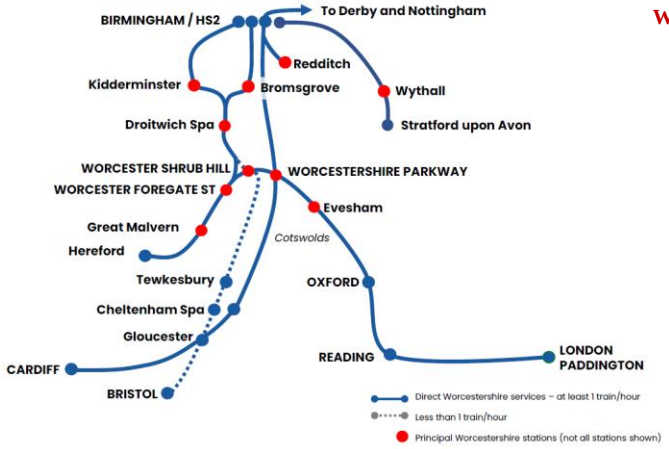
WRIS-2 has thus been developed with its prioritisation process led by prospective passenger demand scenarios looking over a 30-year period towards 2050, taking specific account of evolving post-COVID 19 forecasting led by the Department for Transport, and again directly sharing the data and modelling developed by SLC Rail and SYSTRA and being applied in WMRE's own post-COVID 19 update of its 2019 Rail Investment Strategy.

[2] https://www.worcestershire.gov.uk/info/20055/strategies_plans_and_bids/1922/worcestershire_rail_investment_strategy
[3] https://www.worcestershire.gov.uk/info/20055/strategies_plans_and_bids/806/the_local_transport_plan
[4] https://www.wmre.org.uk/our-strategies/west-midlands-rail-investment-strategy/

THREE - The continuing challenge for Worcestershire's rail network

Many improvements in Worcestershire's rail connectivity and stations have occurred in the past 10 years, with better London frequencies, extension of the electrified Cross City Line to serve the new Bromsgrove Station, completion of Worcestershire Parkway and Kidderminster's much expanded station, and modern, new trains on London and West Midlands local services.

However direct rail connectivity remains limited in serving the County's 605,000 population (2021[5]) and c. 20%+ Local Plan population growth and spatial change, as shown at Figure 1 below.



Worcestershire Rail Connectivity Summary — Trains per hour (tph) - 2022

Worcester – Oxford – London	1 tph
Nottingham – Worcestershire Parkway – Cardiff	1 tph
Worcester - Gloucester – Bristol	0.5 tph
Worcester – Bromsgrove – Birmingham	1 tph
Redditch – Birmingham*	2 tph
Bromsgrove – Birmingham*	3 tph
Kidderminster – Birmingham*	3 tph
Worcester – Hereford	1 tph
Wythall – Birmingham	1 tph
Worcestershire – North-East/North-West	NIL
Worcestershire – South-West past Bristol	NIL
Worcester Shrub Hill – Birmingham (off peak)*	NIL
Bromsgrove – South-West	NIL

Frequencies reduced during COVID *

Figure 1 – Worcestershire rail connectivity 2022

Addressing these connectivity limitations is a core component of WCC's continuing work with the rail industry, in particular:

- **Worcestershire – Oxford – London** – WCC is the lead authority of the 5-authority '*North Cotswold Line Task Force*' which, having completed a Strategic Outline Business Case (SOBC)[6] in 2020 for a doubling of Worcester-London service frequencies and hourly extensions to Great Malvern and Droitwich Spa/Kidderminster, is now progressing the Outline Business Case (OBC) and financing innovation options for the c. £213m North Cotswold Line re-doubling scheme which facilitates these service enhancements.
- **Worcestershire – South-West/North-West/North-East** – Supporting (i) a prospective DfT-led increased frequency GWR 1 train per hour Worcester – Cheltenham Spa – Gloucester – Bristol service from c. 2023/24, (ii) Network Rail's 2021 Bristol-Birmingham '*Continuous Modular Planning Study*' with its significant connectivity enhancement options for Worcestershire, and (iii) Midlands Connect's '*Midlands Rail Hub'* proposals for 2 Birmingham – Worcester – Hereford trains per hour, and additional express Birmingham – Bristol/Cardiff services which could call at Worcestershire Parkway.
- **Restoration of frequencies reduced during COVID-19** - Redditch and Bromsgrove-Birmingham frequencies have been reduced and limited for the immediate future via infrastructure capacity between King's Norton and Birmingham being transferred during the lockdown to the Camp Hill new service scheme led by West Midlands Combined Authority; similarly all off-peak Shrub Hill-Birmingham services were removed in 2021.

FOUR – Stations as places and the continuing challenge of access

Transformed, sustainable connectivity within Worcestershire and with the wider South-West Midlands and the major economic areas of Great Britain is the core output of railway services in supporting economic growth, the major growth in housing and population within the County's several Local Plans, and the County's attraction as a place to live, work and visit.

The railway's purpose is to take people where they want to go, when they do, and with a frequency, speed and cost that works for them. As such WRIS-2's first priority is the range of train services that provide this connectivity.

[5] https://www.worcestershire.gov.uk/info/20044/research/795/population_statistics_and_projections

[6] https://commonslibrary.parliament.uk/research-briefings/cdp-2020-0004/

In parallel, the nature, location, quality and accessibility of railway stations is essential to their usefulness to passengers and how they can play a significant part in the vitality and success of town and city centres, whilst new stations can widen regional access to the National Rail network and support the creation of new communities (e.g. the Worcestershire Parkway Strategic Growth Area).

Prior to the 2017, WRIS WCC played a key partnership role with the rail industry in delivery of the new Bromsgrove Station. Since 2017 Worcestershire Parkway and the new Kidderminster Station buildings projects have been delivered by WCC and funded by WCC and local partners.

However, many journeys continue to be made by road or are via stations outside of Worcestershire (e.g. Birmingham International or Warwick Parkway) given a combination of poor train service connectivity, limited car park capacity and absence of modern standards of access for all. In 2017 the County's 17 stations had only 1,377 car park spaces, only marginally more than Warwick Parkway alone on the Chiltern Railways route; with Worcestershire Parkway opened in 2020 this increased to 1,877 but continues to offer a low ratio of spaces to passengers by comparison with neighbouring counties such as Warwickshire.

WCC established 3 key station development projects to support implementation of the 2017 WRIS. These remain continuing strong priorities under WRIS-2:

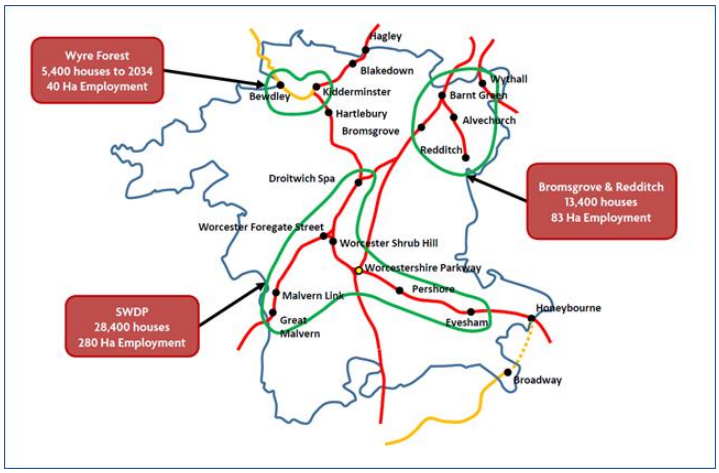
- **Worcester Shrub Hill Station Masterplan** – station, forecourt and public realm improvements as part of the wider Shrub Hill Quarter regeneration scheme, with a bid to the government's Levelling Up Fund in progress.
- **Redditch Station Masterplan** – station, forecourt and public realm improvements to create a modern, high-quality gateway to and from Redditch Town Centre.
- **Project Access** – Developing new capacity for access to stations, meeting both Local Plan growth and spatial change and existing demand suppressed by limited car park capacity, including:
    - **Car park expansion feasibility assessment** – Alvechurch; Blakedown, Droitwich Spa; Kidderminster; Pershore; Worcestershire Parkway
    - **Rushwick/West Worcester New Station** – Business Case development

FIVE - A growing and changing County

The context within which the 2017 WRIS was formulated was one of extensive Local Plan growth, with over 47,000 new homes and more than 108,000 more people living in the County by 2030 (c. 19% growth), together with a c. 30%+ increase in annual Gross Value Added to its economy.

At that time the 2017 WRIS noted "*The County's rail services will not match these ambitions without significant earlier development and investment beyond that committed by the rail industry*."

The quantum and magnitude of housing and population growth in Local Plans has developed further and significantly since 2017, in particular with the South Worcestershire Development Plan (covering Malvern Hills, Worcester City and Wychavon districts) increasing from 28,400 new homes to 43,200, taking overall County growth to 62,120 homes – or c. 140,000 more people – by 2041, a c. 23% growth in Worcestershire's population from 588,400 (2017) to 728,400 people.



CHANGE	2017 →	2021
Wyre Forest	5,400	5,520 (→ 2036)
Redditch	6,400	6,400 (→ 2030)
Bromsgrove	7,000	7,000 (→ 2030)
SWDP	28,400	43,200 (→ 2041)
TOTAL	**47,200**	**62,120**
		+ 31.6%

Figure 2 Housing growth in Worcestershire Local plans in the 2017 WRIS A 31% increase in scale of growth since 2017

Notwithstanding the generic and specific limitations to rail connectivity that the WRISs seek to address it is positive that planned growth is closely aligned geographically to the County's rail corridors:

- **Wyre Forest** – alongside the Worcester-Kidderminster-Stourbridge-Birmingham route, which will benefit from c. 2031 with access at Birmingham Moor Street to the immediately adjacent HS2 Curzon Street station.
- **Bromsgrove** – adjacent both to the Bristol-Worcestershire-Birmingham Main Line and the Stratford-Wythall-Birmingham local/regional route.
- **Redditch** – served by the Redditch-Birmingham-Lichfield 'Cross City' Line.
- **South Worcestershire Development Plan** – crossed by the Great Malvern-Worcester-Oxford-Paddington 'North Cotswold Line' and the national, regional and local services on the Bristol-Worcestershire-Birmingham Corridor, with direct GB-wide strategic interchange at Worcestershire Parkway and local interchange at Worcester Foregate Street, Worcester Shrub Hill and Droitwich Spa.

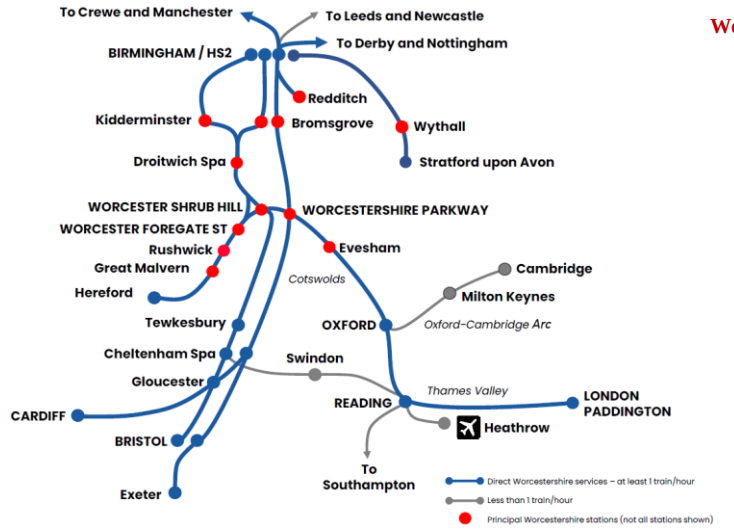
SIX - Worcestershire's ambitions

The central theme of WRIS-2 is continuing and expeditious progress towards transformed national, regional and local rail connectivity for Worcestershire, supported by expanded capability, capacity, accessibility and quality of the railway's infrastructure and stations. This will be essential to:

- **Homes** - Sustainable delivery of the County's expansive quantum of housing and population growth, maximising low-carbon travel choices for all.
- **Business** - Worcestershire as an attractive location for business and commerce, well-connected across Great Britain, with substantial, high quality employment growth.
- **West Midlands/HS2** - County access to neighbouring Birmingham, the wider West Midlands, and the opportunities that will come via HS2's delivery in the 2030s/2040s.
- **Tourism** - Encouraging continued growth of the County's vital tourist and visitor economy, again with maximum low-carbon travel choices for all.
- **Environment** - Protecting the County's precious Severn, Malverns, Vale and AONB natural environments, its historic cathedral city and market townscapes, and its rural villages.
- **Place** - Contributing to the development of the County's city and towns, such as schemes currently being developed at the Shrub Hill Quarter in Worcester and at Redditch.

Worcestershire will be a well-connected place in the West Midlands and across Great Britain with direct, frequent connectivity, as shown at Figures 3 and 4 (below/over), in particular with:

- Oxford, the Oxford-Cambridge Arc, the Thames Valley, Heathrow Airport and London.
- North-West England, Manchester and the East Midlands, together with enhanced connectivity at Birmingham to North-East England.
- South-West facing to Cheltenham Spa, Gloucester, Bristol, Cardiff and Exeter.
- To Birmingham and HS2
- Within Worcestershire itself



Worcestershire Rail Connectivity Summary — Trains per hour (tph) - 2040

Worcester – Oxford – London	2 tph
Great Malvern/Kidderminster/Droitwich Spa – London	1 tph
Nottingham – Worcestershire Parkway – Cardiff	1 tph
Exeter - Bristol - Worcestershire Parkway – Manchester	1 tph
B'ham Moor St/HS2-Worcestershire Parkway-Bristol/Cardiff	2 tph
Worcester - Gloucester – Bristol	2 tph
Bromsgrove - Bristol	1 tph
Hereford - Worcester – Bromsgrove – Birmingham/HS2	2 tph
Worcester Shrub Hill – Bromsgrove – Birmingham/HS2	2 tph
Redditch – Birmingham/HS2	4 tph
Bromsgrove – Birmingham/HS2	4 tph
Kidderminster – Birmingham/HS2	4 tph
Wythall – Birmingham/HS2	2 tph
Worcester – Kidderminster	3 tph

Figure 3 – Worcestershire rail connectivity 2040

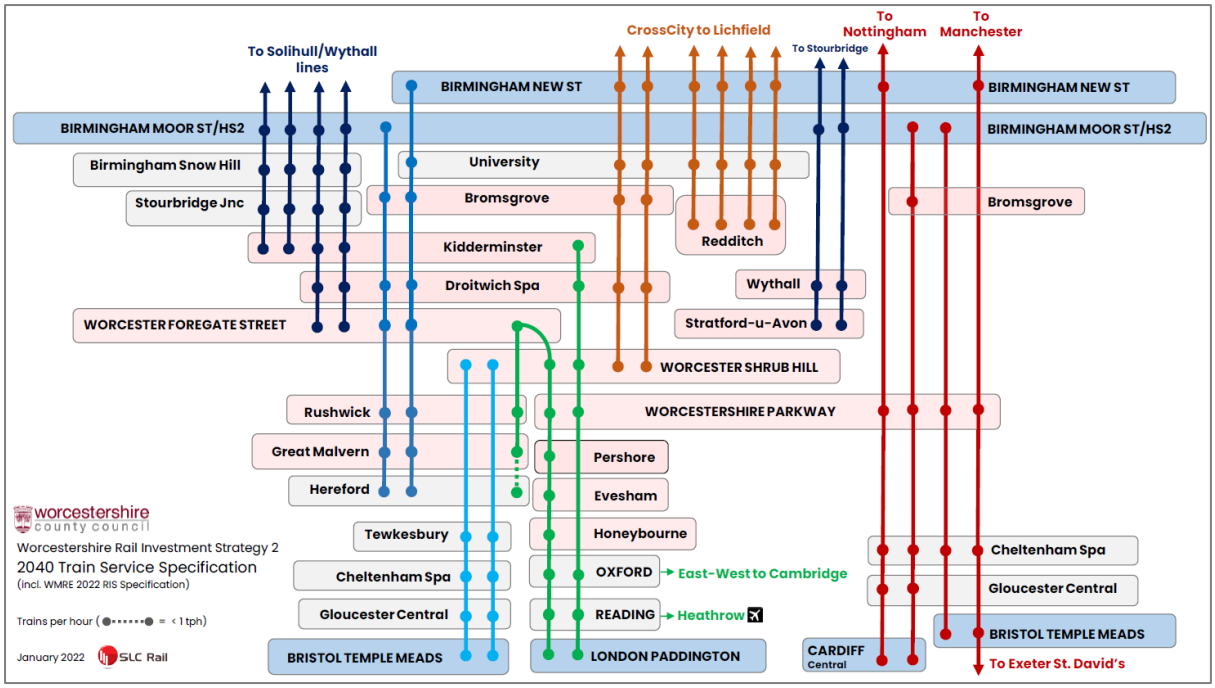


Figure 4 – Worcestershire rail connectivity 2040 – trains per hour

SEVEN - Evidence for change

WRIS-2 brings together the 2017 WRIS's economic evidence with 2021/2022 WMRE West Midlands Rail Investment Strategy (WMRIS) post-COVID demand analysis[7].

The WMRIS assesses percentage and demand volume growth of incrementally enhanced train service specifications, including HS2 and Midlands Rail Hub, from the 2019 pre-COVID 19 base to:

- 2026 with a return to pre-COVID 19 passenger numbers.
- 2031 with the delivery of HS2 Phase 1 and Midlands Rail Hub.
- 2040 with delivery of HS2 Phase 2.
- 2050 as a broad 30-year end-date.

These are tested on 7 West Midlands corridors with 2 covering principal Worcestershire services:

- **'Stourbridge'** – including Worcester and Kidderminster to Birmingham Snow Hill/Moor St; Hagley-Kidderminster and Worcester.
- **'Cross City South'** – including Redditch and Bromsgrove to Birmingham New St; Bromsgrove-Worcester-Hereford; Worcestershire (Bromsgrove-Worcestershire Parkway-Worcester Shrub Hill/Foregate St)-Bristol/Cardiff.

The North Cotswold Line proposition for 2 trains per hour towards London is NOT included in WMRIS given it falls outside of the WMRE area but is within WRIS-2 based upon its existing 2020 Strategic Outline Business Case (footnote # 5 above).

The key conclusions of the WRIS-2 integrated economic GVA/jobs and demand analysis which form the basis of its Conditional Outputs (page 3 above) are:

- **WRIS 2017 priorities** – North Cotswold Line/London and Birmingham-Worcestershire-Bristol/Cardiff Corridor (2017 value £42.9m GVA p.a./947 new jobs) are retained, supported in turn by the North Cotswold Line 2020 business case (post-COVID 'high value for money' Benefit Cost Ratio of 3.5) and combined 'Cross City South' WMRIS results noted below.
- **WMRE WMRIS 2040 train service specifications**:
    - The Cross City South Corridor offers the 2nd highest post-COVID 19 percentage and demand growth to 2050 in the West Midlands, only behind the Coventry-Birmingham Corridor – 31% to 2031 and 60% to 2050 – significantly ahead of the West Midlands at 22% to 2031 and 47% to 2050.
    - This reflects both the new Camp Hill Line in Birmingham and the scale of housing and population growth in Worcestershire.
    - Worcestershire-Bristol/Cardiff Corridor grows by 38% to 2031 and 66% to 2050; whilst from a low base this is a high-fare yield corridor.
    - Birmingham-Bromsgrove-Worcester-Hereford grows by 31% to 2031 and 61% to 2050
    - Snow Hill Lines are a more mature market given high level of pre-existing services; Worcestershire growth forms an increasing proportion of route growth to 2050.
    - Worcestershire's 2019 daily return passengers of more than 9,500 will grow by c. 3,100 per day by 2031 and 4,150 by 2050.

Corridor percentage and demand volume growth across the West Midlands are shown at Figures 5 and 6 below.

[7] SYSTRA using DfT WebTag compliant demand forecasting. Used with permission of West Midlands Rail Executive

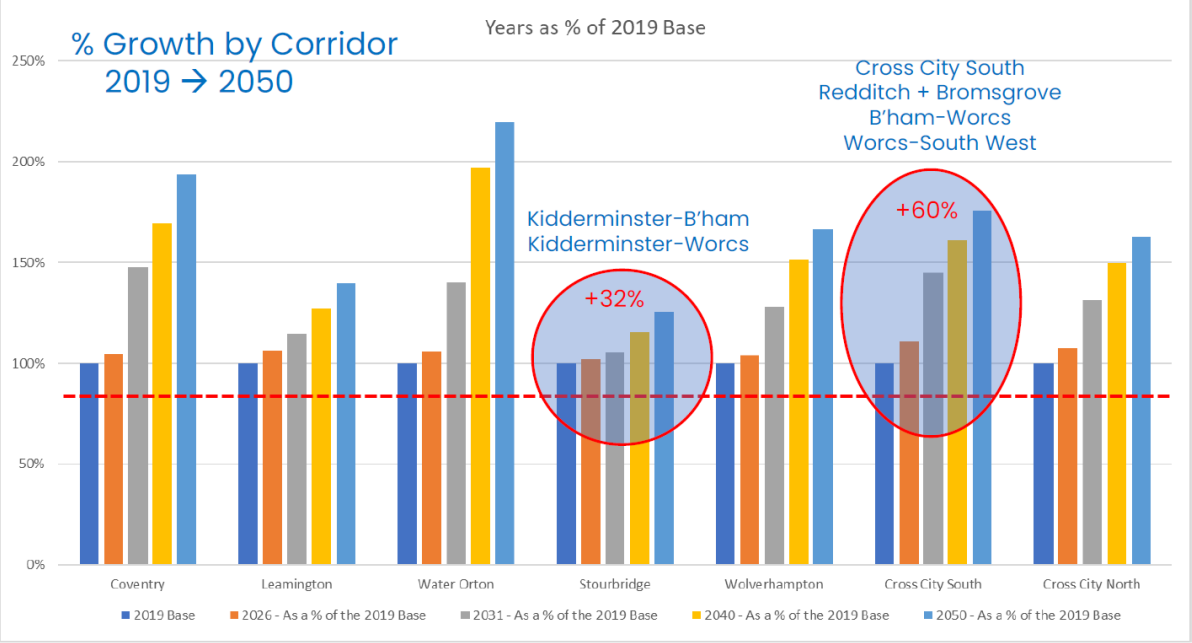


Figure 5 – Percentage growth in passenger demand – West Midlands Rail Corridors – 2019-2050 (WMRE)

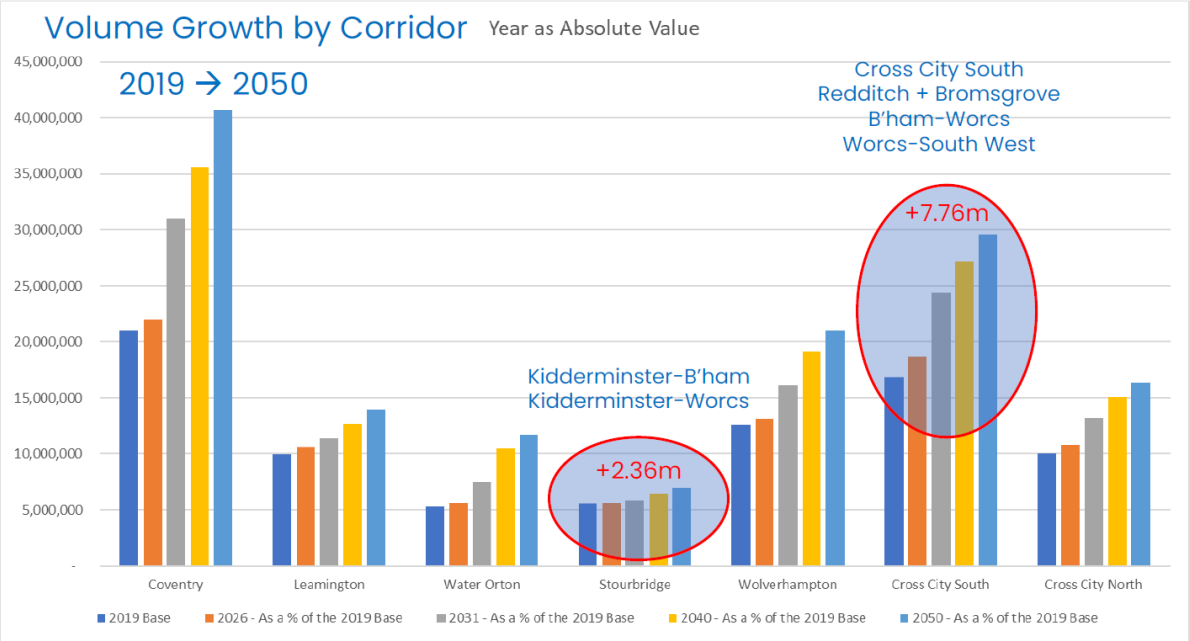


Figure 6 – Demand volume growth in passenger demand – West Midlands Rail Corridors – 2019-2050 (WMRE)

Worcestershire-specific growth broken down within these 2 core corridors is shown at Figure 7 (over).

GROWTH FROM 2019 pre-COVID BASE	2019 BASE		2031 GROWTH 2019-2031				2050 GROWTH 2019-2050			
	Total trips (m)	RTN PAX/DAY	Total trips (m)	Growth (m)	Growth %	NEW RTN PAX/DAY	Total trips (m)	Growth (m)	Growth %	NEW RTN PAX/DAY
West Midlands	67.4	104,963	82.4	*15.0*	*22%*	*23,377*	98.8	*31.4*	*47%*	*48,927*
Snow Hill Lines (west of Birmingham)	7.3	11,344	8.0	*0.7*	*10%*	*1,107*	9.6	*2.4*	*32%*	*3,674*
Hagley-Kidderminster-Worcester	0.7	1,053	0.8	*0.1*	*22%*	*229*	1.0	*0.3*	*49%*	*512*
Worcester-Birmingham	2.5	3,829	2.8	*0.3*	*14%*	*520*	3.4	*0.9*	*37%*	*1,416*
ALL WORCESTERSHIRE Snow Hill Lines	**3.1**	**4,882**	**3.6**	***0.5***	***15%***	***1,857***	**4.4**	***1.2***	***40%***	***1,928***
Worcs % of Snow Hill Lines	43%		45%				45%			
Cross City South/Bristol	12.9	20,139	17.0	*4.0*	*31%*	*6,271*	20.7	*7.8*	*60%*	*12,086*
Worcester FS/SH/Parkway-Bristol/Cardiff	0.2	282	0.3	*0.1*	*38%*	*107*	0.3	*0.1*	*66%*	*187*
Birmingham-Bromsgrove-Worcester-Hereford	0.9	1,408	1.2	*0.3*	*31%*	*430*	1.5	*0.5*	*61%*	*855*
Redditch & Bromsgrove-Birmingham	1.9	3,012	2.4	*0.5*	*24%*	*715*	2.7	*0.8*	*39%*	*1,178*
ALL WORCESTERSHIRE Cross City South	**3.0**	**4,702**	***3.8***	***0.8***	***27%***	***1,252***	**4.4**	***1.4***	***47%***	***2,220***
Worcs % of Cross City South	23%		23%				21%			
WMRIS WORCESTERSHIRE SH plus Cross City S	**6.2**	**9,584**	**7.4**	**1.3**	**17%**	**3,109**	**8.8**	**2.7**	**43%**	**4,148**

Figure 7 – Percentage growth in passenger demand – Worcestershire Rail Corridors – 2019-2050 (Adapted from WMRE data)

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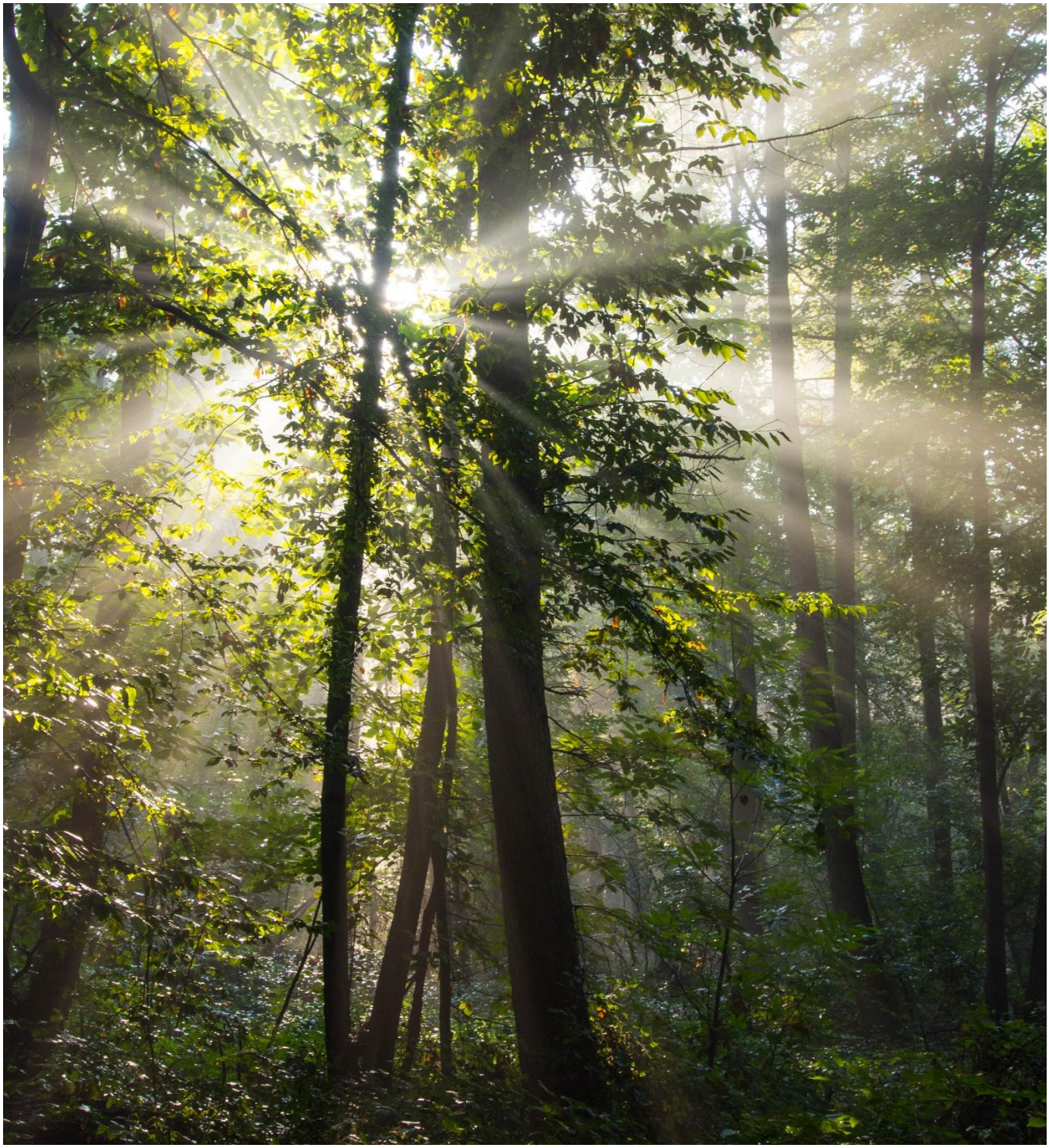


Worcestershire Domestic Abuse Strategy 2022-2025

Contents

Foreword

In the 12 months to March 2020, an estimated 2.3 million adults aged 16 to 74 years experienced domestic abuse in the UK (1.6 million women and 757,000 men).

In Worcestershire in 2020-21, there were a total of 12,887 domestic abuse incidents (reported crimes and non-crimes) reported to the police. In addition to those who have reported domestic abuse, there is thought to be a large unmet domestic abuse need in Worcestershire.

Domestic abuse can have wide-reaching impacts on the physical and mental health of survivors, their financial state and housing. It also affects the health, wellbeing and educational attainment of children who witness it. Physical and emotional harms resulting from domestic abuse are estimated to have cost £47 billion in England and Wales in 2017, with an overall cost to society of £66 billion.

There are a wide range of services, both statutory and voluntary, who work to support families and individuals affected by domestic abuse. The Worcestershire Domestic Abuse Partnership Board will play a key part in strengthening and coordinating the local response to domestic abuse.

It is the aim of the Partnership to ensure that those at risk of, or experiencing domestic abuse in Worcestershire, have the support and services that they require and that perpetrators are appropriately addressed.

It is the aim of this Strategy to enable the Partnership to work together to prevent abuse from occurring, to strengthen the services in Worcestershire and to ensure that services are being steered using the latest research and most robust data. This Strategy also ensures that Worcestershire meets the duties placed on it in relation to part iv of the Domestic Abuse Act 2021.

Introduction

The Worcestershire Domestic Abuse Partnership Board is a partnership between Worcestershire County Council, West Mercia Police, the West Mercia Police and Crime Commissioner, NHS organisations, the National Probation Service, Worcestershire Children First, specialist providers, District Councils and is supported by people with lived experience.

This strategy sets out the joint vision, priorities, and commitments of Worcestershire County Council and the Partnership Board. The overall aim of the Partnership Board is:

To prevent, and reduce the prevalence of, domestic abuse and ensure that all those impacted by domestic abuse have the right support, when they require it.

SAFE ACCOMMODATION NEEDS ASSESSMENT AND ACTION PLAN

This Strategy is informed by best practice, national learning and a Safe Accommodation Needs Assessment. It will inform an Action Plan.

The Safe Accommodation Needs Assessment, brings all the data and information, as required by the duty under part iv of the 2021 Domestic Abuse Act, in relation to safe accommodation together in one place and helps the Partnership Board understand what is working well in Worcestershire and where there are areas for development.

Bringing information together from across the Partnership Board is vital as it enables plans and service decisions to be evidence informed.

The Action Plan will bring together the actions which need to be completed to implement this strategy; it will be overseen by the Domestic Abuse Partnership Board who have the responsibility of ensuring progress on the commitments given.

Domestic Abuse Act 2021

The prevention of abuse and the protection of all victims lies at the heart of the Domestic Abuse Act 2021 and the wider programme of work.

The measures in the 2021 Domestic Abuse Act seek to:

PROMOTE AWARENESS - to put abuse at the top of everyone's agenda, by introducing a statutory definition of domestic abuse and recognise children as victims in their own right.

TRANSFORM THE JUSTICE RESPONSE - including by helping victims to give their best evidence in the criminal courts through the use of video evidence, screens and other special measures, and ensuring that victims of abuse do not suffer further trauma in family court proceedings by being cross-examined by their abuser.

IMPROVE PERFORMANCE - to drive consistency and better performance in the response to domestic abuse.

PROTECT AND SUPPORT VICTIMS - including by establishing in law the office of domestic abuse commissioner, introducing a new domestic abuse protection notice and domestic abuse protection order and placing a new duty on upper tier local authorities to provide support to victims of domestic abuse and their children in refuges and other safe accommodation.

TACKLE PERPETRATORS - extending the controlling or coercive behaviour offence to cover post-separation abuse, extending the offence of disclosing private sexual photographs and films with intent to cause distress to cover threats to disclose such material, creating a new offence of non-fatal strangulation or suffocation of another person, clarifying by restating in statute the general position that a person may not consent to the infliction of serious harm and, by extension, is unable to consent to their own death.

What is Domestic Abuse?

Domestic abuse causes significant harm to individuals, children, families and communities.

This Strategy adopts the Government definition of domestic abuse which is outlined in the 2021 Domestic Abuse Act. The new definition emphasises that domestic abuse is not only physical violence, but can also be emotional, coercive or controlling behaviour, and economic abuse. See Appendix for full definition

BEHAVIOUR IS CLASSED AS "DOMESTIC ABUSE" IF:

- Both individuals are over 16 years of age.
- Both individuals are personally connected to each other, and the behaviour is abusive.

ABUSIVE BEHAVIOUR CAN BE ANY OF THE FOLLOWING:

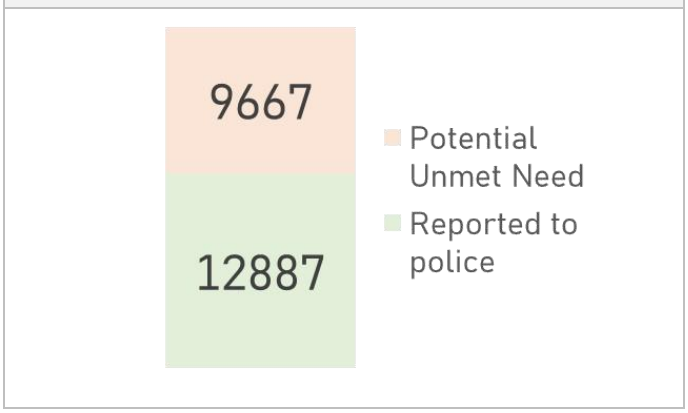
- Physical or sexual abuse
- Violent or threatening behaviour
- Controlling or coercive behaviour
- Economic abuse
- Psychological, emotional or other abuse

Picture in Worcestershire

In the scoping work completed as part of creating this strategy, several datasets were investigated to build a picture of the domestic abuse need in Worcestershire. Below is a summary of those data sets.

EXPECTED PREVALENCE OF DOMESTIC ABUSE INCIDENTS

EXPECTED PREVALENCE



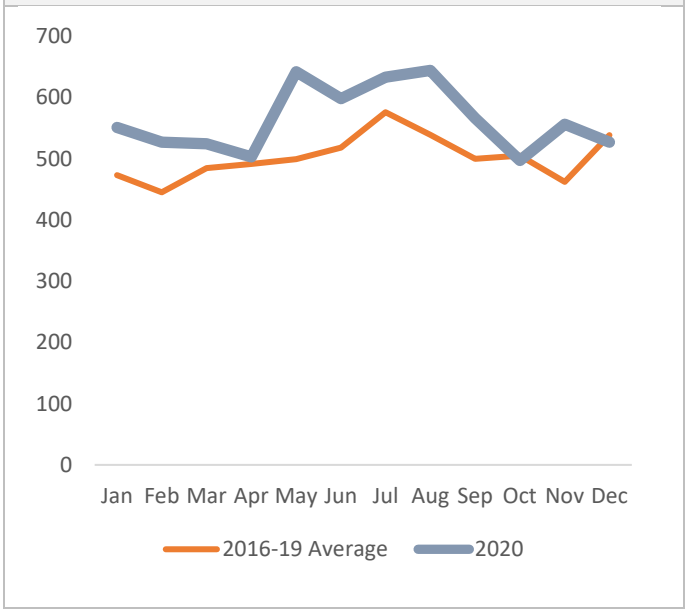
The expected prevalence uses the findings from the Crime Survey of England and Wales and applies them to the population by age across Worcestershire.

For the financial year 2020-21, the prevalence rates indicate that approximately 43% of victims do not report their crimes to the police.

RECORDED CRIMES AND NON-CRIME INVESTIGATIONS

IMPACT OF COVID-19 ON RECORDED CRIMES AND NON-CRIME INVESTIGATIONS (WITH A DOMESTIC ABUSE FLAG) IN WORCESTERSHIRE

(2020 against 2016-19)



The graph compares crimes and non-crimes with a domestic abuse flag between 2020 and 2016-19.

COVID-19 had an impact on the numbers of domestic abuse incidents reported to the police. Nationally, many victims of domestic abuse couldn't distance themselves from their abuser, safely contact the police for help or get support from family and friends.

In Worcestershire, there was overall a greater number of crimes and non-crime incidents during 2020 compared to the average in Worcestershire over the three years between 2016-19.

HOMELESS APPROACHES BY DISTRICT

District	Number of DA Approaches	Owed a homelessness duty	Prevention
Bromsgrove	30	17	8
Malvern Hills	34	34	0
Redditch	35	35	4
Worcester	116	58	11
Wychavon	113	95	0
Wyre Forest	58	48	10

The table on the left shows the number of homeless approaches (the number of people who have asked the council for assistance due to being homeless or worried about becoming homeless) in the financial year 2020-21, where the reason was domestic abuse, by district.

DOMESTIC ABUSE SERVICE USER PROFILE[1]

The needs assessment highlighted the demographic make-up of those accessing domestic abuse services. It should be noted that there can be barriers to services faced by marginalised groups

- Predominantly White British – 79%, second largest ethnic group were White other – 9.8%
- 86% of victims were females, 12% males and 2% identified as transgender
- 81% were heterosexual, 6% lesbian or gay and 12% preferred not to say
- Perpetrators are mainly white males
- The number of male victims reporting domestic abuse is increasing
- Most of the victims have at least one child
- 65% of service users are atheist, 17% Christian and 4% Muslim

In Worcestershire, accessing safe accommodation is particularly challenging for the following groups:

- Refugees and newly arrived migrants (in terms of language, culture, immigration, faith)
- Those with disabilities
- LGBTQ+ groups
- Males
- Parents with teenage boys
- Owner occupiers
- Larger families with older children, especially with complex needs
- Those dependent upon alcohol or other drugs
- Disabled females

CHILDREN AND DOMESTIC ABUSE

In relationships where there is domestic violence and abuse, children witness about three-quarters of the abusive incidents. Children who witness domestic abuse may display aggressive or angry behaviour, become withdrawn, have difficulty at school, experience anxiety, depression or eating disorders, have problems sleeping or wet the bed, exhibit self-harming behaviour, take drugs or excessively drink alcohol. They are at risk of being abused themselves and may repeat the pattern and become abusive when they are older.

The information below is taken from the Needs Assessment and highlights the need for a range of interventions to support children living in families subject to domestic abuse.

District Council	Parents with One or More Children	Individuals with No Children
Bromsgrove	98	8
Malvern Hills	23	2
Redditch	48	54
Worcester	46	53
Wychavon	51	59
Wyre Forest	33	27
Total	299	203

[1] Taken from the Worcestershire Safe Accommodation Needs Assessment 2021

The table below addresses the key themes from the Domestic Abuse Act, the evidence from the Needs Assessment and the way in which the priorities in the Worcestershire Domestic Abuse Strategy will address these themes. Details of the "4 P Priorities" are laid out from page 14 onwards.

KEY THEME FROM DOMESTIC ABUSE ACT	EVIDENCE FROM NEEDS ASSESSMENT	STRATEGY PRIORITIES
Address the need for 'safe accommodation' in Worcestershire	There is a need to increase suitable safe accommodation provision in Worcestershire as many referrals are not being met due to a shortfall. The assessment shows a requirement for 35 units per annum across Worcestershire. Services are not easily accessible to rural communities. Referral times need to be as brief as possible due to the distressing nature of the violence.	PROVISION PARTNERSHIP
Meeting the need for accommodation-based support	Domestic Abuse victims require a holistic, person-centred package of support as well as housing services. For example, victims need assistance with legal and financial matters as well as wellbeing support. Support should be beyond the time of being in safe accommodation.	PREVENTION PROVISION PARTNERSHIP PURSUE
Meeting needs of all those with protected characteristics	Suitable accommodation is required for specific groups including males, LGBTQ, people from ethnic minorities, people with disabilities and difficulties, and larger families. There needs to be improved recognition of the needs of, and response to, male and LGBTQ victims.	PREVENTION PROVISION PARTNERSHIP PURSUE
Address barriers faced by those with protected characteristics	It is crucial to ensure support services are accessible to people from diverse backgrounds, communities and experiences.	PREVENTION PROVISION PARTNERSHIP PURSUE
Address support needs of children	There are gaps in services for children of families affected by domestic abuse.	PREVENTION PROVISION PARTNERSHIP
Meeting the needs of those from outside of Worcestershire	Referrals for refuges and safe accommodation in Worcestershire are received from both within Worcestershire and from further afield. The nature of DA is such that a survivor may choose to move some distance from their abuser creating both a flow into and out of the county	PROVISION PARTNERSHIP

ADDRESS THE NEED FOR 'RELEVANT ACCOMMODATION' IN WORCESTERSHIRE

PREVENTION	PROVISION OF SERVICES	PARTNERSHIP	PURSUING PERPETRATORS AND CRIMINAL JUSTICE
-	The DAPB work to ensure that the appropriate number of additional units are provided as per the needs assessment.	The DAPB should ensure that the full range of 'relevant accommodation' is developed in Worcestershire, including for those survivors who wish to remain in their own home.	-

MEETING THE NEEDS OF ACCOMMODATION BASED SUPPORT

PREVENTION	PROVISION OF SERVICES	PARTNERSHIP	PURSUING PERPETRATORS AND CRIMINAL JUSTICE
Any future service developments and implementations should be based on clear and robust data. There should be a plan for making data collection uniform across all of Worcestershire, including the districts.	The goal of support services should be to provide a person-centred package of support that meets all the needs of survivors of domestic abuse. All communities in Worcestershire, including those in rural areas, should have good access to specialist domestic abuse services.	There should be clear pathways between 'safe accommodation' services and community services to ensure 'wrap around' support for survivors.	The behaviour of the perpetrator must be addressed. Victims must be supported at the earliest stage.

MEETING NEEDS OF ALL THOSE WITH PROTECTED CHARACTERISTICS / ADDRESS BARRIERS FACED BY THOSE WITH PROTECTED CHARACTERISTICS

PREVENTION	PROVISION OF SERVICES	PARTNERSHIP	PURSUING PERPETRATORS AND CRIMINAL JUSTICE
Worcestershire must aim to provide high quality and equitable services. Service planning must be supported by robust data collection. Data should be used to inform needs-led evidenced based commissioning.	It should be ensured that the new definition of domestic abuse is understood by all - survivors and front-line practitioners who may be best placed to identify signs of domestic abuse at the earliest possible stage. Awareness and understanding of domestic abuse should run through all services. There should be access to appropriate and safe accommodation.	There should be appropriate information-sharing between agencies to ensure that survivors receive the most appropriate interventions. This includes protecting them from ongoing harm.	The behaviour of the perpetrator must be addressed. Victims must be supported at the earliest stage.

ADDRESS SUPPORT NEEDS OF CHILDREN

PREVENTION	PROVISION OF SERVICES	PARTNERSHIP	PURSUING PERPETRATORS AND CRIMINAL JUSTICE
Witnessing domestic abuse can have long-term effects on children and young people. Within families, there may be other complex needs present (e.g., mental health, substance misuse, housing, financial issues). There should be a joined-up approach to addressing these issues.	Support services for children and young people should offer age-appropriate services.	There should be a joined-up approach to identifying families where there is a domestic abuse need. Information about children in families where domestic abuse has been identified should also be included in any information sharing. The safeguarding needs of children and young people should be considered when domestic abuse is identified in families.	-

MEETING NEEDS OF THOSE FROM OUTSIDE OF WORCESTERSHIRE

PREVENTION	PROVISION OF SERVICES	PARTNERSHIP	PURSUING PERPETRATORS AND CRIMINAL JUSTICE
-	For those from outside of Worcestershire, there may be difficulties or blockages when transferring from a refuge to long-term accommodation. Appropriate information should reduce these blockages.	Key stakeholders will have to work together to ensure the housing need of those from outside of Worcestershire are met.	-

Strategic Response

The overall aim is to prevent and reduce the prevalence of domestic abuse and ensure that all those impacted by domestic abuse have the right support, quickly. Four key priorities have been identified:

- PREVENTION
- PROVISION OF SERVICES
- PARTNERSHIP
- PURSUING PERPETRATORS AND CRIMINAL JUSTICE

Included under each priority are commitments that demonstrate how we, as a Partnership Board plan to improve the response to domestic abuse within Worcestershire.

The priorities and their commitments are for all people irrespective of gender, sex, age, disability, ethnicity, sexual orientation or religion, recognising intersectionality of these characteristics.

This will be reflected within the Partnership Board Action Plan.

Throughout the priorities below are commitments that deliver upon the duties placed on Worcestershire County Council in relation to Part 4 of the Domestic Abuse Act 2021. The preferred solution is to support victims and their children to remain safely in their own homes. However, where this is not possible, the Act sets out the specific duties placed on upper tier local authorities in relation to the provision of support for victims and their children residing within relevant safe accommodation.

Key Priority 1 – Prevention

THIS PRIORITY AIMS TO INCREASE THE FOCUS ON EARLY INTERVENTION AND PREVENTION.

In Worcestershire, early intervention by the voluntary sector and statutory agencies working together can help to protect adult and child victims from further harm, as well as preventing escalation and recurrence of a range of abuses which can form part of domestic abuse, such as stalking, harassment, and sexual violence.

We will aim for local organisations and agencies to have in place effective ways to identify emerging problems and potential unmet needs of individual children and families experiencing domestic abuse.

Through the Partnership Board we will aim to work with organisations and agencies to develop joined-up early help services based on a clear understanding of local needs, as detailed in the Worcestershire Safe Accommodation Needs Assessment 2021.

This requires all practitioners, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other practitioners to support early identification and assessment.

To achieve the aims of this priority, all front-line practitioners must adopt professional curiosity when engaging with individuals. Often, victims will make contact with a range of services before disclosing their abuse. These contacts represent opportunities for early intervention, so it is crucial that all staff are trained to recognise domestic abuse and ask the right questions.

Increasing practitioner's knowledge and confidence in identifying the signs and symptoms of domestic abuse is critical to early identification of domestic abuse. This includes recognising the barriers to services for those with protected characteristics including male survivors.

COMMITMENT 1

We will **work jointly** to identify and support individuals and families at risk of **domestic abuse**, including where there has been historic abuse or where other risk factors are present. We will deliver **preventative and early intervention services** linked to understanding vulnerabilities and risk.

COMMITMENT 2

We will ensure that a robust offer on **domestic abuse awareness and healthy relationships** is available to **all schools and educational settings**. We will work with schools to challenge gender inequality, sexual stereotyping, and domestic abuse normalisation where it exists.

COMMITMENT 3

We will use our **safeguarding functions** to support the **early identification** of abuse of adults and children including those with **additional needs.** This includes recognising instances of the abuse of older people and children and working in accordance with safeguarding policies and protocols.

COMMITMENT 4

As a Partnership Board, we will **challenge societal attitudes** that allow domestic abuse to occur through targeted communications and services.

COMMITMENT 5

We will **increase awareness** of how to **better prevent and respond** to **domestic abuse** across all agencies, services, and our local communities.

COMMITMENT 6

To aid **identification of domestic abuse** at the earliest possible opportunity **all relevant staff and volunteers** will have a **strong understanding of appropriate responses and pathways** including referrals and interventions.

COMMITMENT 6

We will ensure that **under-represented groups, and those with protected characteristics, are engaged,** and will identify those more vulnerable to certain types of abuse.

Key Priority 2 – Provision of Services

THIS PRIORITY FOCUSES ON THE PROVISION OF RESPONSIVE AND EFFECTIVE SERVICES FOR ADULT AND CHILD VICTIMS AND GROUPS AT RISK OF, OR SUBJECT TO DOMESTIC ABUSE.

There are a variety of factors which may increase the risk of domestic abuse and as such a range of solutions which may be provided to those affected by it. Services include victim support, perpetrator programmes, child-specific services, couple and whole family interventions and criminal justice interventions.

A multi-agency response will be key to providing responsive, flexible services, which respond as early as possible. The ability to recognize the signs and symptoms of domestic abuse and the confidence to do something about it should be in place across all statutory and voluntary services. The wider community should also be better informed about domestic abuse and be assured that there are appropriate services available for those who need them.

Commissioning and service planning will be underpinned by principles which ensure that services meet the required quality standards and meet the diverse needs of those who require them. When services are working with survivors, they will address the holistic needs of the survivor, including mental health and emotional wellbeing needs.

The Partnership Board will work together to provide the full range of 'relevant accommodation' (as described in the Domestic Abuse Act 2021) and ensure that there is appropriate provision to meet the needs as detailed in the needs assessment.

COMMITMENT 1

All services will be commissioned and delivered according to a **robust evidence base** and on **best practice**. Our **joint commissioning approach** will continue to be developed as best practice guidelines evolve.

COMMITMENT 2

We will seek to use **trauma-informed approaches** to support children and adult victims who have experienced abuse to improve outcomes. We will use learning and research on **Adverse Childhood Experiences** to further understand the impact of domestic abuse on young people, and how to **minimise harm** experienced to **build resilience**.

COMMITMENT 3

The Partnership Board will meet the **needs, and respect the diversity,** of those with protected characteristics, and ensure clear signposting and referral mechanisms, particularly for **addressing minority or complex needs** and supporting those with **multiple vulnerabilities**.

COMMITMENT 4

The **commissioning and provision of services** will be informed by the views of those with **lived experience** or who are at significant risk of domestic abuse.

COMMITMENT 5

We will ensure all relevant **front-line staff** are trained in **identifying** and **working with** those experiencing all forms of **domestic abuse**, to help them **recognise risks** and include these in **safety plans** where appropriate for both survivors and perpetrators.

COMMITMENT 6

We will develop and maintain a **complete service directory** to show a clear **picture of available services.** This will ensure that the development of provision meets changing needs within the community and that we are able to quickly **identify any gaps in support** linking with the **Needs Assessment**.

COMMITMENT 7

All partners will **work jointly** to lessen the impact of domestic abuse on **children and young people** through early intervention by supporting activities and services to **develop their resilience and improve their emotional wellbeing**. Partners will support appropriate training and resources including the involvement of the non-abusive parent where appropriate.

COMMITMENT 8

The DAPB will work together to provide the full range of 'relevant accommodation' (as described in the DA Act 2021) and ensure that appropriate support is provided to meet the identified needs is available to all victims of domestic abuse, including males and those with protected characteristics.

Key Priority 3 – Partnership

THIS PRIORITY ENSURES A COLLABORATIVE APPROACH TO IMPROVE WORCESTERSHIRE'S RESPONSE TO DOMESTIC ABUSE.

A partnership approach encourages the broadest possible response to domestic abuse, addressing prevention, early intervention, dealing with crisis, risk fluctuation, and long-term recovery and safety.

Best practice in relation to partnership working states that no single agency or individual can see the complete picture of the life of a family or individual within that family, but all may have insights and can provide interventions that are crucial to their safety and wellbeing.

A true partnership approach moves the responsibility for safety away from individual survivors to the community and services existing to support them.

COMMITMENT 1

All agencies commit to **working together** to provide the **broadest possible response** to domestic abuse. This will cover **co-leadership**, **pooling of resources**, actively engaging to **achieve our shared objectives,** and a **more strategic** and **effective response** to domestic abuse. This will address prevention, early intervention, dealing with crisis, risk fluctuation, and long-term recovery and safety.

COMMITMENT 2

Partners will **work collectively** to bring together **comparable, accurate and consistent data** on areas such as commissioning, provision and gap analysis in an improved, ongoing **Needs Assessment process**. Information-sharing will work to inform our response to **under-reporting** and ensure we draw out the right narratives from the evidence. Where possible we will commission research where gaps in knowledge exist.

COMMITMENT 3

All agencies will ensure they participate in multi-agency panels such as the **Domestic Homicide Review process**, the **Multi Agency Risk Assessment Conference (MARAC)** and the **Domestic Abuse Perpetrator Programme (DAPP)**. **Learning** from these, Serious Case Reviews and Safeguarding Practice Reviews are **proactively shared** with contributing members and the wider workforce.

COMMITMENT 4

We will **work together** to **access external funding opportunities**, working collectively to **identify the areas** that would benefit the most from additional funding.

COMMITMENT 5

We will support any person **within the workforce** who is **experiencing domestic abuse**, and ensure our processes work to assist and **support any staff member** who discloses domestic abuse to us. We will **work with businesses** to ensure that they have access to information on how to support staff members who may disclose abuse.

COMMITMENT 6

Domestic abuse services, housing, and other key services will work together to ensure that domestic abuse survivors and their children have access to **appropriate housing and support**.

Key Priority 4 - Pursuing Perpetrators and Criminal Justice

THIS PRIORITY FOCUSES ON INCREASING PERPETRATOR CONVICTIONS THROUGH THE CRIMINAL JUSTICE SERVICE AND PARTNERS USING THEIR POWERS TO REDUCE THE IMPACT OF DOMESTIC ABUSE AND REDUCE THE LIKELIHOOD OF FURTHER INCIDENTS.

Reducing the impact of domestic abuse can be achieved through a number of routes including prosecuting perpetrators through the criminal justice system, via civil outcomes, through working with perpetrators to change behaviour, or through rehabilitation (within prison or the community). Reducing the impact of domestic abuse requires continuous improvement of the protections and justice available and lobbying for an effective use of sentencing.

All partners should be aware that the violent and harmful behaviour of perpetrators needs to be addressed. Individuals may be continuing to be impacted by abusive behaviour as their case moves through justice processes.

Supporting interventions that lead to sustainable behaviour change in perpetrators themselves should drive a reduction in the prevalence of domestic abuse and reduce the rates of re-offending.

COMMITMENT 1

Focused protection, **support and information** will be available for **all survivors** throughout the **Criminal Justice System** process. An element of this will include the IDVA provision commissioned by the West Mercia PCC. All agencies should ensure that the **survivors' voice is heard** throughout these processes and used to improve and enhance service provision.

COMMITMENT 2

All agencies will work together to ensure that there is a **robust approach to perpetrators**. This will include understanding the behaviour of the perpetrator, supporting interventions that lead to sustainable behaviour change in perpetrators themselves and having a clear plan to bring them to justice or diverting them from offending. We will respond **robustly to harmful and violent behaviour**; and provide greater focus on changing the behaviour of the perpetrator through a combination of disruption, support and the management of offenders.

COMMITMENT 3

We will **support individuals and families** through their **criminal justice journey** from arrest of the perpetrator through to prosecution and beyond to ensure the **timely, meaningful delivery of justice,** working to **reduce further harm through re-traumatisation** and provide **sustainable outcomes**.

COMMITMENT 4

Ensure **staff and volunteers** understand the **legal tools and support available,** and how they can be put **in place in a timely manner**.

COMMITMENT 5

Partners will work together to improve the **process and journey** through the **family court system** for survivors of domestic abuse.

COMMITMENT 6

Provision of **appropriate accommodation and support** to victims will enable them to support Criminal Justice outcomes

COMMITMENT 7

An **Offender Housing Pathway** will encourage offenders to use housing solutions independent of their ex-partners

Achieving our Objectives

This strategy is intended to be an overarching document setting out a common understanding and commitment from key partners to address domestic abuse across Worcestershire. Accountability for this strategy sits with the DAPB. This strategy will be supported by a joint action plan agreed to and championed by each partner within the DAPB.

Actions developed will be directly linked to our identified priorities and commitments. Below this each partner will choose whether to develop bespoke or adopt existing individual action plans to capture the actions that they, as an organisation will have responsibility for.

The DAPB will oversee the action plans arising from this strategy. Feedback from those who use interventions and services will form a vital part of service development, our commissioning which includes joint commissioned activity with the key partners and our monitoring procedures (through the Joint Commissioning Group). We will work to ensure that the voice of survivors, of families affected by domestic abuse and of perpetrators who have interacted with our services informs and continually improves our provision.

The DAPB will provide annual monitoring reports to the Worcestershire Safer Communities Board, setting out progress against our priorities and identified outcomes. The strategy and joint action plan will be regularly reviewed by the DAPB.

Delivery of this Strategy will require sustained commitment from all partners if we are to continue to make a measurable difference to the lives of survivors of domestic abuse and their families. We are focused on delivering real change, strengthening the coordination of services, learning from the latest research and continuing to develop and respond to the needs of our community.

Appendix

DEFINITION OF DOMESTIC ABUSE (DOMESTIC ABUSE ACT 2021)

The Domestic Abuse Act 2021 specifies that behaviour of a person ("A") towards another person ("B") as "domestic abuse" if **A and B are each aged 16 or over** and **are personally connected to each other** and **the behaviour is abusive**.

'Abusive behaviour' is defined as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional, or other abuse

'Personally connected' is defined in the act as parties who:

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

worcestershire county council

Date printed: 08/02/2022
Date Screening completed: 27/10/2021
Requester: Paul Kinsella

Project Screening
Impact Assessment Id: #279

1. Your Details

Name of person completing screening assessment
Paul Kinsella

Job Title
Advanced Public Health Practitioner

Directorate
People

Service Area
Public Health

Email Address
PKinsella@worcestershire.gov.uk

Connection to project (e.g. project manager)
Lead officer

2. Project Summary

For the purposes of the impact assessment screening, we will refer to the activity or area being assessed as a project.

Project Name
Implementation of new Domestic Abuse Duty under Part iv of the DA Act 2021

Name of Project Sponsor
Dr Kathryn Cobain

Name of Project Manager
Tony Mercer

Name of Project Lead
Paul Kinsella

Project Reference (if known)

Please give a brief description of the project
Implementation of the changes introduced by the new duties in part iv of the Domestic Abuse Act 2021

3. Data Protection

We need to establish if the proposal involves processing personal data. Personal data is information that relates to an identified or identifiable individual.

Name of Information Asset Owner **Kath Cobain**
Senior officer responsible for the project's information assets

Does the project, any project work stream or project outcome involve any personal data? Some examples of personal data are given below. **Yes**

Appearance:
photograph, physical description
Basic Identifiers:
name, date of birth, age, biometric data, ethnic origin, gender, genetic data, race, sex
Contact Details:

address, email address, home phone number, mobile phone number, postcode

ID Number:

National Insurance Number, driving licence number, NHS number, online identifier, other general identifier

Employment:

work related training/awards

Financial:

income/financial/tax situation

Lifestyle:

health or social care, living habits, marital status, philosophical beliefs, political opinions, religion, sex life, trade union membership

Technology:

login/username, device MAC address (wireless network interface), device IMEI number, IP Address, location data (travel/GDPS/GSM data), website cookies

Does the project, any project work stream or project outcome involve:

Evaluating or scoring individuals (including profiling and predicting)? No

e.g. building behavioural or marketing profiles of individuals based on their web activity

Profiling, automated decision-making or special category data to help make decisions on access to a service, opportunity or benefit, or otherwise have a significant effect on an individual? Yes

e.g. asking an individual to submit personal data that is then analysed by a computer system, with the result that the individual's request to use a service is either accepted or refused.

Systematic monitoring? No

e.g. installing a CCTV or ANPR system on council premises, or any covert surveillance including anything under RIPA.

Processing of 'special category' personal data (or 'sensitive personal data')? Yes

e.g. processing health or social care data.

Processing personal data on a large scale? Yes

e.g. implementing a new social care record system.

Datasets that involve combining, comparing, or matching data from multiple sources? No

e.g. matching or merging service users' personal data against or with personal data held by a third party (e.g. the NHS).

The personal data of vulnerable people? Yes

e.g. processing children's personal data or social service client's data.

The use or application of innovative technological or organisational solutions? No

e.g. using fingerprint recognition technology to control access to a building.

The transfer of personal data outside of the European Union? No

e.g. storing personal data in a cloud service hosted in the US or using a third party that uses technology hosted in the US.

Preventing individuals from exercising a right or using a service or contract? No

e.g. screening applicants before allowing them to use a web service.

Processing personal data that could result in a risk of physical harm in the event of a security breach? Yes

The use of third parties? Yes

e.g. as a service provider or hosted service

Processing children's data for profiling, automated decision-making, any marketing purposes, or to offer any online services directly to them? Yes

e.g. apps designed for use by children

4. Equality

We need to determine whether the project could affect residents and/or Council staff because they share any of the Protected Characteristics defined in the Equality Act 2010 namely Age, Disability, Gender Reassignment, Marriage/Civil Partnership, Pregnancy, Race, Religion/Belief, Sex and Sexual Orientation.

Does the project relate to an area where data/research indicates that inequalities are already known to exist? Yes

Could this project have any effect on, service delivery or usage, other aspects of daily life or community participation levels for people because they belong to any of the groups below?

Age Yes

e.g. a person belonging to a particular age group (for example 18 – 30-year olds).

Disability Yes

e.g. A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

Gender Re-Assignment Yes

e.g. The process of transitioning from one gender to another.

Marriage/Civil Partnership Status Yes

e.g. Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples (except where permitted by the Equality Act).

Pregnancy/Maternity Yes

e.g. Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Race Yes

e.g. Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

Religion or Belief Yes

e.g. Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Sex Yes

Sexual Orientation Yes

e.g. Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Health Inequalities Yes

e.g. Any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies.

5. Public Health

We also want to understand if the project will have any impacts on public health.

The social, economic, cultural and physical environment in which people live their lives has a significant effect on their health and wellbeing. Although genetics and personal behaviour play a strong part in determining an individual's health, good health starts where we live, where we work and learn, and where we play.

Improving public health requires taking a broader view of the conditions that create health and wellbeing, from how we plan and develop our urban spaces and places, to the opportunities for employment, recreation, and social connection available to all who live in them.

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

Could the project have an impact on any of the following factors?

Social and Economic Yes

e.g. culture, social support (neighbourliness, social networks/isolation), spiritual participation, employment opportunities.

Physical Health Yes

e.g. physical activity is expected to increase, influenza vaccination uptake increase

Mental Health & Wellbeing Yes

e.g. benefits to children's mental health, benefits to adult carer wellbeing.

Access to Services Yes

e.g. access to (location/disabled access/costs) and quality of primary/community/secondary health care, child care, social services, housing/leisure/social security services; public transport, policing, other health relevant public services, non-statutory agencies and services.

5. Environmental Sustainability

We want to understand if the project activity and project outcomes will have an impact on environmental sustainability. Please be mindful that the Council has committed to reduce its emissions to net-zero by 2050 and most projects are likely to have an impact on this target. This should be a key consideration in your project delivery and should be reviewed when completing these screening documents.

Could this project have an impact on the categories listed below?

Greenhouse Gas (GHG) Emissions (including CO2) No

e.g. increased GHG emissions as a result of project implementation, which may also be linked with efficient use of resources in WCC buildings; transport; emissions from waste; and procurement.

Efficient Use of Resources No

e.g. consumption of energy resources, water, electricity, gas and heating fuels.

Transport No

e.g. number of people travelling, alternative transport modes.

Waste No

e.g. increase in waste generated or an increase in waste recycling.

Wildlife and Biodiversity No

e.g. impacts on the natural environment or enhancements to the natural environment.
N.B. This refers to any direct or indirect modifications to landholdings, including but not limited to removal of vegetation, alteration or demolition of buildings or modification of watercourses or lighting (not limited to just green space/trees).

Pollution to Land or Water No

e.g. risk of pollution to the local environment.

Pollution to Air No

e.g. risk of pollution to air, activity which may adversely affect air quality or increase emissions to air

Resilience to climate change No

e.g. risks of extreme weather and climate impacts on the project.

Historic Environment No

e.g. impacts on Historic Environment or enhancements of the Historic Environment.

Procurement No

e.g. could procurement associated with the project result in an increase of natural resources (such as long-distance shipping of goods); could use be made of local resources or work forces to support delivery of the project.

As you answered 'No' to all the questions, please explain your reasoning below:

The activity creates additional activity in housing and supporting domestic abuse survivors - this should not have significant impact on environmental sustainability. (Existing housing stock will be utilised)

7. Results of Screening

Data Protection	Will require a full impact assessment
Equality and Public Health	Will require a full impact assessment
Environmental Sustainability	Does not need a full impact assessment

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worcestershire county council

Date printed: 08/02/2022
Date assessment submitted: 28/10/2021
Requester: Paul Kinsella

Equality and Public Health Full Impact Assessment
Impact Assessment Id: #279

1.0 Screening Information

Project Name
Implementation of new Domestic Abuse Duty under Part iv of the DA Act 2021

Name of Project Sponsor
Dr Kathryn Cobain

Name of Project Manager
Tony Mercer

Name of Project Lead
Paul Kinsella

Please give a brief description of the project
Implementation of the changes introduced by the new duties in part iv of the Domestic Abuse Act 2021

Data Protection screening result
Will require a full impact assessment

Equality and Public Health screening result
Will require a full impact assessment

Environmental Sustainability screening result
Does not need a full impact assessment

1.1 Background and Purpose

Background and Purpose of Project?
To support your answer to this question, you can upload a copy of the project's Business Case or similar document.
To oversee delivery of the additional duties under part iv of the Domestic Abuse Act 2021

Upload Business Case or Support documents
DA Strategy Spec 2021 07 01 Mature Draft.docx

Project Outputs
Briefly summarise the activities needed to achieve the project outcomes.
Accommodation and support to victims of Domestic Abuse

Project Outcomes
Briefly summarise what the project will achieve.
Improve the safety of victims of DA and children involved in DA
Enable victims of DA (and their children to maintain tenancies and recover from the effects of DA

Is the project a new function/service or does it relate to an existing Council function/service?
Existing

Was consultation carried out on this project?
No

1.2 Responsibility

Directorate/Organisation

People

Service Area

Public Health

1.3 Specifics

Project Reference (if known)

Not Recorded

Intended Project Close Date *

April 2024

1.4 Project Part of a Strategic Programme

Is this project part of a strategic programme?

No

2 Organisations Involved

Please identify the organisation(s) involved:

Herefordshire & Worcestershire STP
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
Worcestershire County Council
Worcestershire CCGs
Other - West Mercia Police

Details of contributors to this assessment:

Name	Paul Kinsella
Job title	Advanced PH Practitioner
Email address	pkinsella@worcestershire.gov.uk

3.0 Who will be affected by the development and implementation

Please identify group(s) involved:

Service User
Staff

3.1 Information and evidence reviewed

What information and evidence have you reviewed to help inform this assessment? *

Needs Assessment for Domestic Abuse in Worcestershire

3.2 Summary of engagement or consultation undertaken

Who and how have you engaged, or why do you believe engagement is not required? *

The application of the Act and various duties is a statutory requirement

3.3 Summary of relevant findings

Please summarise your relevant findings. *

NA

4 Protected characteristics - Equality

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please select one or more impact box(es) below for each equality group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative for the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. who are part of these equality groups.

Age

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

Disability

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

Gender reassignment

Potential positive impact selected

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

Marriage and civil partnerships

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

Pregnancy and maternity

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

Race including travelling communities

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

Religion and belief

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

Sex

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

Sexual orientation

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics

5 Characteristics - Public health

Other vulnerable and disadvantaged groups

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon all protected characteristics. It will incorporate an individual tasked with reaching out to such groups

Health inequalities

Potential positive impact selected. Potential neutral impact selected.

Explanation of your reasoning:

This project will offer individuals from all groups access to positive health input from support practitioners

Social and economic

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon victims of DA by offering them accommodation and support to move on from relationships that threaten or reduce their physical/mental health. This will include involving them in broader community activity

Physical health

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon victims of DA by offering them accommodation and support to move on from relationships that threaten or reduce their physical health

Mental health and wellbeing

Potential positive impact selected.

Explanation of your reasoning:

The (part iv) activity is designed to positively impact upon victims of DA by offering them accommodation and support to move on from relationships that threaten or reduce their mental health

Access to services

Potential positive impact selected.

Explanation of your reasoning:

The activity is designed to positively impact upon victims of DA by offering them accommodation and support to move on from relationships that threaten or reduce their physical health. This will include signposting to additional services

6 Actions to mitigate potential negative impacts

You have confirmed that there are no negative impacts for equality protected characteristics and public health characteristics.

7 When will you review this equality and public health estimate(EPHIA)?

At the review of the strategy 2024

8 Declaration

The following statement has been read and agreed:

- **All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation**
- **Our Organisation will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others**
- **All staff are expected to deliver and provide services and care in a manner which respects the individuality of service users, patients, carers etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics**

I confirm to the best of my knowledge that the information I have provided is true, complete and accurate

I confirm that I will make sure that Equality and Public Health have been and continue to be considered throughout the project life cycle and that, if circumstances change in the project, a further Equality and Public Health Impact Assessment Screening will be carried out.

worcestershire county council

Date printed: 08/02/2022
Assessment not yet complete
Requester: Paul Kinsella

Data Protection Full Assessment
Impact Assessment Id: #279

1.0 Screening Information

Project Name
Implementation of new Domestic Abuse Duty under Part iv of the DA Act 2021

Name of Project Sponsor
Dr Kathryn Cobain

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Equality and Public Health screening result
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Environmental Sustainability screening result
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1.1 Background and Purpose

Background and Purpose of Project?
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Is the project a new function/service or does it relate to an existing Council function/service?
Existing

Was consultation carried out on this project?
No

1.2 Responsibility

Directorate/Organisation

People

Service Area

Public Health

1.4 Specifics

Project Reference (if known)

Not Recorded

Intended Project Close Date *

April 2024

1.5 Project Part of a Strategic Programme

Is this project part of a strategic programme?

No

2.0 Personal Data

Who are you processing data about?

Customers, clients or service users
Suppliers
Staff, persons contracted to provide a service
Professional advisers and consultants
Students and pupils
Landlords
Recipients of Benefits
Witnesses
Offenders and suspected offenders
Representatives of other organisations

What personal data will be collected? *

The second stage is to list all of the types of personal data that you believe the project/works/additional processing will utilise. Please select yes for as many examples of types of data that are relevant and include any others in the free text at the bottom of the page.

Basic Identifiers:

Name

Yes

Date of Birth

Yes

Age

Yes

Gender

Yes

Sex

Yes

Contact Details:

Address

Yes

Email Address

Yes

Home Phone Number

Yes

Mobile Phone Number

Yes

Postcode

Yes

ID Number:

National Insurance Number

Yes

Driving Licence/Number

No

NHS Number

Yes

Other General Identifier

Yes

Employment:

Work Related Training/Awards

No

Financial:

Income/Financial/Tax Situation

Yes

Appearance:

Photograph

No

Physical Description

No

Lifestyle:

Living Habits

Yes

Marital Status

Yes

Technology:

Login/Username

No

Device MAC Address (Wireless Network Interface)

No

Device Mobile Phone/Device IMEI No

No

Location Data (Travel/GDPS/GSM Data)

No

Online Identifier e.g. IP Address

No

Website Cookies

No

Other Data Types Collected

Not Recorded

2.1 Legal basis for Personal Data

What is your lawful basis for processing the personal data? *

Please choose one of the following

Data Subject's consent for the purpose
No

Necessary for a contract with the Data Subject
No

Necessary to comply with a legal obligation
Yes

Necessary to protect the vital interests of an individual(s)
Yes

Necessary for a task in the public interest or exercise of official authority of Controller
Yes

Necessary for legitimate interests of Controller unless interests are overridden by the interests or rights of the individual (only available in limited circumstances to public bodies)
No

2.2 Special Data

What special category personal data (if any) will be collected? *

This section will not apply to all projects and should only be completed if it applies to you.
It is important that you read this section carefully, as these data types require additional care and protection.
If you do pick anything from this list, you will be required to give more details in Section 4 of this form.
You can read more about Special Category Data through this link;
https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/special-category-data/

Race

Yes

Ethnic origin

Yes

Political opinions

No

Religion

Yes

Philosophical beliefs

No

Trade union membership

No

Genetic Data

No

Biometric Data

No

Sex life

No

Health or social care

Yes

2.3 Legal basis for Special Data

What is the relevant condition for processing the special category personal data? *

You must qualify under one of the below exemptions as well as having a legal basis from the previous question.

Explicit Consent

The data subject has given explicit consent to the processing of those personal data for one or more specified purposes, except where Union or Member State law provide that the prohibition referred to in paragraph 1 may not be lifted by the data subject;
Yes

Employment and Social Security

Processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment and social security and social protection law in so far as it is authorised by Union or Member State law or a collective agreement pursuant to Member State law providing for appropriate safeguards for the fundamental rights and the interests of the data subject;
No

Vital Interests

Processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent;
No

Legitimate Interests of:

"a foundation, association or any other not-for-profit body with a political, philosophical, religious or trade union aim".

Processing is carried out in the course of its legitimate activities with appropriate safeguards by a foundation, association or any other not-for-profit body with a political, philosophical, religious or trade union aim and on condition that the processing relates solely to the members or to former members of the body or to persons who have regular contact with it in connection with its purposes and that the personal data are not disclosed outside that body without the consent of the data subjects;

Note – this is not often applicable to local authorities.

No

Publicly Available Data

Processing relates to personal data which are manifestly made public by the data subject;

No

Legal or Court Proceedings

Processing is necessary for the establishment, exercise or defence of legal claims or whenever courts are acting in their judicial capacity;

No

Public Interest - Statutory Necessity

Processing is necessary for reasons of substantial public interest, on the basis of Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject;

No

Medical, Health and Social Care Provision

Processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3;

No

Public Health

Processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices, on the basis of Union or Member State law which provides for suitable and specific measures to safeguard the rights and freedoms of the data subject, in particular professional secrecy;

No

Archiving or Scientific, Historical or Statistical Research Purposes

Processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.

No

2.4 Information Involved

Understanding the information flows involved in a project is essential to a proper assessment of privacy risks.

How will the data be collected? *

This section should be filled in for every project, not just those collecting Special Category data.
The data collected is to enable vulnerable victims of domestic abuse to be placed in accommodation with appropriate support services.
This data is already collected for this purpose by the partners involved in the provision of accommodation and services to the survivors of Domestic Abuse , but the act requires an expansion of the scale on which it is collected as there is a need to meet a broader set of needs from a more diverse group of DA survivors

What will the data be used for? *

This section should be filled in for every project, not just those collecting Special Category data.
The data collected is to enable vulnerable victims of domestic abuse to be placed in accommodation with appropriate support services.

Has data already been collected?

No

Are the purposes for which you are collecting the data different? *

If the data you are hoping to use was not collected specifically for this project, please explain in the box below why it was collected. This will include data that you have collected from other teams within WCC.
The data needs to identify and enable engagement with individuals with protected characteristics and as identified under the Equalities Act

Explain why existing and/or less intrusive processes or measures would be inadequate *

In this section, you should explain why your new method/project is absolutely necessary and show that you have thought about all other options.
The data needs to identify and enable engagement with individuals with protected characteristics and as identified under the Equalities Act to meet the statutory duties under the Domestic Abuse Act 2021.

3.0 Other organisations

Are other organisations involved in processing the data?

Yes

Please provide details of each organisation that is involved in the processing of Data. Do this by adding to the below list. *

Organisation Name	WM Police
Data Controller or Data Processor	Data Controller
Organisation's Role	Controller and originator
Data Sharing Agreement or Contract	Yes
Contract Reference Number/DSA Name	DS006395 ISP037 Safer Communities
Organisation involved reason	It owns/originates the data
Disclosure and Security	Secure encrypted email

Organisation Name	Worcester Acute Trust
Data Controller or Data Processor	Data Controller
Organisation's Role	Originator and owner of data
Data Sharing Agreement or Contract	Yes
Contract Reference Number/DSA Name	DS006395 ISP037 Safer Communities
Organisation involved reason	It owns the data
Disclosure and Security	Secure encrypted email

Organisation Name	Herefordshire and Worcestershire Health and Care NHS Trust
Data Controller or Data Processor	Data Controller
Organisation's Role	Controller and originator of data
Data Sharing Agreement or Contract	Yes
Contract Reference Number/DSA Name	DS006395 ISP037 Safer Communities
Organisation involved reason	It is the originator of data and may provide services to the subjects
Disclosure and Security	Secure Encrypted email

Organisation Name	Probation Service
Data Controller or Data Processor	Data Controller
Organisation's Role	Information originator
Data Sharing Agreement or Contract	Yes
Contract Reference Number/DSA Name	DS006395 ISP037 Safer Communities
Organisation involved reason	It holds offender and victim data
Disclosure and Security	Encrypted email

4 records

3.1 Storage detail

How will the information be stored? *

Please include details of whether data will be stored outside of the European Economic Area (EEA).
Please remember that cloud storage and back up servers maybe outside the EEA.
On organisations servers

For how long will the data be retained? *

In accordance with Data retention directives and local policies

What is the deletion process? *

TBC

4 Consultation details

Consultation can be used at any stage of the DPIA process and is important to allow people to highlight privacy risks and solutions based on their own area of interest or expertise.
For further assitance and information please visit the consultation toolkit section on Ourspace.

Explain what practical steps you are going to take to ensure that you identify and address privacy risks *

Through consultation with the partners to the Domestic Abuse Partnership Board (DAPB)

Who should be consulted, internally and externally? Do you need to seek the views of members of the public? *

DAPB has internal and external members with experience in the DA arena and with a view of the issues. This means public consultation is not required

How will you carry out the consultation? *

(You should link this to the relevant stages of your project management process)
Through the DAPB in accordance with existing meeting structure and timescales

5 Risk register

At this stage you should identify the possible privacy risks together with their likelihood, severity and overall level, and for high risks the measures taken to reduce the risk.
Add any risk to the relevant sections below.

Fair and Lawful Processing

Data must be processed lawfully, fairly and in a transparent manner.
Please also consider

- Have you identified at least one lawful basis for the personal data processed as part of the project?
- Does at least one Controller involved have a lawful power to act?
- Do you need to create or amend a privacy notice?
- How is your processing going to be transparent?

Risk that processing is not transparent, and individuals are unaware that data is being collected or why it is processed

No Risk

Risk that information is being processed unlawfully

Unmitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low
Mitigation/Solution

None at this stage

Mitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Result
Accepted

Specific, explicit and legitimate purposes

The purpose for which you process personal data must be specified, explicit and legitimate. Personal data collected must not be processed in a manner that is incompatible with the purpose for which it was originally collected.
Please also consider

- Does your project plan cover all of the purposes for processing personal data? If not your plan needs amending accordingly.
- Are all elements of the processing compatible with the original reason and justification for the processing?
- What are these specific, explicit and legitimate purposes?

Risk of 'mission creep' and information is used for different, or incompatible purposes to that identified when originally collected

Unmitigated Risk
Likelihood - Reasonably Unlikely
Severity - Some Impact
Score - Medium

Mitigation/Solution
This a complex area; the ORIGINAL collection of information may be in connection with delivering each individual service's responsibilities and this exchange drops out of a secondary commitment to housing (and supporting) victims. It is unlikely that data retained for these purposes will then be used for other purposes

Mitigated Risk
Likelihood - Reasonably Unlikely
Severity - Some Impact
Score - Medium

Result
Accepted

Adequate, relevant and not excessive

Personal data processed must be adequate, relevant and not excessive in relation to the purpose for which it is processed.
Please also consider

- Is the quality of the information adequate for the purposes it is used?
- If not, how is this to be addressed?
- Are measures in place to ensure that data is limited to that which is needed to fulfill the aim of the processing?
- Which personal data elements do not need to be included without compromising the needs of the project?

Risk of loss of control over the use of personal data

No Risk

Risk that inadequate data quality means the information is not fit for the identified purpose(s) potentially leading to inaccurate decision making

Unmitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Mitigation/Solution
None - the reason for collecting the data is to improve outcomes

Mitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Result
Accepted

Risk that any new surveillance methods may be an unjustified intrusion on individuals' privacy

No Risk

Accurate and timely

Personal data processed must be accurate and, where necessary, kept up to date, and every reasonable step must be taken to ensure that personal data that is inaccurate is erased or rectified without delay.
Please also consider

- If you are procuring new software does it allow you to amend data when necessary?
- How are you ensuring that personal data obtained from individuals or other organisations is accurate?
- Do you have processes in place to keep data up to date?
- If any data sets are to be merged, what checks are carried out to ensure that the right data records are matched/merged together?

Any data matching or linking, including whole data sets may link wrong records together

Unmitigated Risk
Likelihood - Unlikely
Severity - Some Impact
Score - Low

Mitigation/Solution
This is a part of each organisations data processes and staff development

Mitigated Risk
Likelihood - Unlikely
Severity - Some Impact
Score - Low

Result
Accepted

Storage limitation

Personal data must be kept for no longer than is necessary for the purpose for which it is processed. Appropriate time limits must be established for the periodic review of the need for the continued storage of personal data.
Please also consider

- What are the risks associated with how long data is retained and how they might be mitigated?
- Has a review, retention and disposal (RRD) policy been established?
- How does the software enable you to easily act on retention criteria – does it enable bulk review/destruction; set review periods; extract for long-term preservation/retention of the corporate memory?

Risk information is retained for the wrong length of time (both too long and too short)

Unmitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Mitigation/Solution
Each Data Controller is compliant with national requirements and its own policy and has Data governance structures in place

Mitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Result
Accepted

Risk information is not securely destroyed when its retention period has been reached

Unmitigated Risk
Likelihood - Reasonably Unlikely
Severity - Minimal Impact
Score - Low

Mitigation/Solution
Each Data Controller is compliant with national requirements and its own policy and has Data governance structures in place. The impact in NOT destroying data is compliance, not in terms of delivering service

Mitigated Risk

Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Result
Accepted

Security

Personal data must be processed in a manner that ensures appropriate security of the personal data, using appropriate technical or organisational measures (and, in this principle, “appropriate security” includes protection against unauthorised or unlawful processing and against accidental loss, destruction or damage).
Please also consider

- What technical and organisational measures are in place to ensure that the data is protected to an adequate level?
- What training on data protection and/or information sharing has been undertaken by relevant staff?
- What access controls are in place to enforce the ‘need to know’ principle?
- What assurance frameworks are utilised to assess adequacy of security measures in place e.g. NHS DSPT; Cyber Essentials Plus; PSN Certification?

Risk of loss of confidentiality

Unmitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Mitigation/Solution
This applies to personal data across all the relevant organisations in all their areas of business. Each Data Controller is compliant with national requirements and its own policy and has Data governance structures and oversight in place

Mitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Result
Accepted

Risk of inadequate security controls in place to protect and secure personal data, including inappropriate access

Unmitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Mitigation/Solution
This applies to personal data across all the relevant organisations in all their areas of business. Each Data Controller is compliant with national requirements and its own policy and has Data governance structures and oversight in place. Data security forms part of all training for staff (eg WCC Mandatory training). There is nothing specific to this risk/issue that justifies additional training to staff

Mitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Result
Accepted

Risk that workers processing the data are not aware of their data responsibilities

No Risk

Risk that information is distributed using inappropriate methods

Unmitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Mitigation/Solution
This applies to personal data across all the relevant organisations in all their areas of business. Each Data Controller is compliant

with national requirements and its own policy and has Data governance structures and oversight in place. Data security forms part of all training for staff (eg WCC Mandatory training). There is nothing specific to this risk/issue that justifies additional training to staff

Mitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Result
Accepted

Risk of re-identification of pseudonymized or anonymised data (e.g. collecting matching and linking identifiers and information may result in information that is no longer safely anonymised)

No Risk

Risk that information is transferred to a 'third country' without adequate safeguards

No Risk

Financial and reputational

Risk of identity theft or fraud

Unmitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Mitigation/Solution
This applies to personal data across all the relevant organisations in all their areas of business. Each Data Controller is compliant with national requirements and its own policy and has Data governance structures and oversight in place. Data security forms part of all training for staff (eg WCC Mandatory training). There is nothing specific to this risk/issue that justifies additional training to staff.

Mitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Result
Accepted

Risk of financial loss for individuals or other third parties

Unmitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Mitigation/Solution
This applies to personal data across all the relevant organisations in all their areas of business. Each Data Controller is compliant with national requirements and its own policy and has Data governance structures and oversight in place. Data security forms part of all training for staff (eg WCC Mandatory training). There is nothing specific to this risk/issue that justifies additional training to staff

Mitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Result
Accepted

Risk of financial loss for the Council (including ICO fines)

Unmitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Mitigation/Solution
Measures are in place already: This applies to personal data across all the relevant organisations in all their areas of business. Each Data Controller is compliant with national requirements and its own policy and has Data governance structures and oversight

in place. Data security forms part of all training for staff (eg WCC Mandatory training). There is nothing specific to this risk/issue that justifies additional training to staff

Mitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Result
Accepted

Risk of reputational damage to the Council, partners, and processors

Unmitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Mitigation/Solution
This applies to personal data across all the relevant organisations in all their areas of business. Each Data Controller is compliant with national requirements and its own policy and has Data governance structures and oversight in place. Data security forms part of all training for staff (eg WCC Mandatory training). There is nothing specific to this risk/issue that justifies additional training to staff

Mitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Result
Accepted

Health, safety and wellbeing

Risk of physical harm to individuals

Unmitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Mitigation/Solution
Data breach could expose vulnerable DA Survivors to risk of harm (This is true throughout the DA environment). Each organisation has measures in place and its staff are aware of these risks. No additional measures are required

Mitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Result
Accepted

Risk of physical harm to staff and workers

Unmitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Mitigation/Solution
As above. Staff are aware of the risk to themselves when working within the DA environment. This is not a new or additional risk so existing measures are appropriate

Mitigated Risk
Likelihood - Unlikely
Severity - Serious Impact
Score - Medium

Result
Accepted

Risk of discrimination

Unmitigated Risk
Likelihood - Unlikely

Severity - Serious Impact
Score - Medium

Mitigation/Solution
The part iv duty is designed to address protected characteristics and equalities act issues Staff are/will be tasked to identify and overcome discrimination.

Mitigated Risk
Likelihood - Unlikely
Severity - Some Impact
Score - Low

Result
Accepted

Risk of other significant economic or social disadvantage

Unmitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Mitigation/Solution
Accept

Mitigated Risk
Likelihood - Unlikely
Severity - Minimal Impact
Score - Low

Result
Accepted

Individuals Rights

Data protection legislation gives data subjects' various rights (listed below). Limiting or restricting any of these rights is likely to be a significant impact so the justification for any restriction, as well as mitigations, must be fully outlined.

Inability to meet individuals' right to be informed

No Risk

Inability to meet individuals' right of access

No Risk

Inability to meet individuals' right to rectify inaccurate data

No Risk

Inability to meet individuals' right to erase data

No Risk

Inability to meet individuals' right to restrict processing

No Risk

Inability to meet individuals' right to object

No Risk

Inability to meet individuals' rights relating to automated decision making and profiling

No Risk

Additional project specific risks

No additional risks recorded

6 Declaration

I confirm to the best of my knowledge that the information I have provided is true, complete and accurate *
Selected

I confirm that I will make sure that data protection has been and continues to be considered throughout the project life cycle and should circumstances change in the project to include any processing of personal data a further Data Protection Impact Assessment Screening will be carried out *
Selected

Adult Social Care

Local Account

2021-2022

worcestershire county council

Contents

The Local Account is...

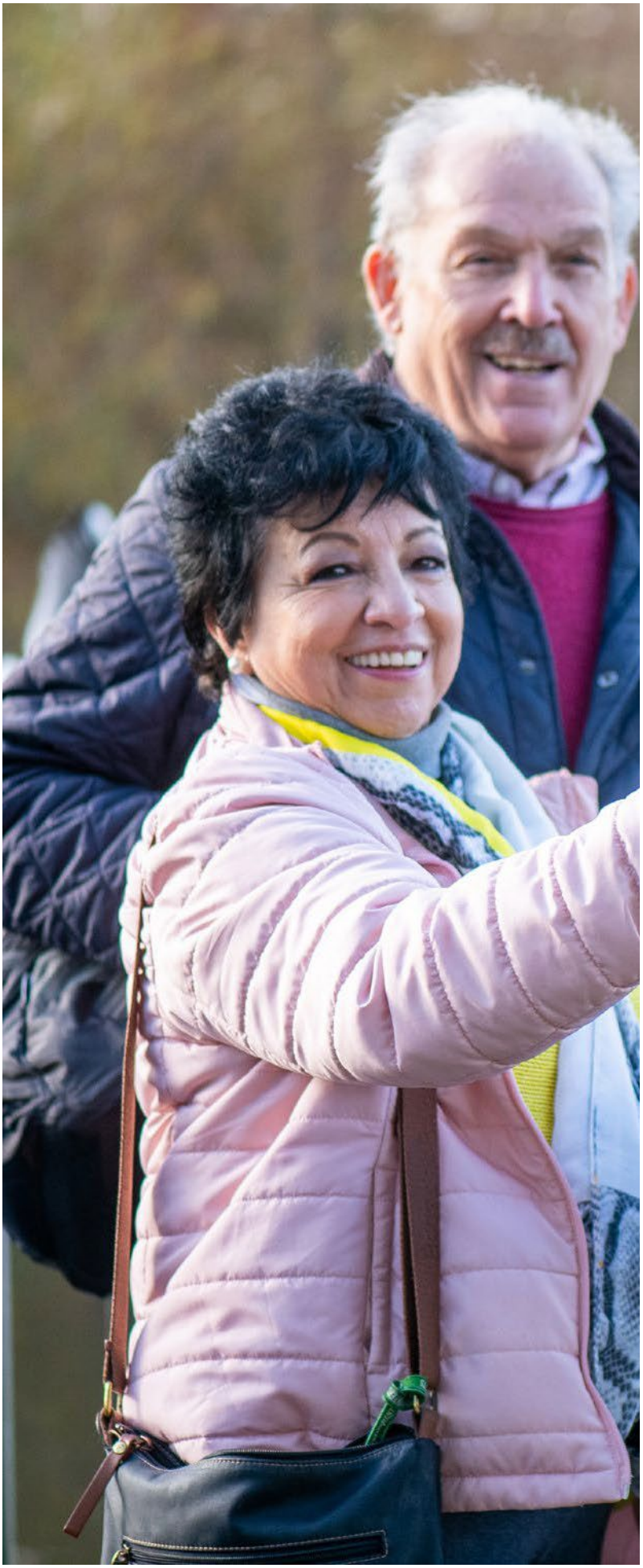
...Worcestershire County Council's annual magazine about Adult Social Care. It sets out our priorities and includes case studies from our residents, carers, partners and staff – demonstrating how collaborative approaches have triggered change and improvements.

Adult Social Care is part of the People Directorate, with a priority to ensure, with support from our partners, "Worcestershire Residents are healthier, live longer and have better quality of life and remain independent for as long as possible..." continues to underpin everything, we do.

In 2020 we have focused on supporting residents though the pandemic whilst continuing to develop services to support people's independence. We are now focusing on developing new ways of working, learning from the pandemic, and working with partners to develop a more integrated way of working together. In 2021/22 we will remain focussed on ensuring we develop with the care market to ensure value for money and support people to be as independent at home as possible, increasing the availability of suitable housing such extra care and shared lives.

Councillor Adrian Hardman

Cabinet Member with Responsibility for Adult Social Care



Our Vision for transforming Adult Social Care in Worcestershire

Recognised as a key Corporate Priority, is Worcestershire County Council's vision to ensure:

"Worcestershire residents are healthier, live longer, have a better quality of life and remain independent for as long as possible."

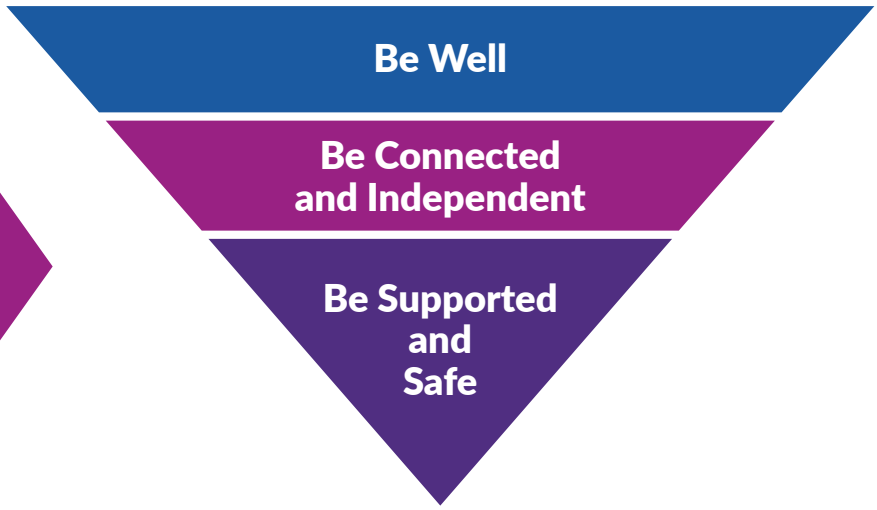
We are working with partners to provide the framework, support, and guidance to enable more adults to live healthy, independent lives and be active for as long as possible, while also ensuring we can provide the best support that people need in times of crisis.

Adult Services in Worcestershire is on a transformation journey to ensure the best outcomes for our residents, in line with our core adult social care functions and ensuring best value. We have become part of the People Directorate with key priorities to:

- Empower Communities by ensuring the right information, advice and support are in place, easily accessible and people and communities become more resilient and self-reliant.
- Person Focused Services developed through collaboration and building on the strengths and capabilities of local communities - ensuring that we make every conversation count consistently across the County's public sector.
- Evidence Based Decision Making to ensure that services and support are shaped to meet the needs of Worcestershire's residents and is responsive to the needs of different communities.
- Increase Healthy Life Expectancy of our residents by reducing health inequalities, so people live independent, healthy lives for as long as possible.
- Improve People's Health and Wellbeing by maximising our local cultural, communities and heritage offer.

The People Strategy

WCC People's Directorate and its partners will co-produce ways of working with citizens to enable them to:



"It is our priority, working with partners, to ensure Worcestershire residents are healthier, live longer, have a better quality of life and remain independent for as long as possible."

Person Centred Approach

HOW

- Develop one People front door for our residents
- Ensure strong digital offer
- Build on strengths of local community assets
- Collaborative work with partners

WHAT

- Develop integrated customer model, across all People services/offers: face to face & digital offer - with Libraries as Community Hubs.
  - Embed Think Local Act Personal ethos; information, advice and guidance based; self reliance, self directed and self assessment embedded.
  - predicitive modeling led
  - incorporate Here2Help learning
  - social marketing
  - include prevention offers from Trading Standards about scams and frauds
  - include all arts and cultural activities and access to employment and training
- Lead and implement a full person centred ethos across People Directorate, the Council, and with partners - to enable and empower people to live the life they wish through a new operating model, appropriate training and assurance.
- Develop formal partnerships with key stakeholders and community and voluntary sector to promote wellbeing and reduce health inequalities based on asset based approach; including comunity engagement in key wellbeing activation.
- Develop locality based integrated teams for social care with health, district council and voluntary sector that focus on the customer, have visibility of needs in one place and offer long term management for some customers.
- Establish with Clinical Commissioning Group Transparent and Fair Funding Arrangement for People with Health and Social Care Needs.

Shaping Services

HOW

- Life course approach.
- Make "strengths" based conversations the norm.
- Redirect resources to independence and enabling.

WHAT

- Increase Share Lives Placements
- Convert day centre resources into offer for independence choice and wellbeing
- Re-purpose internal care home provision for housing with care
- Commission and remodel respite
- Implement single reablement model that can fit into a longer term integrated intermediate care model
- Create single commissioning team in People Directorate
- Align Public health serverices e.g. 0-19, sexual health services in framework with health to focus on imporvement to outcomes and wellbeing
- Ensure community safety demands can be met via the integrated customer offer, incldуing reporting and access to support e.g. Domestic Abuse.

Shaping an Effective Market

HOW

- Engage to develop independence and choice
- Work with partners to create an integration framework
- Commission for the whole population not just those who access "services"

WHAT

- State commissioning intentions clearly to the market
- Refocus use of domicillary care
- Consider Family care opportunities
- Increase extra care
- Increase supported living
- All age disabilites independence offer
- Define respite offer through clear policy and range of response Increse use of DP's and PA's
- Embed effective use of enablers to independence e.g. Assistive Technology, access to training, volunteering, travel support, employment, housing and advice to self funders.

Our Core Functions:

- Assess and meet Care Act 2014 eligible need and commission and deliver services that meet that need directly or through the independent and voluntary sectors.
- Prevent, reduce, and delay the need for care.
- Engage with the market to ensure that they are aware of and can meet current and future needs
- Ensure a robust safeguarding system to protect vulnerable adults.

Our Purpose and Principles:

Our purpose is to ensure that Adult Services' provision, across the County Council, NHS and partners provides the framework, support, and guidance to enable more adults to live healthy, independent lives and be active for as long as possible – whilst ensuring we can provide the best support that people need in times of crisis.

This will be underpinned by our principles to ensure we:

- Promote independence through prevention, reduction, and delay of demand in care.
- Keep people safe and promote wellbeing
- Shape and manage the external market and internal service provision to ensure commissioning of effective and sustainable solutions.
- Efficiently use and manage our resources
- Provide advocacy and support for people's rights, protection, and equality
- Recognise, support, and equip our staff to improving outcomes and quality of life for our residents – through continued best practice, learning and development.

This account will provide you with more information on some of the work we have been doing to achieve this, throughout the last year, and during the pandemic.

Adults Social Care During the Covid-19 Pandemic

Adults Social Care in Worcestershire, in partnership with our Council colleagues quickly and effectively responded to the unprecedented circumstances of the Coronavirus pandemic, which resulted in a fundamental change to our customer and demand landscape and the way our workforce could operate, when lockdown was introduced in March 2020.

Care Homes and Supported Living residences in Worcestershire were closed to visitors and our day services and replacement care provision for people to have breaks, were closed to admissions.

The initial focus was to ensure Worcestershire's residents with care and support needs, living at home or in care home setting, and carers were supported. Our care homes were supported through the provision of protective equipment, information, advice and guidance and all efforts were focused on keeping as many people living in their own homes safely, whilst also ensuring people had a safe place to live when being discharged from hospital that met the infection control guidelines. We established hotel accommodation for those who could not return safely home and worked closely with our District Council colleagues to offer temporary accommodation for people who were homeless and rough sleepers.

All people who were known to Adult Social Care, were quickly assessed and risk stratified by social work teams, and measures were put in place for those at greatest risk due to the changes in their care and support and levels of vulnerability they were experiencing. We offered regular welfare checks by phone, worked closely with colleagues at Worcestershire Association of Carers to ensure carers were supported, and looked at all alternative services available for those unable to attend their regular respite or day service.

Adult Social Care continually reviewed the situation to ascertain if we could continue to fully fulfil the Care Act 2014 duties. Local Authorities were able to consider Care Act 2014 easements, should the situation have reached a position where Local Authorities could not meet all of the duties within the Act due to the pandemic, and should only have been considered as a last resort. This was carefully monitored by the Director for Adult Social Services and her leadership team on a weekly basis, and we are delighted to confirm we continued to meet our duties and the demand throughout the pandemic and no easements were ever used.

The Council quickly established their "Here2Help" offer, with a 7 day a week telephone call centre and 24/7 online access to advice, information and local volunteer support, to help those further with day to day activities, including shopping and collecting medication.

Adult Social Care worked in partnership with NHS colleagues to deliver the principles of the Discharge to Assess model and "Home First" agenda for those leaving hospital, aiming to return 95% of people to their usual place of residence. We invested in additional resources to ensure that during the peaks of demand people were supported to leave hospital as soon as possible with reablement support, and if home was not an option, there were beds available in care home settings that could meet their needs in the short term. Care Homes, Extra Care and Supported Living environments were and continue to be fully supported throughout the pandemic, both through the issue of PPE and coordination and provision of vaccinations, for staff and residents, in partnership with local NHS colleagues.

Worcestershire's Adults Services also coordinated and offered priority vaccinations to the whole of Worcestershire front line social care workforce – from domiciliary care workers through to personal assistants and unpaid carers

Some of our day centres for individuals with more complex needs re-opened in July 2020. Consideration is being taken to re-open all provision subject to full risk assessments and confirmation that social distancing can continue to be provided to ensure our service users and staff can be kept safe.

Our priority has and will continue to be to keep our residents safe, well and supported as lockdown restrictions ease, by continuing to work in partnership with our NHS colleagues and wider care providers in Worcestershire. We will remain focused on improving options to support people in their own homes, increasing the availability of suitable Extra Care and shared lives schemes and only considering residential care when there is no alternative available to meet a person's needs.

Celebrating Success

Three Conversations – Strength based approach to Social Work.

This approach was first launched in 2017 through innovation sites to promote strength based social work that focused on better outcomes for people, by:

- listening better to the concerns and views of the adults and families we are working with
- removing barriers to accessing social work advice and support regardless of what that need is
- improving the experiences of the adults, focusing on all areas or wellbeing, being creative in solutions to support people
- making better use of the networks and resources available in local communities that may be of benefit
- creating a better working environment and more satisfying role for staff
- better delivery against the spirit of the care act and core social work values
- encouraging more direct collaboration between the social work teams, health partners, voluntary agencies, and District Councils.

As part of the new People strategy and to ensure the core principles of the Three Conversation Model are well embedded in all we do, we have launched 'Building Strengths' a new project to further develop and embed the promotion of people's independence. This can be providing support to maintain or regain their independence and wellbeing, following what has been a really challenging year for many people who have had to cope with changes to the way their support is delivered, reduced contact from family, friends, and communities. Our focus for Adult Social Care is to provide the care and support necessary for people to remain at home wherever possible, removing inequalities in care, working in partnership with system partners to ensure we deliver this as effectively and efficiently as possible.

At the heart of the approach are three distinct conversations which are used to understand what really matters to people and families, what needs to happen next for them and how we can best assist using early intervention, preventative work, good community connections, supporting people at times of crisis and co-producing good quality support plans where these are required. The model aligns to core social work values. Below is a quote from a social worker who recently attended a workshop.

"I loved this training. Made me think of the old days being a social worker and how something so little can actually make a massive difference. We tend to forget that now and then!"

Adult Mental Health

In recognition of the specialist nature on mental health social work, Worcestershire County Council's (WCC) Cabinet took the decision in September 2020 to internally deliver adult social care mental health services with effect from 1st April 2021. We wanted to strengthen social work practice and focus on developing skills that are needed to support people with mental health conditions to stay well, engage in the community and improve their opportunities. WCC's newly formed mental health service is now focussed on embedding the strength based Three Conversation approach to support people with complex mental health needs and people who are subject to the mental health legislation including supporting local in-patient services, forensic services and step-down provision. The management of Mental Health Act Assessments will be undertaken by a dedicated Approved Mental Health Professional (AMPH) Hub, likewise there will be a specialist Forensic Worker and Safeguarding Lead. WCC also continues to invest resource in employment to support service users to enter or stay in work.

Social Workers have reported:

"...It feels as though it has more of a social work identity, and there is much more focus on us developing our professional practice and doing so in a reflective manner...."

"I actually feel excited to be part of a new team, where we can all support one another to shape the service going forward... The opportunity to continue to work closely with our NHS colleagues, to me, means that I can enable service users to receive the support they need. I feel increasingly optimistic about the future for the mental health team and my apprehension about my professional future in mental health has significantly reduced. I feel that this is a result of a supportive management team and friendly and supportive colleagues. I feel that as a new team we have so much to do, and so many options to discuss and this has given me a renewed passion for my role as a social worker..."

Carers

A Carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid (NHS Definition).

A young carer is a young person aged between 7 and 17 and a young adult carer is a young person aged between 18 and 25 with a caring role at home. The caring role could be for a parent, a sibling, or a grandparent due to illness, disability, physical or mental health difficulties or substance misuse.

Do you provide any of the following unpaid support to a relative, partner or friend who is ill, frail, disabled or has mental ill-health or substance misuse problems?

- Emotional support
- Medical care
- Personal care
- Physical care
- Domestic Tasks

If you do, then you are a carer. If you would like information and support regarding your own well-being, assessments you are entitled to or how your support needs can be met, please contact the Worcestershire Carers Hub on 0300 012 4272. The opening hours are Monday to Friday 9am to 7pm and 9am to 12pm on Saturday.

- Alternatively, you can talk to us via the web chat facility in the bottom right-hand corner of the website during our opening hours.
- If it is an emergency, please follow this link on our website http://carersworcs.rit.org.uk/emergency-planning
- Website address: Worcestershire Association of Carers (carersworcs.org.uk) - contact us using the self-referral form.

There are **66250** unpaid carers in Worcestershire. There is support, information, and advice available to help you with your caring role from the Carers Hub. This is provided by Worcestershire Association of Carers (WAC).

In April 2021 there were **11,957** unpaid Carers on Worcestershire's Carers Register with WAC.

During the Covid Pandemic WAC:

- Extended the Carers Helpline - opening hours were extended to support carers.
- Completed welfare checks via phone calls, zoom, webchat, WhatsApp video call etc to 'check in' with Carers to see how they were doing and assist with any queries or issues.
- Carers can call WAC anytime via the helpline, webchats or email with any issues relating to Covid 19 or other caring related queries or issues.
- Proactive calls to groups to ensure Carers with specific caring responsibilities felt supported, for example Carers of individuals with mental health conditions and people with dementia.
- Many carers are also working as well as having caring responsibilities. Different pressures were felt such as furlough, redundancy, reduced hours etc, so Working Carers were supported to help maintain a balance of their caring role and work.

Success with volunteers

WAC have many volunteers who assist them. 115 volunteer hours are provided by volunteers each quarter. This is 598 hours over the course of last year.

Working for Carers

Worcestershire County Council has signed up to the 'Working for Carers Charter'. The accreditation recognises a commitment to creating a carer-aware workplace. This means the Council is committed to recognising and understanding the needs of carers in the workforce, by supporting staff who are carers at home.

- 3 in 5 people become carers at some stage of their lives and many must juggle their role with a job
- 1 in 7 members of the workforce is a working carer.
- Carers can often feel burnt out and stressed as finding time to take a break can be impossible for those with caring responsibilities. Supporting the carers in the workforce is 'good for the employees and it's good for businesses.'

Engagement and Co-production in Practice

Here are two examples of how Worcestershire County Council has worked with stakeholders and partners to understand the impacts of the COVID-19 pandemic on people with care and support needs.

Speakeasy Now – People's Parliament

Members of the People's Parliament in 2018

Speakeasy Now is a user led organisation of people with learning disabilities in Worcestershire speaking up for themselves. Supported by funding from Worcestershire County Council, they organise an annual "People's Parliament" to debate key issues and ask for pledges from partner organisations to bring about improvements.

The People's Parliament recently carried out work to understand the impact that the COVID-19 pandemic has had on people with learning disabilities. Extensive engagement took place and online meetings were well attended by their members and partner organisations.

The online debate was successful in understanding four big issues that were identified for people with learning disabilities and for them to share their experiences. Pledges were secured from organisations who agreed to take actions forward to address the issues.

The four Big Issues:

1. **Raising Awareness about why people with learning disabilities are vulnerable.** Making sure that people with learning disabilities receive the same priority as other vulnerable groups
2. **Getting information that is easy to understand.** Helping people with learning disabilities to access online information
3. **Getting informal support from our communities.** How can people with learning disabilities be included in community groups and activities?
4. **Helping people with learning disabilities reduce health risks such as obesity and Type-2 diabetes.** How do we help people with learning disabilities to understand these risks and how they can help themselves?

For more information on the work of People's Parliament please visit:

www.speakeasynow.org.uk/our-work/peoples-parliament

In the words of Sam Sinderberry, Chair of People's Parliament:

"It's important to get our voices heard so that we can improve the lives of people with learning disabilities. We look forward to working more with the council in future."

The Autism Partnership Board

The Autism Partnership Board has representation from autistic people, carers and stakeholders with an interest in Autism.

In April 2021 we held a focussed meeting on understanding the impact that the COVID-19 pandemic had on autistic people. Organisations that support autistic people gave feedback on the experiences of people who access their services.

Key themes raised included:

- The impact on physical and mental health and the increased risk around suicide
- The positives found from online forums but also the impact only being able to engage online has had on many people with autism
- The impact on people who have not been able to access/continue to access the same level of services they had before the pandemic.

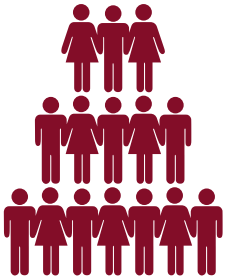
The feedback gave such valuable information that will help inform Health and Social Care strategic plans over the next few years and is supporting Public Health to draft the COVID recovery plan for Worcestershire.

Performance Matters

The demand for Adult Social Care rises each year as people live longer and there are more people living with complex long-term conditions. Adult Social Care faces ongoing demographic and budget challenges, but the care sector also brings millions of pounds to Worcestershire's economy – together, we are working hard to keep people living independently.

24100

enquiries received

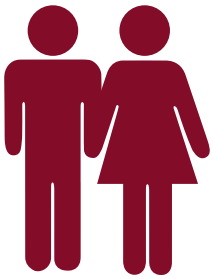


33000

people employed in Worcestershire's Health and Social Care Sector

66250

carers providing unpaid care to family and friends



6700

People in receipt of services funded by Adults Social Care

Proportion of people (65+) who are still at home 91 days after discharge from reablement services:

- 82% Worcestershire
- 82% England average
- 81% West Midlands average

People who use services say these services have made them feel safe & secure

- 93% Worcestershire
- 87% England average
- 87% West Midlands average

Number of people in Supported Living

- 663 in March 2021

Percentage of adults with a learning disability in paid employment

- 5.0% Worcestershire
- 5.6% England average
- 4.2% West Midlands average

Area for improvement (Percentage of adults receiving direct payments):

- 23.6% Worcestershire
- 27.9% England average
- 28.4% West Midlands average

Partnership Working

Integrated care – what is it, and what does it mean for Worcestershire

Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health which, in the past has meant that too many people experienced disjointed care.

Integrated care systems (ICSs) were first developed in England in 2018. These new partnership arrangements between the NHS, local councils and other important strategic partners such as the voluntary, community and social enterprise sector are new partnerships between these organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

By developing better and more convenient services, investing in keeping people healthy and out of hospital and setting shared priorities for the future, the integrated care system enables decisions about how services are arranged to be made as closely as possible to those who use them.

The NHS was set up primarily to provide treatment for acute illness, but it now needs to deliver joined-up support for growing numbers of older people and people living with long-term conditions. As a result, the NHS and its partners need to work more closely together by providing more care in people's homes and the community and breaking down barriers between services. Together we have the potential to drive improvements in health and tackle health inequalities across Worcestershire by working closely together and with other partners to address social and economic determinants of health. Evidence consistently shows that it is the wider conditions of people's lives – their homes, financial resources, opportunities for education and employment, access to public services, and the environments in which they live – that exert the greatest impact on health and wellbeing.

Our involvement is essential to drive meaningful improvements in health and wellbeing and brings three key benefits. The first is the opportunity to join up health and social care at all levels, creating better outcomes and a less fragmented experience for patients and users. The second is the potential to improve population health and wellbeing through the leadership of public health teams as well as NHS and local government acting together to address wider determinants of health such as housing, local planning, and education. Finally, the involvement of local government can enhance transparency and accountability through supporting engagement with local communities and providing local democratic oversight.

Collaborating across the NHS and local government is not easy and requires local leaders (including NHS leaders as well as officers and elected members in local government) to better understand each other's challenges, to recognise and respect differences in governance, accountabilities, funding, and performance regimes, and to find ways to manage these differences.

With our health colleagues, Worcestershire County Council will begin to work towards greater integration of services for the benefit of our residents. We will tell you more of this journey in next year's annual report.

Working in Partnership to help people to go home from hospital

Worcestershire County Council's social work teams developed a joint health and social care hospital discharge team with Worcestershire Health and Care Trust and Worcestershire Acute Trust to reduce the length of time people remain in hospitals, with a focus on ensuring as many people as possible return home and live independently. The joint social work and nursing team, known as the Onward Care Team, has been in place since February 2020 at both the Alexandra Hospital and Worcester Royal Hospital and work is underway to review the effectiveness of this model on patient outcomes and effectiveness of discharge flow. This model is recognised as good practice nationally and has already seen reductions in people leaving hospital and being dependent on long term social care. The investment in more Reablement Services to support people to return home and be as independent as possible is a key priority. A short period of bed-based rehabilitation in a community hospital is

also an option, alongside making sure that for a very small number of people who are not able to return home and require a period of assessment in a care home, can be discharged to a suitable place to meet their needs in a timely manner.

NHS England's guiding principle of a 'Home First' approach, promotes returning home with support at home or intermediate care, having any further assessments needed within their own homes. Implementing a Discharge to Assess model, where going home is the default pathway (with alternative pathways for people who cannot go straight home) is more than good practice – it is the right thing to do.

Using the Home First Approach, at its highest point we were able to discharge 96% of people back to their usual place of residence. We are now working together to learn lessons from the pandemic to shape the future models and ways of working.

Domestic Abuse Bill

Worcestershire County Council is making plans to implement the new statutory duty in the Domestic Abuse Bill 2021. We have formed a multi-agency commissioning partnership to include West Mercia PCC, Worcestershire Children's First (WCF), People Directorate, Public Health, L&D and District Housing officers to design a system of support and safe accommodation to improve outcomes for adults and children who are victims of domestic abuse in Worcestershire.

This will mean re-shaping some of our existing services and streamlining referral pathways to ensure there is a more effective route through the system for people requiring emergency support and refuge to being accommodated in safe, sustainable accommodation.

We will be including a specialist role to support adults with health and care needs affected by domestic abuse while continuing to support the Family Safeguarding Service in WCF, which is helping to prevent children being placed in care as a result of domestic abuse in their family.

A wider multi agency training offer will be made available to all social work professionals in adults and children's services in the future to improve their knowledge and skills working with families affected by domestic abuse.

Worcestershire also commissions a perpetrator programme working closely with the independent domestic violence advisors to enable more in-depth support for some families with particular needs.

Did you know?

- **50.7%** of those suffering from Domestic Abuse stated that the abuse had got worse since the pandemic began
- **17%** of the crimes committed in West Mercia were offences of Domestic Abuse in 2018/2019
- According to the Office of National Statistics, between January-June 2020, there were **64 domestic homicides** in the UK, a **15.1% increase** from 2019.
- **50% of domestic homicides** in West Mercia between 2014-2019, were in Worcestershire
- **2.3 Million** people experienced Domestic Abuse nationally between 2019/20.
- Between 2016-2019 the rate in repeat victims went from **18.8% - 23.9%** as recorded by West Mercia Police
- In 2019, **25,500 households** lost their accommodation due to Domestic Abuse in the UK
- Between April 2020 and December 2020, **51 households** presented as homeless in Worcestershire as a result of Domestic Abuse

What is Domestic Abuse?

Domestic Abuse is defined as in incident or pattern of incidents that consists of controlling, coercive, threatening, manipulative and sometimes violent behaviour, including sexual abuse. This can occur between current or ex partners, or between family members or carers.

Domestic Abuse can include but is not limited to:

- Psychological/emotional abuse
- Physical and/or sexual abuse
- Financial and economic abuse
- Stalking and harassment

All of which are underpinned by coercive and controlling behaviour, that isolates, intimidates, degrades and controls using the threat of physical or sexual violence.

Domestic Abuse is not always visible, physical violence does not happen in isolation without the above behaviours usually presenting themselves in the first instance. Therefore, spotting the signs before it escalates and responding in a non-judgemental way is paramount to supporting survivors.

Domestic Abuse affects women disproportionately. Official figures record that, at present, 2 women a week are killed in the UK as a consequence of Domestic Abuse and that this figure has increased in recent years.

What can we do to reduce Domestic abuse?

- Have an awareness of what Domestic Abuse is and how housing can protect those in need
- Be able to recognise and spot the signs of Domestic Abuse
- Offer an appropriate support package to those suffering from Domestic Abuse
- Engage in Domestic Abuse training to enable us to respond in an informed way

How do we work to support the victims of domestic abuse today?

The Council works across multiple agencies in the support of victims of domestic abuse and the rehabilitation of perpetrators of abuse. We have a **Domestic Abuse Housing Co-ordinator** for Worcestershire who has extensive history working in the Domestic Abuse sector and has a wealth of expertise to share by providing training, supporting housing officers and providing a link between housing and other specialist services.

West Mercia Women's Aid is one of our lead providers of specialist support to victims of Domestic Abuse in Worcestershire, for example, they currently run a temporary housing project, providing support to victims of Domestic Abuse that have fled an abusive relationship and who are placed in temporary accommodation.

Worcester Community Trust (WCT) employs Domestic Abuse Champions who have specialist knowledge of domestic abuse, support options and signposting, befriending individuals as they settle into permanent accommodation. They provide support in accessing other community services, such as clubs, interest groups, volunteering opportunities and job coaches, both within WCT and beyond. This support helps build resilience and provides stability and autonomy amongst Domestic Abuse survivors exiting temporary accommodation, preventing them returning to the cycle of abuse. This can also include support in accessing specialist Domestic Abuse support services for empowerment to move towards emotional recovery. They support communities in the south of the county to play a key role in prevention and resilience, to bring about cultural change. 'Professional Champions' are first port of call within their businesses and professional settings for colleagues and customers to seek support from. They are also embedding domestic abuse policies in business settings. 'Community Champions' are based in the community and offer a similar service to those who require support within the community of south Worcestershire, as well as spreading awareness of the issues.

A Focus on Reablement

The County Council launched a new service in October 2020 to ensure people receive the right support, at the right time to help them live independently at home for as long as possible.

The new, therapy-led service helps to prevent the need for any unnecessary admissions either to hospital or residential/nursing care and, where an admission is required, support people to return home as soon as they are well enough, with a plan for recovery and reablement.

The County Council has recognised the benefits reported from other authorities by offering a reablement-focused approach to social care and is investing in the new service, which will ensure decisions are made with people rather than for people and that our resources are targeted in an efficient manner. Since launching the service, we have supported more than 300 people, many of whom have left the service without the need for ongoing support, or with a reduced need.

Therapists and Promoting Independence Assistants will work with individuals, drawing on their strengths to identify and set goals to:

- **Focus on what an individual can do and build on these strengths** rather than focusing on what the individual cannot do.
- **Provide short-term intensive support** to enable individuals to learn how to live their lives as independently as they can; supporting them to regain their independence during the period of support.
- **Work across the health, social care, voluntary and community sectors** leading required interventions to reduce hospital and care admissions.

Any adult in the County will be considered for reablement when they, or their family/carer contact Adults Social Care for support.

As part of the learning from the pandemic, in partnership with our health colleagues, additional funding has been agreed to increase the reablement service to enable more people to be discharged from hospital with support at home. A recruitment campaign started in June 2021 with the aim of appointing an additional 100 front line workers as part of the reablement service, this almost doubles the capacity available. This will improve the speed in which people can leave hospital as a package of support is available for them to settle back in at home. This additional resource is really important in meeting our home first approach supporting people to live independently at home for longer.

Community Action - Here2Help

HERE 2 HELP WORCESTERSHIRE

There is a dedicated Here2Help website where you can offer support, ask for non urgent help or read some useful hints and tips to get you through self isolation:

www.worcestershire.gov.uk/here2help

If you can't access the internet, we have a helpline to call where someone will be there to help you to complete the forms.

Call us on 01905 768053

Here2Help was launched in March 2020 as One Worcestershire's community action response to COVID-19. The purpose of Here2Help is to provide support to the residents of Worcestershire who are having to self-isolate and/or have additional needs due to the COVID-19 outbreak and do not have friends, family or neighbours to support them. As of the 30 April 2021 there have been over 5200 requests for help made and over 2400 offers of help. Some key recent highlights include:

- Here2Help has been supporting Herefordshire and Worcestershire Clinical Commissioning Group (CCG) deliver COVID vaccination clinics in Worcestershire where volunteers fulfilled a number of non-clinical roles helping to underpin the successful roll out of the vaccination programme throughout Worcestershire. Between December 2020 to April 2021, over 12000 hours of volunteer support has been organised.
- From November 2020, during periods of national lockdown, 835 requests were received from clinically extremely vulnerable (CEV) individuals via the National Shielding Support Service (NSSS) - a national system that people could use to ask for support if they had a condition which meant they were classed as CEV. Contact and support was offered to all individuals who registered during the period they were shielding.
- From 1st April 2021, Here2Help have been providing support to those who are self-isolating as part of the national 'Self Isolation Practical Support' scheme. During April 2021, 34 requests were received under this scheme either via Test and Trace or directly to Here2Help.
- Here2Help telephone lines have been open for additional hours at weekends during times of local surge testing. The team have supported local residents with testing arrangements, test kit enquiries and practical support for those who are self-isolating.
- The Here2Help service continues to meet the needs of our residents and after overwhelming positive feedback on the difference this makes to people, we are now evolving the service and a public search facility that public, social prescribers, professional staff and other partners can use to search for organisations that can offer help and support to people in the community. During the COVID pandemic we built up a great set of community data in Here2Help from organisations who signed up with us and this was used by Here2Help staff to search and match resources to people who requested help. We now intend to turn the data public facing so that people can search and signpost themselves or someone they were assisting to an organisation.

Feedback from Individuals who have requested support via Here2Help:

"I am hopeful this is the correct email address to write to say a huge thank you for your help and support given to my aunt during this pandemic. Your help and support to her with phone calls of help and regular food deliveries have been very much appreciated by us all and for that we thank you"

"What a fabulous community service you have provided"

"Your help, advice and kindness towards me this afternoon was a huge help and also a big relief to me. I didn't realise I don't have to suffer in silence"

"I so appreciate being able to talk to you today. Thank you for doing so much to support the community in these difficult times."

"I wanted to email you and thank you for everything you have done today… You have done more in an afternoon than anyone has in years thank you."

Feedback from staff running COVID Vaccination Clinics:

"I cannot thank you and the volunteers enough for your continued support! The vaccination programme is going really well, and all volunteers have been amazing!"

"The volunteers have been absolutely invaluable over the last few weeks, and I don't know what we would have done without them"

"Thank you for your support and the fantastic volunteers. We are humbled and extremely grateful."

Promoting Independence Using Technology to support Independent Living

Many of the teams of people work closely together to support the lives of Worcestershire's residents and we'd like to share two such success stories with you. Both residents have given permission for their stories to be shared, but we have changed their names for additional privacy.

These stories show how the commissioned services – in this case for assistive technology – can be used in the various home settings such as supported living environments to maintain independent living and to improve the individual's quality of life as a result of collaborative working between our commissioning and social work teams and a Worcestershire based TEC service provider – even during the challenges of Covid-19, resulting in great feedback from our service users and their families!

Michael is 38 years old and is bed bound due to a broken back when he was 16. He is very up to date with TEC and currently uses a head nano device, although some such devices have been known to fail after a period of time. When our Lead Commissioner, Laura Westwood, undertook a review, she asked the provider to investigate to source a replacement or to provide an alternative solution. The provider telephoned Michael to gain a better understanding of his issues and learned that Michael's device was no longer in production but similar devices such as the "Eye Gaze" could provide a longer-term solution. A full assessment was undertaken, and Michael tested several devices, but they did not quite fit the bill. The provider returned and was able to secure two, free of charge, back-ups to Michael's old device, also signing him up as a volunteer tester for new equipment to help them learn about further equipment that potentially will support Michael once his current equipment can no longer be maintained, giving him a real purpose in helping to develop products that benefit himself and others for years to come.

Cathy is in her twenties and has Cerebral Palsy. She lives in a supported living environment with her own flat and wanted to explore technology that would provide her more independence avoiding the need to always wait for support to arrive. Laura discussed options for home automation with the provider, that would allow Hannah the freedom of turning lights and plug sockets on and off, seeing who is at the front door and opening and closing the blinds. When the provider presented the proposals to Cathy she was quite overcome and cried many happy tears – this would revolutionise her ability to remain, - improve even – her level of independent living. The cost of the options was calculated and another lead commissioner, Steve Medley, presented some challenges to ensure there were no other more cost-effective suppliers of the equipment. He challenged us with the costings and asked us to explore alternative suppliers to make the solution more value for money. A different supplier was located, and the equipment installed and linked to both Cathy's Alexa and mobile phone. Although Cathy has subsequently had to move to a different supported living environment, our commissioners, service providers in conjunction with Cathy and her father, the core tech moved with her and Cathy will be utilising the plug sockets to support with lamps to light the property when needed and a pendant to alert staff on site will also be provided for when Cathy needs help, allowing her independence in her own room. Cathy's family are so pleased to see their daughter able to live with relative independence and again, thanks are due to the council teams and their chosen providers.

Adult Social Care Reforms

The Government White Paper, People at the Heart of Care: Adult Social Care Reform, was released on 1st December 2021. It emphases the need for high-quality personalised care that is available to people across the country. It's 3 main objectives are to provide people with

- More choice, control, and support to live independent lives
- Access outstanding quality and tailored care and support
- Fair and Accessible adult social care support

In Worcestershire, this aligns to our People Strategy, Housing Strategy, Carers Strategy and digital strategy in which we aim to enhance our offer in providing accessible high quality, early advice and information, a variety of support options to assist people to remain independent, increase the number of people requiring care and support to be able to use Direct Payments and Assistive Technology and working closely with our Housing Partners to provide affordable housing that enables people to live independently.

The announcement for funding includes investment in:

- A workforce to enable a thriving and sustainable social care workforce
- Housing and home adaptations, integrating housing into new local health and care strategies
- Better access and use of technology and digital support
- Support for unpaid carers

We will work closely with our Partners and gather the views of our residents and those who use our services to understand the changes further over the coming months.

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county council

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Herefordshire and Worcestershire Clinical Commissioning Group

NHSE Herefordshire and Worcestershire NHS Continuing Healthcare and Funded Nursing Care

Working in Partnership Policy

Document Reference Information

Version	1.0
Status	
Author	Jane Lodwig
Directorate responsible	
Directorate lead	Lisa Levy
Ratified by	
Date ratified	
Date effective	
Date of next formal	
Target Audience	

Version Control Record

Version	Description of changes	Reason for changes	Author	Date
2	Addition of a statement regarding access to universal services	Omission recognised at CCEC and recommendation made	Jane Lodwig	21/01/2022

NHSE Herefordshire and Worcestershire CHC Operational Policy

Operating Framework

1.0 Introduction

This Operational Policy confirms the agreed approach for the delivery of NHS Continuing Healthcare services for the population for whom NHS Herefordshire and Worcestershire Clinical Commissioning Group ("the CCG") is the responsible commissioner. The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care *October 2018 (Revised)* [the 'Framework'] sets out the principles and processes relevant to NHS Continuing Healthcare and NHS-funded Nursing Care. The Framework also provides national tools to be used in assessments and for Fast Track cases.

2.0 References

Links to key documents:

This local policy describes the processes that will be followed by the CCG and should be read in conjunction with the following documents:

- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, incorporating the NHS Continuing Healthcare Practice Guidance (Department of Health & Social Care, 2018, revised); 20181001 National Framework for CHC and FNC - October 2018 Revised (publishing.service.gov.uk)
- Who Pays? Determining responsibility for payments to providers (NHS England 2020); Who-Pays-final-24082020-v2.pdf (england.nhs.uk)
- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended): The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (legislation.gov.uk)

3.0 Definitions

Assessment of eligibility for NHS Continuing Healthcare: The assessment process used by a multidisciplinary team to make a recommendation regarding eligibility for NHS Continuing Healthcare. The assessment of eligibility requires the completion of the Decision Support Tool in order to arrive at an eligibility recommendation.

Assessment of needs: The collection and evaluation of a range of relevant information relating to an individual's needs.

Care: Support provided to individuals to enable them to live as independently as possible, including anything done to help a person live with ill health, disability, physical frailty or a learning difficulty and to participate as fully as possible in social activities. This encompasses health and social care.

Care package: A combination of care and support and other services designed to meet an individual's assessed needs.

Care planning: A process based on an assessment of an individual's needs that involves working with the individual to identify the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Clinical Commissioning Group (CCG): CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. The CCG cannot delegate its final decision-making function in relation to eligibility decisions and remains legally responsible for all eligibility decisions made (in accordance with Standing Rules).

Commissioning: Commissioning is the process of specifying and procuring services for individuals and the local population

Decision Support Tool (DST): A standardised tool completed by clinicians, informed by a comprehensive multidisciplinary assessment of an individual's health and social care needs. The completion of the DST enables the MDT to make a recommendation regarding the eligibility of a client/patient for NHS Continuing Healthcare.

End-of-life care: Care that helps those with advanced, progressive, incurable illness to live as well as possible until they die.

Local authority social services: Local authorities are statutory bodies responsible for a wide range of public services in specified geographic area, including social services. Individually and in partnership with other agencies, local authority social services departments provide a wide range of care and support for people who are in need and meet nationally specified eligibility criteria for care and support.

Mental capacity: The ability to decide about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is set out in section 2 of the Mental Capacity Act 2005

Multidisciplinary: 'Multidisciplinary' refers to when professionals from different disciplines (such as social work, nursing and occupational therapy etc) work together to assess and/or address the holistic needs of an individual, in order to improve delivery of care.

Multidisciplinary team: In the context of assessing eligibility for NHS Continuing Healthcare, a multidisciplinary team (MDT) is a team of at least two professionals from different disciplines and should usually include professionals from both the health and the social care disciplines. Whilst, as a minimum, the MDT can compromise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs.

NHS Continuing Healthcare: A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual has a 'primary health need'.

NHS-funded Nursing Care: Funding provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible

Palliative care: Palliative care is the active holistic care of patients with advanced, progressive illness.

Personal health budget: A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local NHS.

Primary Health Need: An individual has a primary health need if, having taken account of all their needs (following completion of the Decision Support Tool), it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs. Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality.

4.0 Purpose and scope

4.1 This policy sets out the CCG's role and responsibilities for the delivery of the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. It outlines the process for determining eligibility for NHS Continuing Healthcare funding and the procedures to be followed.

4.2 The policy also sets out the responsibilities of the CCG in those situations where there is no eligibility for NHS Continuing Healthcare and for the management of disagreements that may arise as a result of NHS Continuing Healthcare eligibility-related decisions.

4.3 In addition, the policy describes the way in which the CCG will commission care to meet needs in a manner that reflects patient choice and preferences, whilst balancing the requirement to stay within the set financial limit allocated by NHS England to the organisation.

4.4 The policy applies to all NHS Continuing Healthcare applications for adults 18 years or older who are registered with a General Practice in Herefordshire and Worcestershire or who are resident within the CCG boundary and are not registered with a General Practitioner elsewhere or where the CCG retains commissioning responsibility for an individual placed outside that boundary. It includes all care groups.

4.5 This policy does not apply to children for whom the National Framework for Children and Young People's Continuing Care (2016) applies. It is acknowledged that, at times, joint working may be required to support an adult who has parenting responsibilities and care needs in line with relevant legislation.

5.0 Roles and responsibilities

Herefordshire and Worcestershire CCG	The organisation that is responsible and accountable for system leadership for NHS Continuing Healthcare within the local health and social care economy, including: - Ensuring delivery of, and compliance with, the National Framework for NHS Continuing Healthcare. - Promoting awareness of NHS Continuing Healthcare. - Establishing and maintaining governance arrangements for NHS Continuing Healthcare eligibility processes and commissioning NHS Continuing Healthcare packages. - Ensuring that assessment mechanisms are in place for NHS Continuing Healthcare across relevant care pathways, in partnership with the local authority as appropriate. The Standing Rules require CCGs to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for NHS Continuing Healthcare. - Making decisions on eligibility for NHS Continuing Healthcare, in partnership with Local Authorities. - Identifying and acting on issues arising in the provision of NHS Continuing Healthcare. - Commissioning arrangements, both on a strategic and an individual basis. - Having a system is place to record assessments undertaken and their outcomes, and the costs of NHS Continuing Healthcare packages. -Sharing relevant data and information with Local Authority partners within the limits of the relevant data sharing agreements. - Implementing and maintaining good practice. - Ensuring that quality standards are met and sustained. - Ensuring training and development opportunities are available for practitioners, in partnership with the local authority. - Having clear arrangements in place with other NHS organisations
Herefordshire Council and Worcestershire County Council	-The organisations that provide social care practitioner input into DSTs, assessments and reviews to support the completion of DSTs and recommendations on eligibility. -Provide social care practitioners who are responsible for assessing persons who may have needs for care and support under Part 1 of the Care Act (2014) and who may also complete checklists triggering the initial stages of the CHC process. - Actively participate in quality assurance and audit processes, in agreeing joint integrated funding, dispute processes, Local Review Panels and appeals. - Implementing and maintaining good practice. - Ensuring that quality standards are met and sustained. - Ensuring training and development opportunities are available for practitioners, in partnership with the local authority. - Having clear arrangements in place with other NHS organisations
Continuing Healthcare (CHC) Team	The team that: - Receives and reviews all checklists and Fast Track referrals for assessment for eligibility or receipt of service. - Maintains the continuing healthcare database, ensuring all referrals are recorded and that full records are maintained. - Appoints a nurse assessor to carry out a co-ordination role which is pivotal to the assessment process and completion of the DST by the multidisciplinary team. - Reviews completed DSTs to ensure they are completed fully, in an appropriate manner, in accordance with the National Framework, supported by robust clinical

	evidence and have a clearly stated recommendation from the multidisciplinary team who have completed it, seeking further clarification as necessary. All DSTs are quality checked by an identified senior clinician. - Makes every attempt to secure social care attendance at the assessment and DST completion. Where this has not been possible the reason must be stated on the DST. - Where required, arranges for the DST to be presented to the CCG along with any supporting information. - Writes to the individual or their representative with the outcome of the CHC assessment. - When a recommendation of eligibility for NHS Continuing Healthcare has been verified by the CCG, completes a Commissioned Care Plan (CCP), arranges the package of care based on the needs of the individual ['brokerage function'] and provides the costings of the package of care for approval by the CCG. - If the individual is not eligible for NHS Continuing Healthcare but is entitled to NHS-funded Nursing Care arranges for the payments to be made to the care home (with nursing). - Records all CCG decisions in individuals' case records and ensures all communication of CCG decisions is undertaken in a timely and professional manner. - Ensures individual case management arrangements are in place. - Ensures reviews are undertaken in line with the framework and at other times if needs change. - Receives requests for review of an eligibility decision and manages the process on behalf of the CCG. - Undertakes regular audit to ensure the service is meeting agreed KPIs, including patient, staff and customer feedback. - Ensures the CCG is alerted to issues with care providers which may compromise quality of care. - Raises any safeguarding concerns with the local authority.
Herefordshire and Worcestershire Health and Care Trust **Wye Valley Trust** **St Michaels Hospice** **St Richards Hospice**	The organisations that provide acute and community care in Herefordshire and Worcestershire and may, as part of discharge planning processes: - Identify appropriate discharge pathways for individuals e.g. Discharge to Assess (DTA), Home First. - Completes checklists triggering the initial stages of the CHC process or following agreed protocols proceeds straight to completion of DST. - Submit checklists (positive and negative) to the CCG for recording on the CHC database. - Complete and submit the Fast Track tool for those individuals identified as having a rapidly deteriorating condition that may be entering a terminal phase.
CHC Senior Nurse Team	- Verifies recommendations of continuing healthcare eligibility when required in a timely and robust manner, ensuring consistency and quality of content and that the evidence submitted supports the recommendation. -Participates in the CHC eligibility decision quality assurance process. -Ensures that an appropriate selection of packages, including PHBs, are offered to each patient based on their individual care plan in line with the CCG's NHS Fully Funded Adult Continuing Healthcare Choice and Resource Allocation policy.

	- Reviews all complex packages of care ensuring value for money has been considered. - Regularly reviews commissioned care package agreements to ensure that they continue to meet assessed needs. - Approves the placing of contracts for packages up to the manager's delegated limit. - Seek assurances that providers are fit and proper organisations to provide care. - Ensures that a database of clients and packages is maintained. -
Contracting Team	The team that manages the contracted providers who deliver packages of care will: - Maintain a database of accredited providers. - Seek assurances that the providers utilised have CQC accreditation. - Negotiate prices and terms and conditions for services offered by providers. If such providers have not been previously used by the CCG lead the procurement process, including Pre-Qualifying Questionnaire completion. - Procure and develop contracts with providers that ensure high quality care delivery and value for money. - Monitor all contracts to ensure adherence to all key performance indicators.
Finance Director	-Periodically review delegated limits for managers working in this area. - Sign off very high cost packages.

6.0 Governance

6.1 Implementation and delivery of the requirements of the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2018, Department of Health and Social Care) will be monitored through performance reports to the Partnership Board and associated sub-committees:

• CHC Quality and Performance meeting will receive a monthly activity performance report that details activity levels and compliance with framework targets and standards,

• Partnership Board will receive a monthly report providing an overview of CHC activity and current issues.

7.0 Continuing Healthcare Operational Procedure

7.1 Principles

NHS Continuing Healthcare is a package of ongoing care arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in the Framework. Such care is provided to an individual aged 18 or over to meet health and associated social care needs that have arisen as a result of disability, accident or illness.

Clinical Commissioning Groups have a responsibility to ensure that the assessment of eligibility for NHS Continuing Healthcare is completed and the funding decision is made, in most cases, within 28 days from the date of receipt of a fully completed CHC Checklist. The CCG, Worcestershire County Council and Herefordshire County Council are committed to working in partnership to achieve these timeframes.

The key principle underpinning this policy is that all individuals for whom a CCG is responsible have fair and equitable access to NHS Continuing Healthcare. It should be noted that all individuals registered with a Herefordshire and Worcestershire GP (regardless of their eligibility for CHC) have the access to universal NHS services. Other principles are:

- The individual's informed consent will be obtained before starting the process to determine eligibility for NHS CHC. If the individual lacks the mental capacity either to refuse or consent, a 'Best Interests' decision should be taken and recorded in line with the Mental Capacity Act (2005) as to whether to proceed with assessment for eligibility for NHS Continuing Healthcare. A third party cannot give or refuse consent for an assessment of eligibility for Continuing Healthcare on behalf of a person who lacks capacity, unless they have valid and applicable Lasting Power of Attorney for Health and Welfare, or have been appointed as a Deputy by the Court of Protection for Health and Welfare. Where Lasting Power of Attorney for Health and Welfare exists, a copy of this should be obtained and submitted with checklist. This consent will need to encompass permission to undertake the NHS Continuing Healthcare 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 NHS Continuing Healthcare and, where appropriate, for audit and monitoring of decisions.
- Health and social care professionals will work in partnership with individuals and their representatives throughout the process.
- All individuals and their representatives will be provided with information to support them to participate as fully as possible in the process.
- The CCG supports the use of independent advocacy for individuals through the process of application for NHS Continuing Healthcare, where this is appropriate.
- The process for decisions about eligibility for NHS Continuing Healthcare will be transparent for individuals and their representatives and for partner agencies. Once an individual has been referred for and is eligible for a full assessment for NHS CHC, all assessments will be undertaken by the Multi-Disciplinary Team (MDT).
- The Decision Support Tool (DST) will be completed using all of the relevant and contemporaneous information available, ensuring a comprehensive multi-disciplinary assessment of an individual's health and social care needs.

The DST has been developed to aid consistent decision making and supports the practitioner in identifying the individual's needs. This, combined with the practitioner's own experiences and professional judgement, should enable them to apply the primary health needs test in practice.

7.2 Eligibility for NHS Continuing Healthcare

The Framework provides a consistent approach to establishing eligibility for NHS Continuing Healthcare. Legal judgements in the cases of Coughlan (1999) and Grogan (2006) have heavily influenced the law relating to NHS Continuing Healthcare and clarified the distinctions between what the NHS and local authorities, respectively, can fund. The concept of "primary health need" has, at least in part as a

result, evolved to assist in deciding when it is appropriate for the NHS to commission both health and social care services (as NHS Continuing Healthcare), and to distinguish those circumstances from situations where services should be provided solely by the local authority under the Care Act 2014 or funded jointly with the NHS.

Where a person has been assessed to have a “primary health need”, they are eligible for NHS Continuing Healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs from the assessment process. Where an individual has a primary health need, the NHS is responsible for providing for all of that individual’s assessed health and associated social care needs. This will include accommodation, if that is part of the overall need.

Consideration of primary health need includes consideration of the characteristics of need and their impact on the care required to manage the needs; in particular, to determine whether the quantity or quality of care is more than the limits of responsibility of Local Authorities (as in the Coughlan judgement and the Care Act 2014). Consideration is given to the following areas:

- **Nature**: This describes the particular characteristics of an individual’s 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 both to the extent (‘quantity’) and severity (‘degree’) of the needs and to 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 required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction 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 where a physical health need results in the individual developing a mental health need.
- **Unpredictability:** This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person’s health if adequate and timely care is not provided. An individual with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual’s needs. The totality of the overall needs and the effects of the interaction of needs will be carefully considered when completing the Decision Support Tool (DST).

7.3 Assessment of eligibility process

Screening

If NHS Continuing Healthcare is under consideration a Checklist should normally be completed. Such screening should take place at the right time and location for the individual and when the individual's ongoing needs are known. There will be many situations when it is not necessary to complete a Checklist, for example, when it is clear to health and social care practitioners that there is no need for NHS Continuing Healthcare at this point in time. Such decisions should be recorded, along with the rationale for the decision.

The purpose of the Checklist is to encourage proportionate assessments so that resources are directed towards those people who are more likely to be eligible for NHS Continuing Healthcare. Its use also provides evidence to demonstrate that the CCG has taken reasonable steps to ensure that individuals are assessed for NHS Continuing Healthcare in all cases where it appears that there may be a need for such care. In certain circumstances, in accordance with agreed protocols, a positive checklist outcome may be assumed and the individual case may proceed directly to the DST stage.

Before applying the Checklist, it is necessary to ensure that the individual and their representative, where appropriate, understand that the Checklist does not indicate the likelihood that the individual will be found eligible for NHS Continuing Healthcare, only that they are entitled to consideration for eligibility. At this stage, the threshold is set deliberately low to ensure that all those who require a full consideration of their needs get the opportunity.

A nurse, doctor or other qualified healthcare professional or social care practitioner can apply the Checklist to refer individuals for a full consideration of eligibility from within the community or hospital setting, although in the majority of cases eligibility should be considered after discharge or a period of rehabilitation when the individual's on-going needs should be clearer. Whoever applies the Checklist should be familiar with the Framework and should be trained in the use of the Checklist.

Consent should be obtained before applying the Checklist (see section 7.1) and provided to the CCG when the Checklist is submitted. Consent should also be obtained when, in accordance with the aforementioned protocol, a decision is made to proceed straight to DST stage. The consent will need to encompass permission to undertake the NHS Continuing Healthcare assessment process and also to the 'sharing and processing of data'. In cases where the individual is unable to consent (determined in accordance with the Mental Capacity Act 2005) or consent from a valid and applicable Lasting Power of Attorney for Health and Welfare or Deputy (Health and Welfare) appointed by the Court of Protection is not available the referrer must make a decision on whether to proceed in the individual's "best interests". This decision should be recorded and the dates of the Mental Capacity Act assessment and Best Interest decision should be submitted to the CCG with the Checklist. All completed NHS CHC Checklists should be sent to the CCG at: Hwccg.chc@nhs.net.

Receipt of completed checklists will be acknowledged by the CCG within one working day.

A negative Checklist means the individual does not require a full assessment of eligibility and they are not eligible for NHS Continuing Healthcare. If an individual has been screened out following completion of the Checklist, the referred may ask the CCG to reconsider the Checklist outcome. Such requests should be made to the CCG by emailing Hwccg.chc@nhs.net. The CCG will give these requests due consideration, taking account all of the information available, and/or including

additional information from the individual or representative, however the CCG is under no obligation to undertake a further Checklist.

7.4 Discharge Planning

The CCG is committed to:

- reducing the number of individuals who are delayed in hospital when they are fit to be discharged
- Working in partnership to ensure that individuals receive the care they need, when and where they need it, in accordance with the Care & Support (Discharge of Hospital Patients) Regulations 2014
- Working in partnership to ensure that agreed Discharge to Assess models of care are followed.

In a hospital setting, where a NHS body is considering issuing an assessment notice to a local authority under the provisions of the Care & Support (Discharge of Hospital Patients) Regulations 2014, the responsible NHS body is required to consider the individual's need for NHS Continuing Healthcare before issuing such a notice. Screening and assessment of eligibility should be at the right time and location for the individual and when the individual's ongoing needs are known. If it is considered that there is no need for NHS Continuing Healthcare at this time a decision not to screen can be made and should be recorded along with the rationale for the decision.

Herefordshire and Worcestershire CCG patients receiving acute hospital treatment will be considered for and offered appropriate reablement or rehabilitation prior to consideration for NHS Continuing Healthcare. Such reablement or rehabilitation will take place in a community based 'Discharge to Assess' (DTA) bed or through other interim NHS-funded services. The CCG does not generally support the provision of a CHC assessment in an acute hospital setting. DTA beds are commissioned with the aim of maximising an individual's independence to ensure an appropriate assessment of their healthcare needs once they have had a period outside of an acute hospital setting and have reached their optimal potential. Where it is anticipated the individual may have NHS Continuing Healthcare needs, a Checklist may be submitted and a DST completed in the Discharge to Assess (DTA) setting.

7.5 Assessment and DST

If completion of the Checklist indicates that the individual patient is entitled to a full assessment to determine their eligibility for NHS Continuing Healthcare, the CCG aims to complete the DST, with MDT recommendation, and reach a funding decision within 28 days of receipt of the completed Checklist- in line with the National Framework (revised 2018).
Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. The DST provides the basis for decisions on eligibility for NHS Continuing Healthcare. The DST should be completed by a multidisciplinary team, which must include, as a minimum, two health clinicians from different health

disciplines or one professional from a healthcare profession and one who is responsible for undertaking community care assessments (a social care professional). Specialist staff and mental health staff may be involved, dependent on the individual's needs.
On receipt of a completed Checklist the Continuing Healthcare Team will contact the individual or their representative to schedule the assessment and the date will be confirmed in writing. In accordance with agreed procedure 5 days' notice of attendance will be given to the relevant Local Authority by email. If, at the scheduled appointment, consent to undertake the NHS Continuing Healthcare assessment is withdrawn, for example by refusal to allow the assessment to take place as agreed, the potential consequences of this will be explained to the individual. If consent remains withdrawn following the explanation the checklist will be closed and the process will be considered complete. However, withdrawal of consent will only be accepted from the individual or from someone who has a Lasting Power of Attorney for Health and Welfare. In cases where the individual is unable to consent (determined in accordance with the Mental Capacity Act 2005) or consent from a Lasting Power of Attorney for Health and Welfare is not available the CCG will make a decision on whether to proceed with the assessment process will be made in the person's "best interests". The dates of the Mental Capacity Act assessment and Best Interest decision and the outcome of the decision will be recorded in the CCG's records.

7.6 Verification of MDT recommendations

It is anticipated that all DSTs will be completed by appropriate Health and Social Care professionals and a clear recommendation regarding eligibility for funding will usually be made by the MDT, on the date of the DST. A lead nurse for the CCG, not involved in the DST process, will scrutinise all DSTs during the verification process for quality and consistency. Within two working days of receipt of the MDT recommendation the CCG will:

- Verify the recommendations of the multidisciplinary team where the DST is completed by an appropriately constituted MDT and MDT consensus has been reached in relation to the recommendation.
- Where funding is reduced or removed, provide a detailed explanation of the rationale for the decision to the applicant and/or their representative.

The CCG expects to verify all MDT recommendations, however in exceptional circumstances the CCG will:

- Send the DST back to the MDT for further consideration where there is no recommendation consensus between MDT members.
- Defer verification of the recommendations of the multi-disciplinary team where the evidence provided does not support the level of need indicated in the DST; in such circumstances, asking the MDT to provide additional information to support the recommendation.

The MDT will make a recommendation as to whether or not the individual has a primary health need and is eligible for NHS Continuing Healthcare (CHC). The rationale for the recommendation should be recorded.

As per Framework requirements the recommendations available to the MDT at DST are as follows:

- Individual has primary health need - **Eligible for CHC**
- Individual does not have a primary health need - **Not eligible for CHC**
- Individual does not have a primary health need but the individual has specific needs (nature and levels of need to be identified in the DST) which are beyond the power of the LA to meet on its own - **Not eligible for CHC but a joint package of care is indicated.** This may require further discussions to agree funding responsibilities for each organisation and will be referred to and resolved at Quality Assurance Panel (QAP).
- Individual does not have a primary health need but is assessed as having the need for care from a registered nurse and those needs are most appropriately met in a care home with nursing - **Not eligible for CHC but awarded NHS-funded Nursing Care (FNC).**

Every effort should be made to facilitate a decision by the MDT on the day of the DST and it is anticipated that the final version of the DST is shared and agreed by all Professionals before submission. If the MDT is unable to reach agreement on the recommendation this should be clearly recorded. A dispute form will be completed by the MDT and submitted to the CCG by the end of the working day following the DST meeting.

The eligibility recommendation from the MDT will be verified in order to facilitate completion of the decision-making process within the 28-day timescale. An individual only becomes eligible for NHS Continuing Healthcare once a recommendation regarding eligibility has been verified by the CCG. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment. In such cases without prejudice agreements may be made between the CCG and any existing funding organisation in accordance with agreed local protocols.

Where individuals are found to be newly eligible for NHS Continuing Healthcare, funding will be agreed from the date of the verification decision on eligibility or from day 29 from the date of receipt of the Checklist, whichever is the earlier.

7.7 Disputes raised by the Local Authority (inter-agency disputes)

The CCG, Herefordshire County Council and Worcestershire County Council subscribe to the principle that there should be no delay in the provision of services due to disagreements or disputes on the assessment recommendation or outcome of eligibility. Should such situations arise, the Framework is explicit in stating that any existing funding arrangements cannot be unilaterally withdrawn without a joint assessment being carried out and alternative funding arrangements put in place.

It is anticipated that, in the event of an MDT being unable to agree a recommendation at the time of the DST that the MDT will complete a Dispute form and submit this to the CCG by the end of the working day following the DST meeting. There are 3 Dispute resolution stages:

Informal resolution –

- **Stage one:** where the MDT has been unable to agree a recommendation when completing a Decision Support Tool (DST) the MDT and their line managers (Clinical team Leaders, CHC and Team Leaders, LA) will hold a meeting within 5 working days to agree an outcome. It is anticipated that, in most cases, disputes will be resolved with the MDT who undertook the assessment. At this stage, if there is insufficient evidence to make a decision then the MDT may request further information. The MDT need to request specific information and agree who will obtain this, confirm timescales and set a date to reconvene.

Formal resolution –

- **Stage Two:** if unresolved at stage one the case will be reviewed at the earliest opportunity (no later than 5 working days of the stage one meeting) at a senior manager (Senior Nurse Managers, CHC or Operational Managers, LA) level to agree an outcome. If the case is likely to escalate at this stage, then the senior managers must alert Associate Directors on the day of the meeting.
- **Stage Three:** if unresolved at stage two the case will be reviewed at CCG Associate Director and LA Associate Director level within 5 working days of the stage two meeting and a final decision made.

Independent arbitration –

- **Final stage:** The final stage will be invoked as a last resort. It will be triggered at Associate Director-level within 1 working day of the stage three meeting.

Escalation to NHS England –

- All disputes that remain unresolved in excess of 12 weeks will be escalated to NHS England for guidance, using the appropriate documentation.

Individuals and care/support providers will never be left without support whilst disputes between the statutory bodies about funding responsibilities are resolved. It is anticipated that, where a responsible commissioner is already in place, then this will continue but, where there is an increase in care identified, partnership working may be required to ensure there is always appropriate care in place.

For those individuals without an existing funding stream or where existing funding is not sufficient to meet assessed needs an interim funding agreement will be discussed and agreed between the CCG and relevant Local Authority and an interim Lead Commissioner identified with agreed next steps to confirm the permanent position.

7.8 Fast Track Applications

The Fast Track application is there to ensure that individuals who have a “rapidly deteriorating condition, that may be entering a terminal phase” get the care they require as quickly as possible. No other criterion need be fulfilled. (Fast Track applications will be funded from the date of the introduction of the agreed package of care.)

The Framework provides the Fast Track Tool for use in these circumstances. The Fast Track Tool should be completed by an ‘appropriate clinician’ described in the Framework as a person who is:

- Responsible for the diagnosis, treatment or care of the individual under the 2006 Act in respect of whom a Fast Track Pathway Tool is being completed:
- A registered nurse or registered medical practitioner.

The registered nurse or registered medical practitioner completing the Fast Track Tool, should be knowledgeable about the individual’s health needs, diagnosis, treatment or care and be able to provide an assessment of why the individual meets the Fast Tracking criteria. The reasons stated should be supported by evidence clearly demonstrating a rapid deterioration of condition. Where this is not demonstrated, a CHC clinician can challenge the referring clinician to determine eligibility. However, resolution of such concerns should not delay the delivery of an urgent package of care via the Fast Track process. In exceptional circumstances, if there is no evidence to support eligibility, the referrer may be advised to send in a Checklist as an alternative and a DST may be arranged, as appropriate.

The HWCCG NHS Continuing Healthcare Service currently operates Monday to Friday, 09.00 to 17.00 (excluding Bank Holidays). Decisions about eligibility for ‘fast tracking’ of NHS Continuing Healthcare will be made within 48 hours of application, in order to support the preferred priorities of the individual for their end of life care. Only in exceptional circumstances will completion of the process exceed 48 hours when an application is received within operating hours. In cases where an application is made after 17.00 on a Friday the decision will be made by 12 noon the next working day.

Use of Fast Track applications will be closely monitored by the CCG and action will be taken where it is suspected that improper use of the process has occurred. Such actions will be treated as a separate matter from the task of arranging for service provision in the individual case.

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Herefordshire and Worcestershire
Integrated Care System

Equality Impact Assessment Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (mark with an 'X' in the right-hand column)

Herefordshire & Worcestershire STP	
Worcestershire Acute Hospitals NHS Trust	
Herefordshire & Worcestershire Health and Care NHS Trust	
Herefordshire Council	
Worcestershire County Council	
Wye Valley NHS Trust	
Herefordshire & Worcestershire CCG	**X**
Other (please state)	

Name of lead for activity	Jane Lodwig
Details of individual(s) completing this assessment, please include name, job title and email contact	Associate Director of Nursing jane.lodwig@nhs.net
Date assessment completed	08/12/2021

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**CHC 'Working in Partnership 'Policy**

What is the aim, purpose and/or intended outcomes of this Activity?	The delivery of an effective and efficient CHC service is a statutory responsibility of the CCG and the purpose of this policy is to set out the CCGs approach to the delivery of this service, working in partnership with Local Authority colleagues. At the heart of the National Framework is the process for determining whether an individual is eligible for NHS Continuing Healthcare or NHS-funded Nursing Care. An individual is eligible for NHS Continuing Healthcare if they have a 'primary health need'. This is a concept developed by the Secretary of State to assist in determining when the NHS is responsible for providing for all of the individual's assessed health and associated social care needs. In order to determine whether an individual has a primary health need, a detailed assessment and decision-making process must be followed, as set out in the National Framework. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for commissioning a care package that meets the individual's health and associated social care needs. The National Framework is underpinned by Standing Rules Regulations issued under the National Health Service Act 2006. These regulations, referred to henceforth as the Standing Rules, require Clinical Commissioning Groups (CCGs) to have regard to the National Framework. The National Framework takes account of legislative changes brought about by the Care Act 2014, which preserves the existing boundary and limits of local authority responsibility in relation to the provision of nursing and/or healthcare. The individual, the effect their needs have on them, and the ways in which they would prefer to be supported should be kept at the heart of the process. Access to assessment, care provision and support should be fair, consistent and free from discrimination. This is an operational policy that sets out the CCG's role and responsibilities for the delivery of the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. It outlines the process for determining eligibility for NHS Continuing Healthcare funding and the procedures to be followed. The policy also sets out the responsibilities of the CCG in those situations where there is no eligibility for NHS Continuing Healthcare and for the management of disagreements that may arise as a result of NHS Continuing Healthcare eligibility-related decisions. In addition, the policy describes the way in which the CCG will commission care to meet needs in a manner

	that reflects patient choice and preferences, whilst balancing the requirement to stay within the set financial limit allocated by NHS England to the organisation. The policy applies to all NHS Continuing Healthcare applications for adults 18 years or older who are registered with a General Practice in Herefordshire and Worcestershire or who are resident within the CCG boundary and are not registered with a General Practitioner elsewhere or where the CCG retains commissioning responsibility for an individual placed outside that boundary. It includes all care groups. This policy does not apply to children for whom the National Framework for Children and Young People's Continuing Care (2016) applies. It is acknowledged that, at times, joint working may be required to support an adult who has parenting responsibilities and care needs in line with relevant legislation. NHS Herefordshire and Worcestershire CCG is the organisation that is responsible and accountable for system leadership for NHS Continuing Healthcare within the local health and social care economy. The CCG's role and responsibilities are as follows: - Ensuring delivery of, and compliance with, the National Framework for NHS Continuing Healthcare. - Promoting awareness of NHS Continuing Healthcare. - Establishing and maintaining governance arrangements for NHS Continuing Healthcare eligibility processes and commissioning NHS Continuing Healthcare packages. - Ensuring that assessment mechanisms are in place for NHS Continuing Healthcare across relevant care pathways, in partnership with the local authority as appropriate. The Standing Rules require CCGs to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for NHS Continuing Healthcare. - Making decisions on eligibility for NHS Continuing Healthcare, in partnership with Local Authorities. - Identifying and acting on issues arising in the provision of NHS Continuing Healthcare. - Commissioning arrangements, both on a strategic and an individual basis. - Having a system in place to record assessments undertaken and their outcomes, and the costs of NHS Continuing Healthcare packages. -Sharing relevant data and information with Local Authority partners within the limits of the relevant data sharing agreements. - Implementing and maintaining good practice. - Ensuring that quality standards are met and sustained.

	- Ensuring training and development opportunities are available for practitioners, in partnership with the local authority. - Having clear arrangements in place with other NHS organisations The policy sets out the responsibilities of the CCG to deliver the CHC National Framework as set out by NHSE. This is a mandated and monitored process which includes formal consent, referral, assessment, decision, verification of that decision and the operational delivery of any required service. The key principle underpinning this policy is that all individuals for whom a CCG is responsible have fair and equitable access to NHS Continuing Healthcare. It should be noted that all individuals registered with a Herefordshire and Worcestershire GP (regardless of their eligibility for CHC) have the access to universal NHS services. Other principles are: • The individual's informed consent will be obtained before starting the process to determine eligibility for NHS CHC. If the individual lacks the mental capacity either to refuse or consent, a 'Best Interests' decision should be taken and recorded in line with the Mental Capacity Act (2005) as to whether to proceed with assessment for eligibility for NHS Continuing Healthcare. A third party cannot give or refuse consent for an assessment of eligibility for Continuing Healthcare on behalf of a person who lacks capacity, unless they have valid and applicable Lasting Power of Attorney for Health and Welfare, or have been appointed as a Deputy by the Court of Protection for Health and Welfare. Where Lasting Power of Attorney for Health and Welfare exists, a copy of this should be obtained and submitted with checklist. This consent will need to encompass permission to undertake the NHS Continuing Healthcare 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 NHS Continuing Healthcare and, where appropriate, for audit and monitoring of decisions. • Health and social care professionals will work in partnership with individuals and their representatives throughout the process. • All individuals and their representatives will be provided with information to support them to participate as fully as possible in the process.

	• The CCG supports the use of independent advocacy for individuals through the process of application for NHS Continuing Healthcare, where this is appropriate. • The process for decisions about eligibility for NHS Continuing Healthcare will be transparent for individuals and their representatives and for partner agencies. Once an individual has been referred for and is eligible for a full assessment for NHS CHC, all assessments will be undertaken by the Multi-Disciplinary Team (MDT). • The Decision Support Tool (DST) will be completed using all of the relevant and contemporaneous information available, ensuring a comprehensive multi-disciplinary assessment of an individual's health and social care needs. The DST has been developed to aid consistent decision making and supports the practitioner in identifying the individual's needs. This, combined with the practitioner's own experiences and professional judgement, should enable them to apply the primary health needs test in practice. The Framework explicitly states "It is important to establish at the outset whether the individual has any particular communication needs and, if so, how these can be addressed. If English is not their first language an interpreter may be required, or if they have a learning disability the use of photographs, pictures or symbols may be helpful to support communication. Hearing difficulties are often exacerbated where there is background noise (so a quiet room might be needed), and many older people in particular struggle to use any hearing aid they may have. If the individual uses British Sign Language (BSL) it will be necessary to arrange for a BSL interpreter, which may have to be booked well ahead. CCGs should consider the most likely communication needs to arise in the course of assessing for NHS Continuing Healthcare and make ongoing arrangements for appropriate support to be readily accessible. This could be, for example, by having arrangements with identified formal interpreters to be available at short notice. Preferred methods of communication should be checked with the person or their relatives, friends or representatives in advance. Where a person has specific communication needs such that it takes them longer than most people to express their views, this should be planned into the time allocated to carry out their assessment. Reasonable adjustments may need to be made (in accordance with the Equalities Act 2010) to enable the individual or their representative to fully participate in the process. For example, if the individual or their representative is not able to take or read written notes it

	may be considered a reasonable adjustment for them to take an audio recording of a meeting which they can refer to at a later date. However, it is important to be mindful of confidentiality issues and for an explicit agreement to be reached regarding the purpose and use of the recording. This is particularly important when a third party is recording the meeting rather than the individual concerned. In these circumstances either the individual concerned should give consent or, if they lack capacity, a best interest decision should be made by the professional chairing or leading the meeting. The overall approach to carrying out the assessment is of equal importance in terms of accessibility to the technical arrangements that are put in place. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion naturally progresses, rather than working through an assessment document in a linear fashion. It is important that the person's own view of their needs is given due regard alongside professional views".

Who will be affected by the development & implementation of this activity? (mark with an 'X' in

Service user	**X**
Patient	**X**
Carers	**X**
Staff	**X**
Communities	**X**
Other (please state)	

This is a… (mark with an 'X' in the right-hand column)

Review of an existing activity	**X**
New activity	
Planning to withdraw or reduce a service, activity or presence?	

What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	This is a refreshed policy which has been co-written with representatives from both Hereford and Worcestershire Local Authorities and which has been reviewed by their relevant legal teams. This policy should be read in conjunction with the: • The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, incorporating the NHS Continuing Healthcare Practice Guidance (Department of Health & Social Care, 2018, revised); 20181001 National Framework for CHC and FNC - October 2018 Revised (publishing.service.gov.uk) • Who Pays? Determining responsibility for payments to providers (NHS England 2020); Who-Pays-final-24082020-v2.pdf (england.nhs.uk) • The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended): The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (legislation.gov.uk)
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	The Framework itself had extensive engagement by NHSE- as we are required to implement it locally, there has not been patient engagement in the development of the operational policy. There will be in the related Choice and Equity policy which is under development.
Summary of relevant findings	As above

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	X			This policy applies to all NHS Continuing Healthcare applications for adults 18 years or older who are registered with a General Practice in Herefordshire and Worcestershire or who are resident within the CCG boundary and are not registered with a General Practitioner elsewhere or where the CCG retains commissioning responsibility for an individual placed outside that boundary. It includes all care groups. This policy does not apply to children for whom the National Framework for Children and Young People's Continuing Care (2016) applies. It is acknowledged that, at times, joint working may be required to support an adult who has parenting responsibilities and care needs in line with relevant legislation. This is an inclusive, transparent policy which sets out how the CCG will assess eligibility and commission care for all eligible individuals. Eligibility is clearly described in the NHS CHC Framework and equality and fair access to services is at the heart of this document.
Disability	X			Under the Equality Act 2010, a person is deemed to have a disability if: • They have a physical or mental impairment • The impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities Where a person has been assessed to have a "primary health need", they are eligible for NHS Continuing Healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs from the assessment process. Where an individual has a primary health need, the NHS is responsible for providing for all of that individual's assessed health and associated social care needs. This will include accommodation, if that is part of the overall need.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
				Consideration of primary health need includes consideration of the characteristics of need – this includes physical, mental health or psychological needs. People with physical/mental long term health conditions or disabilities may therefore be more likely to meet the eligibility criteria for CHC and this policy should positively impact this group as it ensures they are able to access care that meets their needs. The totality of the overall needs of patients and the effects of the interaction of needs will be carefully considered when completing the Decision Support Tool (DST). The MDT will make a recommendation as to whether or not the individual has a primary health need and is eligible for NHS Continuing Healthcare (CHC). The rationale for the recommendation should be recorded. As per Framework requirements the recommendations available to the MDT at DST are as follows: • Individual has primary health need - **Eligible for CHC** • Individual does not have a primary health need - **Not eligible for CHC** • Individual does not have a primary health need but the individual has specific needs (nature and levels of need to be identified in the DST) which are beyond the power of the LA to meet on its own - **Not eligible for CHC but a joint package of care is indicated.** This may require further discussions to agree funding responsibilities for each organisation and will be referred to and resolved at Quality Assurance Panel (QAP). • Individual does not have a primary health need but is assessed as having the need for care from a registered nurse and those needs are most appropriately met in a care home with

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
				nursing - **Not eligible for CHC but awarded NHS-funded Nursing Care (FNC).** The eligibility recommendation from the MDT will be verified in order to facilitate completion of the decision-making process within the 28-day timescale. An individual only becomes eligible for NHS Continuing Healthcare once a recommendation regarding eligibility has been verified by the CCG. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment. The Fast Track application is there to ensure that individuals who have a “rapidly deteriorating condition, that may be entering a terminal phase” get the care they require as quickly as possible. No other criterion need be fulfilled. (Fast Track applications will be funded from the date of the introduction of the agreed package of care.) Where individuals are found to be newly eligible for NHS Continuing Healthcare, funding will be agreed from the date of the verification decision on eligibility or from day 29 from the date of receipt of the Checklist, whichever is the earlier. If NHS Continuing Healthcare is under consideration a Checklist should normally be completed. Such screening should take place at the right time and location for the individual and when the individual’s ongoing needs are known. There will be many situations when it is not necessary to complete a Checklist, for example, when it is clear to health and social care practitioners that there is no need for NHS Continuing Healthcare at this point in time. Such decisions should be recorded, along with the rationale for the decision. 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

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
				of health need (for example, whether the need is physical, mental or psychological). Assessments of eligibility for NHS Continuing Healthcare and NHS-funded Nursing Care is organised so that the individual being assessed and their representative understand the process and receive advice and information that will maximise their ability to participate in the process in an informed way. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike This is an inclusive, transparent policy which sets out how the CCG will assess eligibility and commission care for all eligible individuals. Eligibility is clearly described in the NHS CHC Framework and equality and fair access is at the heart of this document.
Gender Reassignment		X		This policy sets out how the CCG will assess eligibility and commission care. There are currently no identified impacts on this group. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. The process to determine eligibility is clearly described in the NHS CHC Framework and equality and fair access is at the heart of this document. Adults in this group will be assessed for CHC where they have an ongoing need for skilled medical or clinical care.
Marriage & Civil Partnerships		X		This policy sets out how the CCG will assess eligibility and commission care. There are currently no identified impacts on this group. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. The process to determine eligibility is clearly described in the NHS CHC Framework and equality and fair access is at the heart of this document. Adults in this group will be assessed for CHC where they have an ongoing need for skilled medical or clinical care.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Pregnancy & Maternity		X		This policy sets out how the CCG will assess eligibility and commission care. This policy sets out how the CCG will assess eligibility and commission care. This policy does not apply to children for whom the National Framework for Children and Young People's Continuing Care (2016) applies. It is acknowledged that, at times, joint working may be required to support an adult who has parenting responsibilities and care needs in line with relevant legislation.
Race including Traveling Communities		X		This policy sets out how the CCG will assess eligibility and commission care. There are currently no identified impacts on this group. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. The process to determine eligibility is clearly described in the NHS CHC Framework and equality and fair access is at the heart of this document. Adults in this group will be assessed for CHC where they have an ongoing need for skilled medical or clinical care. The Framework explicitly states "It is important to establish at the outset whether the individual has any particular communication needs and, if so, how these can be addressed. If English is not their first language an interpreter may be required. Reasonable adjustments may need to be made (in accordance with the Equalities Act 2010) to enable the individual or their representative to fully participate in the process. For example, if the individual or their representative is not able to take or read written notes it may be considered a reasonable adjustment for them to take an audio recording of a meeting which they can refer to at a later date. However, it is important to be mindful of confidentiality issues and for an explicit agreement to be reached regarding the purpose and use of

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
				the recording. This is particularly important when a third party is recording the meeting rather than the individual concerned. In these circumstances either the individual concerned should give consent or, if they lack capacity, a best interest decision should be made by the professional chairing or leading the meeting. The overall approach to carrying out the assessment is of equal importance in terms of accessibility to the technical arrangements that are put in place. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion naturally progresses, rather than working through an assessment document in a linear fashion. It is important that the person's own view of their needs is given due regard alongside professional views. Work is planned to allow NHSE to collect and review CHC data regarding protected characteristics – this will help to identify any potential gaps or inequity in access to this policy.
Religion & Belief		X		This policy sets out how the CCG will assess eligibility and commission care. There are currently no identified impacts on this group. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. The process to determine eligibility is clearly described in the NHS CHC Framework and equality and fair access is at the heart of this document. Adults in this group will be assessed for CHC where they have an ongoing need for skilled medical or clinical care.
Sex		X		This policy sets out how the CCG will assess eligibility and commission care. There are currently no identified impacts on this group. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. The process to determine eligibility is clearly described in the NHS CHC

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
				Framework and equality and fair access is at the heart of this document. Adults in this group will be assessed for CHC where they have an ongoing need for skilled medical or clinical care.
Sexual Orientation		X		This policy sets out how the CCG will assess eligibility and commission care. There are currently no identified impacts on this group. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. The process to determine eligibility is clearly described in the NHS CHC Framework and equality and fair access is at the heart of this document. Adults in this group will be assessed for CHC where they have an ongoing need for skilled medical or clinical care.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	X			This policy sets out how the CCG will assess eligibility and commission care. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. Regular, multidisciplinary assessments of need should particularly benefit those who may be marginalised and find it difficult to access core services.
Health Inequalities (reduce inequalities between patients with respect to the ability to access health services, and (b) reduce inequalities between patients with respect to the	X			This policy sets out how the CCG will assess eligibility and commission care. Eligibility for NHS Continuing Healthcare is based on an individual's assessed health and social care needs. Regular, multidisciplinary assessments of need should particularly benefit those who may be marginalised and find it difficult to access core services. The DST specifically asks whether the individual was involved in its completion, whether they were offered the opportunity to have a representative and whether the representative attended the DST completion. It also asks for details of the individual's view of their own care/support

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
outcomes achieved for them by the provision of health services. NHS Act 2006 (as amended)				needs, whether the MDT assessment accurately reflects these and whether they contributed to the assessment. It also asks for the individual's views on the completion of the DST, including their view on the domain levels selected. The provision of advocacy, where appropriate, is an important means of achieving meaningful participation.

Ongoing Monitoring:

NHSE will be launching a Patient Level Data Set in 2022 which will collate patient demographics and other information in a more detailed way. This will support ongoing monitoring as it applies to specific groups, especially those with protected characteristics.

CHC is described as open and transparent because it is accessible to everyone who meets the referral criteria and is referred. Each referral is processed in line with the Framework and with the robust operational process as laid out in the policy, including Dispute and Complaint management- both of which are monitored and overseen so that any themes and patterns may be identified.

Section 4: Health Inequalities

The following section is designed to help you systematically assess health inequalities related to your work programme and identify what you can do to help reduce inequalities. Health inequalities are unjust differences in health and wellbeing between different groups of people (communities) which are systematic and avoidable. Health inequalities in England exist across a range of dimensions or characteristics, including the nine protected characteristics of the Equality Act 2010, socio-economic status, geographic deprivation, or being part of a vulnerable or Inclusion Health group. Please complete the following section

Health Inequalities (HI) questions	Issues to Consider	Response
1. What health inequalities (HI) exist in relation to your work?	Explore existing data sources (eg JSNA, local/national data) on the distribution of health across different population groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.) Consider protected characteristics and different dimensions of HI e.g. socioeconomic status or geographic deprivation	CHC processes referrals from a wide variety of sources (hospital, community, social care etc) and there are particular areas of expertise eg. transition, Learning disability, mental health, fast track (end of life). All referrals are treated and processes in an identical manner and, where issues exist (eg. no GP or no family support) we always seek to ensure there is no inequality of access and help is offered.

2. How might your work affect HI (positively or negatively)?	a) Consider the causes of these inequalities. What are the wider determinants? b) Think about whether outcomes vary across groups, and who benefits most and least, looking at socio-economic status and geographical location where a project is going to be based and what impact that will have on different communities c) Consider what the unintended consequences of your work might be	CHC processes referrals from a wide variety of sources (hospital, community, social care etc) and there are particular areas of expertise eg. transition, learning disability, mental health, fast track (end of life). All referrals are treated and processes in an identical manner and, where issues exist (eg. no GP or no family support) we always seek to ensure there is no inequality of access and help is offered.
3. What are the next steps?	Is there anything that can be done to reduce the health inequalities? Please record the mitigations in the action plan in step 5	CHC is a well established, statutory responsibility of the CCG with an equitable approach at the heart of the NHS CHC National Framework

Section 5

What actions will you take to mitigate any potential negative impacts?

Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe

How will you monitor these actions?	**There is continual monitoring of all CHC functions (eligibility, quality, compliance with national requirements and benchmarking data undertaken by the team and reported monthly to Finance Committee, NHSE and ELT.**
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	Annual review of individual patients Continual monitoring of complaints to both respond to individual issues and identify themes and shape feedback and training.

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

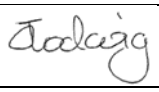
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

1.4 Our organisations are expected to use the appropriate interpreting, translating or preferred method of communication for those who have language and/or other communication needs. Practitioners will need to assess that the implementation of the CHC Working in Partnership policy is fair and equitable for all groups covered under the Equality Act 2010 and that they are implementing the Accessible Information Standard and have considered health inequalities.

1.5. HWCCG must meet its statutory duty to reduce inequalities of access and outcomes, as set out in the NHS Act 2006 (as amended). As a result, the CCG aims to design and implement policy documents that seek to reduce any inequalities that already arise or may arise from any new policy. Therefore, the CCG will consciously consider the extent to which any policy reduces inequalities of access and outcomes.

1.6. Any change to a service will require a conscious effort from the author(s) of that change to actively consider the impact that this will have on any Protected group(s) and act due diligently. Where an impact on any of the Equality groups is realised after the implementation of the Project/Service, the commissioners and or Providers, who are implementing the said Project and or service will seek to minimise such an impact and simultaneously carry out a full review.

Signature of person leading & or completing the EIA	
Date signed	08/12/2021
Comments:	
Signature of person approving the EIA	
Date signed	
Comments:	

Herefordshire and Worcestershire CCGs Addendum to the Equality Impact Analysis

Human Rights Consideration:

NHS organisations must ensure that none of their services, policies, strategies or procedures infringes on the human rights of patients or staff. You should analyse your document using the questions provided to determine the impact on human rights. Using human rights principles of fairness, respect, equality, dignity and autonomy as flags or areas to consider is often useful in identifying whether human rights are a concern.

Can you please answer the following Human Rights screening questions:

	Human Rights	Yes/No	Please explain
1	Will the policy/decision or refusal to treat result in the death of a person?	No	
2	Will the policy/decision lead to degrading or inhuman treatment?	No	
3	Will the policy/decision limit a person's liberty?	No	
4	Will the policy/decision interfere with a person's right to respect for private and family life?	No	
5	Will the policy/decision result in unlawful discrimination?	No	
6	Will the policy/decision limit a person's right to security?	No	
7	Will the policy/decision breach the positive obligation to protect human rights?	No	
8	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	No	
9	Will the policy/decision interfere with a person's right to participate in life?	No	

If any Human Rights issues have been identified in this section please get in touch with your Equality and Inclusion lead who will advise further and a full Human Rights Impact Assessment maybe required to be completed.

Department of Health & Social Care

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

October 2018 (Revised)

Published March 2018

Incorporating the NHS Continuing Healthcare Practice Guidance

October 2018 (revised), published March 2018

DH ID box
Title: National Framework for NHS Continuing Healthcare & NHS-funded Nursing Care
Author: SCLGCP-SCP 25370
Document Purpose: Guidance
Publication date: March 2018
Target audience: Health and social care professionals Public
Contact details: NHS Continuing Healthcare and NHS-funded Nursing Care team Department of Health and Social Care 39 Victoria Street London SW1H 0EU

Published to gov.uk, in PDF format only.

www.gov.uk/dh

October 2018 (revised), published March 2018

The 2018 National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

The revised 2018 National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care. This guidance replaces the previous version of the National Framework, published in November 2012, and will be implemented on 1 October 2018. It includes Practice Guidance to support staff delivering NHS Continuing Healthcare. This revised 2018 National Framework follows an extensive period of external engagement with stakeholders, across the NHS, Local Authorities, and patient representative groups. The 2018 National Framework has been collaboratively written by the Department, NHS-England and Local Authorities.

In addition to the 2018 revision of the National Framework, there is also an update to the Practice Guidance and the annexes which accompany the Framework. The user notes for the Checklist, Decision Support Tool and Fast Track Pathway Tool have been updated, alongside some minor clarifications to the domain wordings and descriptors. The updated National Tools should be used from 1st October 2018 alongside the updated National Framework.

The 2018 National Framework is intended to:

1) provide greater clarity to individuals and staff, through a new structure and style

2) reflect legislative changes since the 2012 National Framework was published, primarily to reflect the implementation of the Care Act 2014,

3) clarify a number of policy areas, including:
    a) Setting out that the majority of NHS Continuing Healthcare assessments should take place outside of acute hospital settings. This will support accurate assessments of need and reduce unnecessary stays in hospital.
    b) Providing additional advice for staff on when individuals do and do not need to be screened for NHS Continuing Healthcare in order to reduce unnecessary assessment processes and respond to a call for greater clarity on this.
    c) Clarifying that the main purpose of three and 12 month reviews is to review the appropriateness of the care package, rather than reassess eligibility. This should reduce unnecessary re-assessments.
    d) Introducing new principles for CCGs regarding the local resolution process for situations where individuals request a review of an eligibility decision. The aim is to resolve such situations earlier and more consistently.
    e) Providing clearer guidance, including dedicated sections, on: the roles of CCGs and local authorities, NHS-funded Nursing Care, inter-agency disputes, well-managed needs, and the Fast Track Pathway Tool.

Importantly, none of the 2018 amendments and clarifications to the National Framework, Practice Guidance, annexes or National Tools are intended to change the eligibility criteria for NHS Continuing Healthcare.

All those involved in the delivery of NHS Continuing Healthcare should become familiar with the whole National Framework, Practice Guidance, annexes and National Tools and should align their practice accordingly.

Contents

Other pathways

Additional considerations

Practice Guidance

Annexes

Executive summary

1. This revised National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care.
2. This guidance replaces the previous version of the National Framework, published in November 2012 and will be implemented on 1 October 2018. It includes Practice Guidance to support staff delivering NHS Continuing Healthcare.
3. At the heart of the National Framework is the process for determining whether an individual is eligible for NHS Continuing Healthcare or NHS-funded Nursing Care.
4. An individual is eligible for NHS Continuing Healthcare if they have a 'primary health need'. This is a concept developed by the Secretary of State to assist in determining when the NHS is responsible for providing for all of the individual's assessed health and associated social care needs.
5. In order to determine whether an individual has a primary health need, a detailed assessment and decision-making process must be followed, as set out in this National Framework. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for commissioning a care package that meets the individual's health and associated social care needs.
6. This National Framework is underpinned by Standing Rules Regulations[1], issued under the National Health Service Act 2006[2]. These regulations, referred to henceforth as the Standing Rules, require Clinical Commissioning Groups (CCGs) to have regard to the National Framework.
7. This revised National Framework takes account of legislative changes brought about by the Care Act 2014[3], which preserves the existing boundary and limits of local authority responsibility in relation to the provision of nursing and/or healthcare.
8. The individual, the effect their needs have on them, and the ways in which they would prefer to be supported should be kept at the heart of the process. Access to assessment, care provision and support should be fair, consistent and free from discrimination.

[1] *The National Health Service Commissioning Board and Clinical Groups (Responsibilities and Standing Rules) Regulations 2012*

[2] *National Health Service Act 2006*

[3] *Section 22 of the Care Act 2014*

9. CCGs, the National Health Service Commissioning Board (referred to throughout this National Framework as NHS England) and local authorities have legal duties and responsibilities in relation to NHS Continuing Healthcare.
10. Those eligible for NHS Continuing Healthcare continue to be entitled to access the full range of primary, community, secondary and other health services.

Key Definitions

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a 'primary health need' as set out in this National Framework. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS Continuing Healthcare is not determined by the setting in which the package of support can be offered or by the type of service delivery.

NHS-funded Nursing Care is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS-funded Nursing Care has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS Continuing Healthcare before a decision is reached about the need for NHS-funded Nursing Care.

Primary Health Need is a concept developed by the Secretary of State for Health to assist in deciding when an individual's primary need is for healthcare (which it is appropriate for the NHS to provide under the 2006 Act) rather than social care (which the Local Authority may provide under the Care Act 2014). To determine whether an individual has a primary health need, there is an assessment process, which is detailed in this National Framework. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for providing for all of that individual's assessed health and associated social care needs, including accommodation, if that is part of the overall need.

Clinical Commissioning Group (CCG) is intended to include any person or body authorised by the CCG to exercise any of its functions on its behalf in relation to NHS Continuing Healthcare. Where a CCG delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework. The CCG cannot delegate its final decision-making function in relation to eligibility decisions, and remains legally responsible for all eligibility decisions made (in accordance with Standing Rules).

Introduction

11. This guidance is based on statutory responsibilities, case law, input from the Parliamentary and Health Service Ombudsman, and comments received from stakeholders. It sets out the process for the National Health Service (NHS), working together with its local authority partners wherever practicable, to assess health needs and to decide on eligibility for NHS Continuing Healthcare. It is to be read in conjunction with the national tools to support decision making: the Checklist tool, the Decision Support Tool (DST) and the Fast Track Pathway Tool. Separate notes are attached to the tools themselves to explain how they should be applied.

12. The audience for this National Framework is wide ranging. The primary purpose of this National Framework is to support practitioners across health and social care to undertake assessments and deliver NHS Continuing Healthcare and NHS-funded Nursing Care. The National Framework is also of interest to individuals and their representatives involved in the Continuing Healthcare process. A public information leaflet, entitled 'NHS Continuing Healthcare and NHS-funded Nursing Care' is available from the Gov.uk website[1].

13. NHS England, CCGs and local authorities must comply with their responsibilities, as set out in the Standing Rules and Care Act legislation[2], as appropriate, in relation to NHS Continuing Healthcare.

14. **CCGs** should consider how the principles and processes in this guidance relate to what is currently in place, and should align their processes accordingly. They should consider where their responsibilities under the National Framework require clearer arrangements to be made with provider and other relevant organisations, and should ensure that these are built into commissioning processes. NHS England should help facilitate these processes.

15. In addition there is a requirement for **NHS England** to have processes in place to respond to requests for independent reviews of NHS Continuing Healthcare eligibility decisions. Guidance on the operation of these review processes is set out in this National Framework.

16. **Local authorities** should consider this National Framework and review whether their current practice and processes fit with their responsibilities outlined within this National Framework. CCGs and local authorities should work together collaboratively when they review existing processes.

[1] NHS Continuing Healthcare website

[2] Department of Health and Social Care, *The Care and Support (Provision of Health Services) Regulations 2014*

17. **Provider organisations** should consider this National Framework and review whether their current practice and processes fit with any delegated responsibilities outlined within this National Framework.
18. **Individuals** who need ongoing care or support may require services arranged by CCGs and/or local authorities. CCGs and local authorities should ensure that the assessment of eligibility for care or support and its provision take place in a timely and consistent manner, in accordance with their respective statutory responsibilities.
19. If a person does not qualify for NHS Continuing Healthcare, the NHS may still have a responsibility to contribute to that individual's health needs – either by directly commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both a local authority and a CCG, this is known as a 'joint package of care'.

Leadership and governance

20. The roles and responsibilities of the different bodies involved in NHS Continuing Healthcare are set out below. However, NHS Continuing Healthcare is fundamentally a 'whole system' issue requiring leadership across and within statutory agencies in order to ensure that the needs of individuals who might have a primary health need are properly assessed and addressed. These individuals are, by definition, some of the most vulnerable in our society and it is vital that systems deliver a person-centred approach to the wide variety of situations that NHS Continuing Healthcare encompasses. Strong system leadership is therefore critical to the successful implementation of this National Framework.

Roles and responsibilities of CCGs

21. CCGs are responsible and accountable for system leadership for NHS Continuing Healthcare within their local health and social care economy (refer to paragraphs 40-41), including:

    a) ensuring delivery of, and compliance with, the National Framework for NHS Continuing Healthcare;

    b) promoting awareness of NHS Continuing Healthcare;

    c) establishing and maintaining governance arrangements for NHS Continuing Healthcare eligibility processes and commissioning NHS Continuing Healthcare packages.

    d) ensuring that assessment mechanisms are in place for NHS Continuing Healthcare across relevant care pathways, in partnership with the local authority as appropriate. The Standing Rules require CCGs to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for NHS Continuing Healthcare (the Care and support statutory guidance[1] should be used to identify the relevant social services authority).

    e) making decisions on eligibility for NHS Continuing Healthcare;

    f) identifying and acting on issues arising in the provision of NHS Continuing Healthcare;

    g) commissioning arrangements, both on a strategic and an individual basis;

[1] Department of Health and Social Care, Care and support statutory guidance

h) having a system in place to record assessments undertaken and their outcomes, and the costs of NHS Continuing Healthcare packages. It is important that any such system should clearly identify those receiving NHS Continuing Healthcare as a distinct group from those being supported via joint packages or any other funding routes;

i) implementing and maintaining good practice;

j) ensuring that quality standards are met and sustained;

k) nominating and making available suitably skilled professionals to be members of Independent review panels (in accordance with Standing Rules[1]);

l) ensuring training and development opportunities are available for practitioners, in partnership with the local authority; and

m) having clear arrangements in place with other NHS organisations (e.g. Foundation Trusts) and independent or voluntary sector partners to ensure effective operation of the National Framework.

Roles and responsibilities of NHS England

22. NHS England's functions include providing strategic leadership and organisational and workforce development, and ensuring that local systems operate effectively and deliver improved performance. NHS England holds CCGs accountable and therefore engages with them to ensure that they discharge their functions. In carrying out this role, NHS England should be aware of the range of responsibilities that CCGs hold in relation to NHS Continuing Healthcare, as detailed in paragraph 21 above.

23. NHS England is also responsible for appointing persons to act as chairs of independent review panels (IRPs) and establishing a list of IRP members drawn from local authorities and CCGs, in accordance with Standing Rules.

24. In some limited circumstances, NHS England may also have commissioning responsibility for some individuals who are either prisoners, or serving military personnel and their families. Where NHS England does have such responsibility, this National Framework will apply. Where a CCG is referred to throughout the National Framework, the responsibilities will also apply to NHS England in these limited circumstances.

Roles and responsibilities of the local authority

25. Where it appears that a person may be eligible for NHS Continuing Healthcare, the local authority must refer the individual to the relevant CCG.

26. There are specific requirements for local authorities to cooperate and work in partnership with CCGs in a number of key areas.

27. Local authorities must, as far as is reasonably practicable, provide advice and assistance when consulted by the CCG in relation to an assessment of eligibility for NHS Continuing Healthcare. This duty applies regardless of whether an assessment of needs for care and support under section 9 of the Care Act 2014 is required (refer to paragraphs 124-130). Where the local authority has carried out such an assessment of needs it must (as far as it is relevant) use information from this assessment to assist the CCG in carrying out its responsibilities (refer to paragraph 21).

28. A local authority must, when requested to do so by the CCG, co-operate with the CCG in arranging for a person or persons to participate in a multidisciplinary team. Local authorities should:

    - respond within a reasonable timeframe when consulted by a CCG prior to an eligibility decision being made (refer to paragraph 21)

    - respond within a reasonable timeframe to requests for information when the CCG has received a referral for NHS Continuing Healthcare.

29. It is also good practice for local authorities to work jointly with CCGs in the planning and commissioning of care or support for individuals found eligible for NHS Continuing Healthcare wherever appropriate, sharing expertise and local knowledge (whilst recognising that CCGs retain formal commissioning and care planning responsibility for those eligible for NHS Continuing Healthcare).

30. Regulations[1] state that local authorities must nominate individuals to be appointed as local authority members of independent review panels where requested to do so by NHS England. This duty includes both nominating such individuals as soon as is reasonably practicable and ensuring that they are, so far as is reasonably practicable, available to participate in independent review panels.

Involvement of provider organisations

31. Provider organisations should consider their general duty of care to individuals, any Care Quality Commission requirements, and any contractual obligations in relation to NHS Continuing Healthcare. In particular they should ensure that individuals who may require a full assessment of eligibility are referred to the CCG, and that accurate records regarding the needs of individuals are made available, as

[1] Department of Health and Social Care, *Regulation 3(5) of the Care and Support (Provision of Health Services) Regulations 2014*

appropriate, in the assessment and review process.

Information available for members of the public about NHS Continuing Healthcare

32. Further information for the public on NHS Continuing Healthcare is available on the Gov.uk website. CCGs should make the Public Information leaflet available to members of the public, for example through local NHS websites, hard copies on hospital wards, through primary care outlets, local care homes and local voluntary sector organisations. Any individual being considered for NHS Continuing Healthcare at the screening or referral stage should be given a copy of the leaflet along with any relevant local information about processes and contact details and arrangements.

Legal context

33. Many people have ongoing care needs as a result of disability, accident or illness. Individuals requiring ongoing support to meet such needs might receive this from a range of sources including from friends and family, from their local authority or from the NHS.

34. Where adults receive care and support from local authorities they normally do so under the provisions of the Care Act 2014, subject to them meeting national eligibility criteria for care and support and usually subject to means testing, which may require them to make a financial contribution towards the cost or to meet the full cost themselves.

35. Where individuals receive care, treatment or support from the NHS this is normally under the provisions of the National Health Service Act 2006, referred to from this point onwards as the NHS Act. This support is provided free at the point of delivery to the individual.

36. These two distinct but overlapping legislative schemes work in parallel to create a system for care, support and treatment for adults in need.

37. Some individuals' nursing or healthcare needs are such that the local authority is not permitted to meet their ongoing care and support needs, and instead they become fully the responsibility of the NHS. These are individuals who have been assessed as having a 'primary health need' through the processes set out in this National Framework and who are eligible for NHS Continuing Healthcare. The limits of local authority provision and the concept of 'primary health need' arise from the interaction between duties and limitations placed on local authorities under the Care Act 2014 and the duties placed on CCGs and NHS England under the NHS Act.

Key legislation

38. Section 1 of the NHS Act requires the Secretary of State to continue the promotion in England of a comprehensive health service, designed to secure improvement in:

    a) the physical and mental health of the people of England; and

    b) the prevention, diagnosis and treatment of illness.

39. Section 1H of the NHS Act established the NHS Commissioning Board, known as NHS England, which is also subject to the duty outlined above to promote a comprehensive health service. Under the NHS Act, NHS England is responsible for ensuring that the NHS delivers better outcomes for patients within its available resources by supporting, developing and performance-managing an effective system of CCGs. In addition, NHS England has responsibility for commissioning

services that can only be provided efficiently and effectively at a national or a regional level.

40. Section 3 of the NHS Act requires CCGs to arrange for the provision of the following to the extent that they consider necessary to meet the reasonable requirements of the persons for whom it has responsibility:

    (a) hospital accommodation,

    (b) other accommodation for the purpose of any service provided under this Act,

    (c) medical, dental, ophthalmic, nursing and ambulance services,

    (d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the group considers are appropriate as part of the health service,

    (e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service,

    (f) such other services or facilities as are required for the diagnosis and treatment of illness.

41. CCGs must exercise these functions consistently with the duty to promote a comprehensive health service. NHS Continuing Healthcare is provided as part of these functions, and the majority of the CCG's legal responsibilities in this regard are set out in the Standing Rules, in particular in regulations 21 and 22. Regulation 21(12) of the Standing Rules requires CCGs to have regard to this National Framework.

42. Under section 9 of the Care Act 2014, each local authority is under a duty to assess any person who it appears may be in need of care and support. Where a local authority is satisfied, on the basis of their assessment, that the adult has needs for care and support, it must then determine whether any of these needs meet the Care Act 2014 national eligibility criteria[1]. If not, the local authority may still have the power to meet them. If the local authority is required to meet needs or decides to meet them, the local authority must consider how it will do so. The Care Act 2014 replaces previous local authority duties to provide particular services with a duty to meet eligible needs.

43. Section 22 of the Care Act 2014 places a limit on the care and support that can lawfully be provided to individuals by local authorities. That limit is set out in section 22(1) and is as follows:

    'A local authority may not meet needs under sections 18 to 20 by providing or arranging for the provision of a service or facility that is required to be provided under the National Health Service Act 2006 unless-

[1] Department of Health and Social Care, *Regulation 2 and 3 of the Care and Support (Eligibility Criteria) Regulations 2015*

(a) doing so would be merely incidental or ancillary to doing something else to meet needs under those sections, and

(b) the service or facility in question would be of a nature that the local authority could be expected to provide'.

44. The limit on social care pre-existed the Care Act 2014 and was considered and clarified in 1999 by the Court of Appeal in the Coughlan judgment (refer to Annex B). This judgment considered the responsibilities of health authorities and local authorities for social service provision, in particular the limits on the provision of nursing care (in a broad sense, i.e. not just registered nursing care) by local authorities. The principles from this judgment therefore inform section 22 of the Care Act 2014.

45. Section 22(3) of the Care Act 2014 provides a further limit of the care and support that can be provided by a local authority. This section prohibits local authorities from providing, or arranging for the provision of, nursing care by a registered nurse.

46. When carrying out a needs assessment under section 9 of the Care Act 2014, where it appears that a person may be eligible for NHS Continuing Healthcare the local authority must refer the individual to the relevant CCG (regulation 7 of the Care and Support (Assessment) Regulations 2014). The CCG then has a duty to take reasonable steps to ensure an assessment of eligibility is carried out where it appears there may be a need for such care (regulation 21(2) of the Standing Rules[1]).

47. Also, if in the course of undertaking a needs assessment (under the Care Act 2014) the local authority identifies needs which might be met by other agencies (e.g. Housing or the NHS) it should make the necessary referrals to these other agencies.

48. If an NHS body is assessing a person's needs (whether or not potential eligibility for NHS Continuing Healthcare has been identified) and the assessment indicates a potential need for care and support that may fall within a local authority's responsibilities, it should notify the local authority of this in order for the local authority to then fulfil its responsibilities.

Health need and social care need

49. Some needs are clearly health needs and some needs are clearly social care needs; and some needs may be either or both. The difference between health needs and social care needs emerging from the legal principles outlined above are set out below.

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

51. Similarly, there is not a legal definition of the term 'social care need' in the context of NHS Continuing Healthcare. However, the Care Act 2014 introduced National Eligibility Criteria for care and support to determine when an individual or their carer has eligible needs which the local authority must address, subject to means where appropriate. These criteria set out that an individual has eligible needs under the Care Act 2014 where these needs arise from (or relate to) a physical or mental impairment or illness which results in them being unable to achieve two or more of the following outcomes which is, or is likely to have, a significant impact on their wellbeing:

    - managing and maintaining nutrition;
    - maintaining personal hygiene;
    - managing toilet needs;
    - being appropriately clothed;
    - being able to make use of the home safely;
    - maintaining a habitable home environment;
    - developing and maintaining family or other personal relationships;
    - accessing and engaging in work, training, education or volunteering;
    - making use of necessary facilities or services in the local community, including public transport and recreational facilities or services; and
    - carrying out any caring responsibilities the adult has for a child.

52. In the context of NHS Continuing Healthcare, therefore, a 'social care need' can be taken to relate to the Care Act 2014 eligibility criteria outlined above.

Other legislation

53. There is a range of other legislation which may well be relevant to individuals who are being assessed in relation to NHS Continuing Healthcare, such as the Mental Health Act 1983[1] and the Mental Capacity Act 2005[2]. References are made to other key legislation at appropriate points within this National Framework and statutory bodies will need to consider the broader legislative context when assessing and addressing needs relating to NHS Continuing Healthcare.

[1] *Mental Health Act 1983*

[2] *Mental Capacity Act 2005*

Primary health need

54. To assist in determining which health services it is appropriate for the NHS to provide under the NHS Act, and to distinguish between those and the services that local authorities may provide under the Care Act 2014, the Secretary of State has developed the concept of a 'primary health need'. Where a person has been assessed to have a primary health need, they are eligible for NHS Continuing Healthcare and the NHS will be responsible for providing for all of that individual's assessed health and associated social care needs, including accommodation, if that is part of the overall need. Determining whether an individual has a primary health need involves looking at the totality of the relevant needs. In order to determine whether an individual has a primary health need, an assessment of eligibility process must be undertaken by a multidisciplinary team (MDT) (refer to paragraphs 119-123) which must use the national Decision Support Tool (DST) (refer to paragraphs 131-141).

55. An individual has a primary health need if, having taken account of all their needs (following completion of the Decision Support Tool), it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs. Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality.

56. Each individual case has to be considered on its own facts in accordance with the principles outlined in this National Framework.

57. There should be no gap in the provision of care. People should not find themselves in a situation where neither the NHS nor the relevant local authority (subject to the person's means and the person having needs that fall within the eligibility criteria for care and support[8]) will fund care, either separately or together.

58. Therefore, the 'primary health need' test should be applied, so that a decision of ineligibility for NHS Continuing Healthcare is only possible where, taken as a whole, the nursing or other health services required by the individual:

    a) are no more than incidental or ancillary to the provision of accommodation which local authority social services are, or would be but for a person's means, under a duty to provide; and

    b) are not of a nature beyond which a local authority whose primary responsibility it is to provide social services could be expected to provide.

59. In applying the primary health need test as set out above CCGs should take into account that section 22(1) of the Care Act 2014, in setting out the limits of Local Authority responsibilities, applies the 'incidental and ancillary' test in all situations,

including where care is being provided in the person's own home. As there should be no gap in the provision of care, CCGs should consider this test when determining eligibility. Eligibility is the same for all individuals, whether their needs are being met in their own home or in care home accommodation. Certain characteristics of need – and their impact on the care required to manage them – may help determine whether the 'quality' or 'quantity' of care required is more than the limits of a local authority's responsibilities, as set out in section 22(1) of the Care Act 2014:

- **Nature**: This describes the particular characteristics of an individual's 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 both to the extent ('quantity') and severity ('degree') of the needs and to 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 required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction 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 where a physical health need results in the individual developing a mental health need.

- **Unpredictability**: This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. An individual with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

60. Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is 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 (refer to paragraphs 131-141).

61. It may be helpful for practitioners to think about these characteristics in terms of the sorts of questions that each generates. Examples of the type of question that might be relevant are given in Practice Guidance note 3 in this National Framework. Answering such questions may help practitioners describe and understand how each characteristic relates to the needs of the individual in question.

62. Eligibility for NHS Continuing Healthcare is a decision to be taken by the relevant CCG, based on an individual's assessed needs. The diagnosis of a particular

disease or condition is not in itself a determinant of eligibility for NHS Continuing Healthcare.

63. NHS Continuing Healthcare may be provided in any setting (including, but not limited to, a care home, hospice or the person's own home). Eligibility for NHS Continuing Healthcare is, therefore, not determined or influenced either by the setting where the care is provided or by the characteristics of the person who delivers the care. The decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs (refer to paragraphs 142-146). Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on NHS Continuing Healthcare eligibility.

64. Financial issues should not be considered as part of the decision on an individual's eligibility for NHS Continuing Healthcare.

65. In summary, the reasons given for a decision on eligibility should not be based on the:

- individual's diagnosis;
- setting of care;
- ability of the care provider to manage care;
- use (or not) of NHS-employed staff to provide care;
- need for/presence of 'specialist staff ' in care delivery;
- the fact that a need is well-managed;
- the existence of other NHS-funded care; or
- any other input-related (rather than needs-related) rationale.

66. Eligibility for NHS Continuing Healthcare is not indefinite, as needs could change. This should be made clear to the individual and/or their representatives.

Core values and principles

67. Individuals being assessed for NHS Continuing Healthcare are frequently facing significant changes in their life and therefore a positive experience of the assessment process is crucial. The process of assessment of eligibility and decision-making should be person-centred. This means placing the individual at the heart of the assessment and care-planning process.

68. There are many elements to a person-centred approach, including:

    a) ensuring that the individual and/or their representative is fully and directly involved in the assessment process;

    b) taking full account of the individual's own views and wishes, ensuring that their perspective is incorporated in the assessment process;

    c) addressing communication and language needs;

    d) obtaining consent to assessment and sharing of records (where the individual has mental capacity to give this);

    e) dealing openly with issues of risk; and

    f) keeping the individual (and/or their representative) fully informed.

    These are explained in the Practice Guidance note 4.

69. 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). CCGs and partner organisations are responsible for ensuring that discrimination does not occur and should use effective auditing to monitor this.

70. Assessments of eligibility for NHS Continuing Healthcare and NHS-funded Nursing Care should be organised so that the individual being assessed and their representative[1] understand the process and receive advice and information that will maximise their ability to participate in the process in an informed way. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike (refer to paragraphs 100, 159-161).

71. When commissioning the care package, the individual's wishes and expectations of how and where the care is delivered should be documented and taken into

[1]In this National Framework the term **representative** is intended to include any friend, unpaid carer or family member who is supporting the individual in the process as well as anyone acting in a more formal capacity (e.g. welfare deputy or power of attorney, or an organisation representing the individual).

account, along with the risks of different types of provision and fairness of access to resources. This may include the option of a Personal Health Budget (PHB). More information on commissioning and PHBs can be found in paragraphs 296-300.

Consent

72. While health and social care professionals can rely on a lawful basis other than consent to lawfully process personal data, consent is required to satisfy the common law duty of confidentiality. Where the individual concerned has capacity, their informed consent should be obtained before the start of the process to determine eligibility for NHS Continuing Healthcare. This consent will need to encompass permission to undertake the NHS Continuing Healthcare 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 NHS Continuing Healthcare and, where appropriate, for audit and monitoring of decisions). For consent to be valid for these purposes it must be:

    - **Explicit.** Consent must be expressly confirmed and recorded in writing, in a very clear and specific statement of consent, which is prominent and kept separate from other information.
    - **Specific.** It should be made clear to the individual what they are being asked to consent to (e.g. just to having a Checklist completed or to the full assessment of eligibility process as well, if their Checklist is positive) and whether their information will be obtained and shared for a specific aspect of the eligibility consideration process or for the full process. Also it needs to be explained that, subject to their consent, their personal information will be shared between different organisations involved in their care in order to complete the assessment of eligibility for NHS Continuing Healthcare.
    - **Informed**. The individual should be informed about what the NHS Continuing Healthcare eligibility assessment process involves, what information will be obtained, and who it will be shared with before the start of the process to determine eligibility for NHS Continuing Healthcare.
    - **Freely given.** This means consent must be given voluntarily by an appropriately informed person who has both the capacity and authority to consent to the intervention in question. It also means giving people genuine ongoing choice and control over how their personal information is used and shared. In the context of NHS Continuing Healthcare this means that the individual must have the capacity to consent freely and voluntarily to the NHS Continuing Healthcare eligibility assessment process as set out in this Framework. The individual should have a choice about whether or not to consent, and consent must not be conditional on the individual agreeing to something that is not related to the NHS Continuing Healthcare eligibility assessment process.

- **Can be withdrawn**. 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 NHS Continuing Healthcare eligibility assessment.

73. If an individual with capacity does not consent to being assessed for NHS Continuing Healthcare or to sharing information which is essential for carrying out this assessment, the potential consequences of this should be carefully explained. This might affect the ability of the NHS and the local authority to provide appropriate services to them. The fact that an individual declines to be assessed for NHS Continuing Healthcare does not, in itself, mean that a local authority has an additional responsibility to meet their needs, over and above the responsibility it would have had if they had been assessed for NHS Continuing Healthcare. Where there are concerns that an individual may have significant ongoing needs, and that the level of appropriate support could be affected by their decision to decline the assessment, or to withhold consent to sharing essential information, the appropriate way forward should be considered jointly by the CCG and the local authority, taking account of each organisation's legal powers and duties. It may be appropriate for the organisations involved to seek legal advice (refer to Practice Guidance note 5 and 6 for more information).

Capacity

74. If there is a concern that the individual may not have capacity to give consent to the assessment process or the sharing of information, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice[1]. CCGs should be particularly aware of the five principles of the Act:

- A person individual must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- 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 his best interests.
- 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.

75. It is important to be aware that just because an individual may have difficulty in expressing their views or understanding some information, this does not in itself mean that they lack capacity to make the decision in question. Appropriate support and adjustments, for example, using alternative methods of communication, should be made available to the person in compliance with the Mental Capacity Act 2005[2], and with disability discrimination legislation[3].

76. CCGs and local authorities should ensure that all staff involved in NHS Continuing Healthcare assessments are appropriately trained in Mental Capacity Act 2005 principles and responsibilities. Where the assessor is not familiar with Mental Capacity Act principles and the person appears to lack capacity the assessor should consult their employing organisation and ensure that appropriate actions are identified (refer to Practice Guidance note 7-10 for more information).

[1] Capacity Act Code of Practice

[2] Section 1(3) and Section 3(2) Mental Capacity Act 2005

[3] Equality Act 2010

Best interest decisions

77. If the person lacks the mental capacity to either give or refuse consent to the assessment process or the sharing of information, a decision must be made in the person's 'best interests' as to whether to proceed with the assessment and sharing of information. The best interests decision should be recorded. The person leading the assessment is responsible for making this decision and should bear in mind the expectation that everyone who is potentially eligible for NHS Continuing Healthcare should have the opportunity to be considered for eligibility. A third party cannot give or refuse consent for an assessment of eligibility for NHS Continuing Healthcare, or for sharing information, on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (Health and Welfare)[1] or they have been appointed as a Deputy (Health and Welfare) by the Court of Protection.

78. If someone states that they have such authority the assessor should request sight of a certified copy of the original Deputyship Order or registered Lasting Power of Attorney and check the wording of the order to confirm that the person does have the relevant authority stated.

79. Where a 'best interests' decision needs to be made, the 'decision-maker' must take into account[2] the views of any relevant third party who has a genuine interest in the individual's welfare (if it is reasonable and practicable to consult them). This will normally include family and friends. The decision-maker should be mindful of the need to respect confidentiality and should not share personal information with third parties unless it is considered in the best interests of the individual for the purposes of the NHS Continuing Healthcare assessment of eligibility. Where the individual has made an 'advanced statement' to the effect that they do not want personal information shared with specific individuals, this should be taken into account in assessing the individual's best interests.

80. Although the decision-maker must take account of the views of relevant third parties, those consulted (including family members) do not have the authority to consent to or refuse consent to the actions proposed as a result of the best interests process. The responsibility for the decision rests with the decision maker, not with those consulted. Where there is a difference of opinion between the decision-maker and those consulted, every effort should be made to resolve this informally. However, this process should not unduly delay timely decisions being made in the person's best interests.

81. An individual's capacity to make decisions may fluctuate, and there may be circumstances where an individual presents with a temporary loss of decision-making capacity. In these circumstances a decision needs to be made as to

[1] *Lasting power of attorney: acting as an attorney*

[2] Section 4(7) Mental Capacity Act 2005

whether it would be in the person's best interests to delay seeking consent until capacity is regained. If this is the case, the best interests decision to be made may also include whether to provide an interim care or support package.

Screening for NHS Continuing Healthcare using the Checklist tool

What is the Checklist tool and why is it used?

82. The Checklist is the NHS Continuing Healthcare screening tool which can be used in a variety of settings to help practitioners identify individuals who may need a full assessment of eligibility for NHS Continuing Healthcare. It is essential that the appropriate consent is sought prior to commencing this process (refer to paragraphs 72-73).

83. The Standing Rules[1] require a CCG to take reasonable steps to ensure that individuals are assessed for NHS Continuing Healthcare in all cases where it appears that there may be a need for such care. These regulations also state that 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[2].The purpose of the Checklist is to encourage proportionate assessments of eligibility so that resources are directed towards those people who are most likely to be eligible for NHS Continuing Healthcare, and to ensure that a rationale is provided for all decisions regarding eligibility.

84. The Checklist has 11 care domains broken down into three levels: A, B or C (where A represents a high level of care need, and C is a low level of care need). The outcome of the Checklist depends on the number of As, Bs, and Cs identified.

85. The Checklist threshold at this stage of the process has intentionally been set low, in order to ensure that all those who require a full assessment of eligibility have this opportunity. There may, very occasionally, be exceptional circumstances where a full assessment of eligibility for NHS Continuing Healthcare is appropriate even though the individual does not apparently meet the indicated threshold.

86. Completion of the Checklist is intended to be relatively quick and straightforward. It is not necessary to provide detailed evidence along with the completed Checklist (refer to paragraphs 97-99).

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[1] *Section 21(2), The National Health Service Commissioning Board and Clinical Groups (Responsibilities and Standing Rules) Regulations 2012*

[2] *Section 21(4), The National Health Service Commissioning Board and Clinical Groups (Responsibilities and Standing Rules) Regulations 2012*

87. There are two potential outcomes following completion of the Checklist:

    - a **negative** Checklist, meaning the individual does not require a full assessment of eligibility, and they are not eligible for NHS Continuing Healthcare; or

    - a **positive** Checklist meaning an individual now requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean the individual is eligible for NHS Continuing Healthcare.

When should a Checklist be completed?

88. Where there may be a need for NHS Continuing Healthcare, a Checklist should normally be completed.

89. Screening for NHS Continuing Healthcare should be at the right time and location for the individual and when the individual's ongoing needs are known. This will help practitioners to correctly identify individuals who require a full assessment of eligibility for NHS Continuing Healthcare.

90. Local health and social care joint processes should be in place to identify individuals for whom it may be appropriate to complete a Checklist, including for individuals in community settings. Wherever an individual requires a long-term care home placement with nursing or has significant support needs, a Checklist would be expected to be completed (unless the decision is made to go straight to the completion of a Decision Support Tool).

91. There will be many situations where it is not necessary to complete a Checklist. These include where:

    - It is clear to practitioners working in the health and care system that there is no need for NHS Continuing Healthcare at this point in time. Where appropriate/relevant this decision and its reasons should be recorded. If there is doubt between practitioners a Checklist should be undertaken.

    - The individual has short-term health care needs or is recovering from a temporary condition and has not yet reached their optimum potential (if there is doubt between practitioners about the short-term nature of the needs it may be necessary to complete a Checklist). See paragraphs 109-117 for how NHS Continuing Healthcare may interact with hospital discharge.

    - It has been agreed by the CCG that the individual should be referred directly for full assessment of eligibility for NHS Continuing Healthcare.

    - The individual has a rapidly deteriorating condition and may be entering a terminal phase – in these situations the Fast Track Pathway Tool should be used instead of the Checklist.

- An individual is receiving services under Section 117 of the Mental Health Act that are meeting all of their assessed needs.
- It has previously been decided that the individual is not eligible for NHS Continuing Healthcare and it is clear that there has been no change in needs.

Who can complete the Checklist Tool?

92. The Checklist 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 local authority staff such as social workers, care managers or social care assistants (refer to Practice Guidance note 13).
93. It is for each CCG and local authority to identify and agree who can complete the tool but it is expected that it should, as far as possible, include staff involved in assessing or reviewing individuals' needs as part of their day-to-day work.

The role of the individual in the screening process

94. The individual should be given reasonable notice of the intention to undertake the Checklist, and should normally be given the opportunity to be present at the completion of the Checklist, together with any representative they may have.
95. Before the Checklist is completed, it is necessary to ensure that the individual and (where appropriate) their representative understand that the Checklist does not indicate that the individual will be eligible for NHS Continuing Healthcare – only that they are entitled to be assessed for eligibility.
96. An individual cannot self-refer for NHS Continuing Healthcare by completing a Checklist themselves. The individual can request a Checklist from their CCG, for further details see Practice Guidance note 14.

How should the Checklist be completed?

97. The Checklist requires practitioners to record a brief description of the need and source of evidence used to support the statements selected in each domain. This could, for example, be by indicating that specific evidence for a given domain was contained within the inpatient nursing notes on a stated date. This will enable evidence to be readily obtained for the purposes of the MDT if the person requires a full assessment of eligibility for NHS Continuing Healthcare.

98. The principles in relation to 'well-managed need' (outlined in the Assessment of Eligibility section of this National Framework) apply equally to the completion of the Checklist as they do to the Decision Support Tool.

99. A link to the Checklist tool can be found on the NHS Continuing Healthcare website. Practitioners should refer to the Checklist User Notes for more detail on how it should be completed.

What happens after the Checklist?

100. Whatever the outcome of the Checklist – whether or not a referral for a full assessment of eligibility for NHS Continuing Healthcare is considered necessary – the outcome must be communicated clearly and in writing to the individual or their representative, as soon as is reasonably practicable. This should include the reasons why the Checklist outcome was reached. Normally this will be achieved by providing a copy of the Checklist.

What happens following a negative Checklist?

101. A negative Checklist means the individual does not require a full assessment of eligibility and they are not eligible for NHS Continuing Healthcare.

102. If an individual has been screened out following completion of the Checklist, they may ask the CCG to reconsider the Checklist outcome. The CCG should give this request due consideration, taking account of all the information available, and/or including additional information from the individual or carer, though there is no obligation for the CCG to undertake a further Checklist.

103. A clear and written response should be given including the individual's (and, where appropriate, their representative's) rights under the NHS complaints procedure if they remain dissatisfied with the position.

What happens following a positive Checklist?

104. A positive Checklist means that the individual requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean the individual is eligible for NHS Continuing Healthcare.

105. An individual should not be left without appropriate support while they await the outcome of the assessment and decision-making process. A person only becomes eligible for NHS Continuing Healthcare once a decision on eligibility has been made by the CCG. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is

an urgent need for adjustment. If, at the time of referral for an NHS Continuing Healthcare assessment, the individual is already receiving an ongoing care package (however funded) then those arrangements should continue until the CCG makes its decision on eligibility for NHS Continuing Healthcare, subject to any urgent adjustments needed to meet the changed needs of the individual. In considering such adjustments, local authorities and CCGs should have regard to the limitations of their statutory powers. For details on how refunding arrangements might apply in such situations please refer to annex E.

106. Where the Checklist has been used as part of the process of discharge from an acute hospital and has indicated a need for full assessment of eligibility, a decision may be made at this stage first to provide other services and then to carry out a full assessment of eligibility at a later stage. This should be recorded. The relevant CCG should ensure that full assessment of eligibility is carried out once it is possible to make a reasonable judgement about the individual's ongoing needs. This should be completed in the most appropriate setting – whether another NHS setting, the individual's home or some other care setting. In the interim, the relevant CCG retains responsibility for funding appropriate care. For further information on how NHS Continuing Healthcare interacts with hospital discharge please see paragraphs 109-117.

107. Once an individual has been referred for a full assessment of eligibility for NHS Continuing Healthcare then, irrespective of the individual's setting, the CCG has responsibility for coordinating the process until the decision on funding has been made. The CCG should identify an individual (or individuals) to carry out this coordination role, which is pivotal to the effective management of the assessment and decision-making process. By mutual agreement, the coordinator may either be a CCG member of staff or be from an external organisation.

When and where to screen and assess eligibility for NHS Continuing Healthcare

108. Screening and assessment of eligibility for NHS Continuing Healthcare should be at the right time and location for the individual and when the individual's ongoing needs are known. The full assessment of eligibility should normally take place when the individual is in a community setting. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and ongoing needs.

Understanding how NHS Continuing Healthcare interacts with Hospital Discharge

109. In the majority of cases, it is preferable for eligibility for NHS Continuing Healthcare to be considered after discharge from hospital when the person's ongoing needs should be clearer. The aim in most cases will be for the individual to return to the place from which they were admitted to hospital, preferably their own home. It should always be borne in mind that an assessment of eligibility for NHS Continuing Healthcare 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.

110. CCGs should ensure that local protocols are developed between themselves, other NHS bodies, local authorities and other relevant partners. These should set out each organisation's role and how responsibilities are to be exercised in relation to hospital discharge, including intermediate or interim arrangements for step down or sub-acute care. In particular, CCGs should ensure (i.e. through contractual arrangements) that discharge policies with providers who are not NHS Trusts are clear. Where appropriate, the CCG may wish to make provisions in its contract with the provider. There should be processes in place to identify those individuals for whom it is appropriate to undertake a screening for NHS Continuing Healthcare using the Checklist and, where the Checklist is positive, for full assessment of eligibility to be undertaken at the appropriate time and place.

111. 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 NHS Continuing Healthcare should not be allowed to delay hospital discharge.

112. In order to ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is

appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few weeks or months. It might also include intermediate care or an interim package of support, preferably in an individual's own home. In such situations, assessment of eligibility for NHS Continuing Healthcare, if still required, should be undertaken when an accurate assessment of ongoing needs can be made. The interim services should continue until it has been decided whether or not the individual has a need for NHS Continuing Healthcare (refer to paragraph 114). There must be no gap in the provision of appropriate support to meet the individual's needs.

113. Where an NHS body is considering issuing an Assessment Notice to a local authority under the provisions of the Care & Support (Discharge of Hospital Patients) Regulations 2014[1], the responsible NHS body is required to consider whether or not to provide the individual with NHS Continuing Healthcare before issuing such a notice. This does not necessarily mean a Checklist needs to be completed if it is clear to the professionals involved that there is no need for NHS Continuing Healthcare (refer to paragraph 91).

114. CCGs and their partner organisations should ensure appropriate processes and pathways exist for individuals who may have a need for NHS Continuing Healthcare, for example:

a) rather than completing a Checklist in hospital a decision is made to provide interim NHS-funded services to support the individual after discharge. In such a case, before the interim NHS-funded services come to an end, screening, if required, for NHS Continuing Healthcare should take place through use of the Checklist and, where appropriate, the full MDT process using the DST (i.e. an assessment of eligibility); or

b) a 'negative' Checklist is completed in an acute hospital (i.e. the person does not have a need for NHS Continuing Healthcare) in which case, where appropriate, an Assessment Notice may be issued to the local authority; or

c) a 'positive' Checklist is completed in an acute hospital and interim NHS-funded services are put in place to support the individual after discharge until it is either determined that they no longer require a full assessment (because a further Checklist has been completed which is now negative) or a full assessment of eligibility for NHS Continuing Healthcare is completed; or

d) a 'positive' Checklist is completed in acute hospital and (exceptionally and for clear reasons) a full assessment of eligibility for NHS Continuing Healthcare takes place before discharge. In a small number of circumstances it may be decided to go directly to a full assessment within the acute hospital, without the need for a Checklist. If the full assessment

[1] Department of Health and Social Care, *The Care & Support (Discharge of Hospital Patients) Regulations 2014*

does not result in eligibility for NHS Continuing Healthcare then, where appropriate, an Assessment Notice may be issued to the local authority; or,

e) where the individual has an existing package or placement which all relevant parties agree can still safely and appropriately meet their needs without any changes, then they should be discharged back to this placement and/or package under existing funding arrangements. In such circumstances any screening for NHS Continuing Healthcare, if required, should take place within six weeks of the individual returning to the place from which they were admitted to hospital. If this screening results in a full assessment of eligibility and the individual is found eligible for NHS Continuing Healthcare through this particular assessment, then re-imbursement will apply back to the date of discharge.

115. CCGs are reminded that if an individual's needs reduce in a short time frame between a positive Checklist and a full assessment of eligibility taking place, it is legitimate to undertake a second Checklist, rather than necessarily proceeding to full assessment of eligibility for NHS Continuing Healthcare. The individual should be kept fully informed of the changed position.

Intermediate care and NHS Continuing Healthcare

116. Intermediate care is a programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live independently. Intermediate care is aimed at individuals who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute or longer-term in-patient care or long-term residential care. It should form part of a pathway of support. For example, intermediate care may be appropriately used where an individual has received other residential rehabilitation support following a hospital admission and, although having improved, continues to need support for a period prior to returning to their own home. It should also be used where an individual is at risk of entering a care home and requires their needs to be assessed in a non-acute setting with rehabilitation support provided where needed. This is irrespective of current or potential future funding streams.

117. Individuals should not be transferred directly to a long-term residential care setting from an acute hospital ward unless it is clearly appropriate under the circumstances. These circumstances might include:

a) where the individual has an existing placement that can continue to meet their needs;

b) where the individual has already completed a period of specialist rehabilitation, such as in a stroke unit, and where long-term residential care is their preferred option;

c) where the individual has had previous failed attempts at being supported at home (with or without intermediate care support); or

d) those for whom the professional judgement is that a period in residential intermediate care followed by another move is likely to be unduly distressing for that individual.

Assessment of eligibility for NHS Continuing Healthcare using the Decision Support Tool

118. Once an individual has been referred for a full assessment of eligibility for NHS Continuing Healthcare (following use of the Checklist or, if a Checklist is not used in an individual case, following direct referral for full consideration), then, a multidisciplinary team must assess whether the individual has a primary health need using the Decision Support Tool.

The Multidisciplinary Team (MDT)

119. The core purpose of the MDT is to make a recommendation on eligibility for NHS Continuing Healthcare drawing on the multidisciplinary assessment of needs and following the processes set out in this National Framework.

120. In accordance with regulations an MDT in this context means a team consisting of at least:

- two professionals who are from different healthcare professions, or
- one professional who is from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014.

121. Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs and, where possible, have recently been involved in the assessment, treatment or care of the individual. Standing Rules[1] require that, as far as is reasonably practicable, the CCG must consult with the relevant local authority before making any decision about an individual's eligibility for NHS Continuing Healthcare and in doing so cooperate with that local authority in arranging for such persons to participate in an MDT for that purpose. CCGs may use a number of approaches (e.g. face-to-face, video/tele conferencing etc.) to arranging these MDT assessments in order to ensure active participation of all members as far as is possible.

122. If a local authority is consulted, there is a requirement for it to provide advice and assistance to the CCG, as far as is reasonably practicable. A local authority must, when requested to do so by a CCG, co-operate with the CCG in arranging for persons to participate in an MDT. The involvement of local authority colleagues as well as health professionals in the assessment process should streamline the

process of care planning and will make decision-making more effective and consistent. As with any assessments that they carry out, local authorities should not allow an individual's financial circumstances to affect its participation in a joint assessment.

123. The MDT works together to collate and review the relevant information on the individual's health and social care needs. The MDT uses this information to help clarify individual needs through the completion of the DST, and then works collectively to make a professional judgement about eligibility for NHS Continuing Healthcare, which will be reflected in its recommendation. This process is known as a multidisciplinary assessment of eligibility for NHS Continuing Healthcare.

Identifying an individual's needs

124. 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 multidisciplinary 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 NHS Continuing Healthcare. The individual and (where appropriate) their representative should be enabled to play a central role in the assessment process.

125. It is important that the individual's own view of their needs, including any supporting evidence, is given appropriate weight alongside professional views. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion naturally progresses, rather than working through an assessment document in a linear fashion.

126. It is important that those contributing to this process have the relevant skills and knowledge. It is best practice that where the individual concerned has, for example a learning disability, or a brain injury, someone with specialist knowledge of this client group is involved in the assessment process.

127. The multidisciplinary assessment of an individual's needs informs the process for determining whether or not they are eligible for NHS Continuing Healthcare. However, regardless of whether the individual is determined to be eligible for NHS Continuing Healthcare, CCGs and local authorities should always consider whether the multidisciplinary assessment of needs has identified issues that require action to be taken. For example, if a multidisciplinary assessment of needs indicates that the individual has significant communication difficulties, referral to a speech and language service should be considered.

128. If a needs assessment under the Care Act 2014 has already been carried out by the local authority and is still relevant to an individual's current needs then, in accordance with the relevant regulations[5], the local authority must use this assessment to provide advice and assistance to the CCG. This should be done in a timely way and according to locally agreed arrangements. For clarity, the local authority's duty to provide advice and assistance does not, in itself, trigger a duty to assess under section 9 of the Care Act 2014. The local authority should provide any other relevant information relating to the individual's up-to-date needs, where appropriate.

129. However, once an individual has been brought to the attention of the local authority, in addition to giving advice and assistance it should, having regard to the facts of the case, also consider whether a needs assessment under the Care Act 2014 is required. The absence of a needs assessment under the Care Act 2014 should not delay an assessment of eligibility for NHS Continuing Healthcare.

130. This National Framework encourages a joint approach to the assessment of eligibility for NHS Continuing Healthcare and it is important that all agencies respond in a timely manner. Local protocols should set how this is achieved, including in the absence of an existing local authority needs assessment under the Care Act 2014.

Using the Decision Support Tool

131. The Decision Support Tool (DST) has been developed to aid consistent decision making. The DST supports practitioners in identifying the individual's needs. This, combined with the practitioners' skills, knowledge and professional judgement, should enable them to apply the primary health need test in practice.

132. The DST is not an assessment of needs in itself. Rather, it is a way of bringing together and applying evidence in a single practical format, to facilitate consistent, evidence-based assessment regarding recommendations for NHS Continuing Healthcare eligibility. The evidence and rationale for the recommendation should be accurately and fully recorded.

133. The DST should not be completed without a multidisciplinary assessment of needs (meaning a comprehensive collection and evaluation of an individual's needs, refer to paragraphs 124-130). If any assessments relating to the individual's health and wellbeing (such as a needs assessment under the Care Act 2014) have recently been completed by practitioners, they may be used to complete the DST. However, care should be taken to ensure that such assessments provide an accurate reflection of current need.

134. The purpose of the DST is to help identify eligibility for NHS Continuing Healthcare. It is designed to collate and present the information from the assessments of need in

a way that assists consistent decision making regarding NHS Continuing Healthcare eligibility. The DST is a national tool and should not be altered.

135. 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.

136. The care domains are:

    1. Breathing
    2. Nutrition
    3. Continence
    4. Skin Integrity
    5. Mobility
    6. Communication
    7. Psychological & Emotional needs
    8. Cognition
    9. Behaviour
    10. Drug therapies and medication
    11. Altered states of consciousness
    12. Other significant care needs.

137. Completion of the tool should result in a comprehensive picture of the individual's needs that captures their nature, and their complexity, intensity and/or unpredictability – and thus the quality and/or quantity (including continuity) of care required to meet the individual's needs. Figure 1 indicates how the domains in the Decision Support Tool can illustrate (both individually and through their interaction) the complexity, intensity and/or unpredictability of needs. The overall picture, and the descriptors within the domains themselves, also relate to the nature of needs.

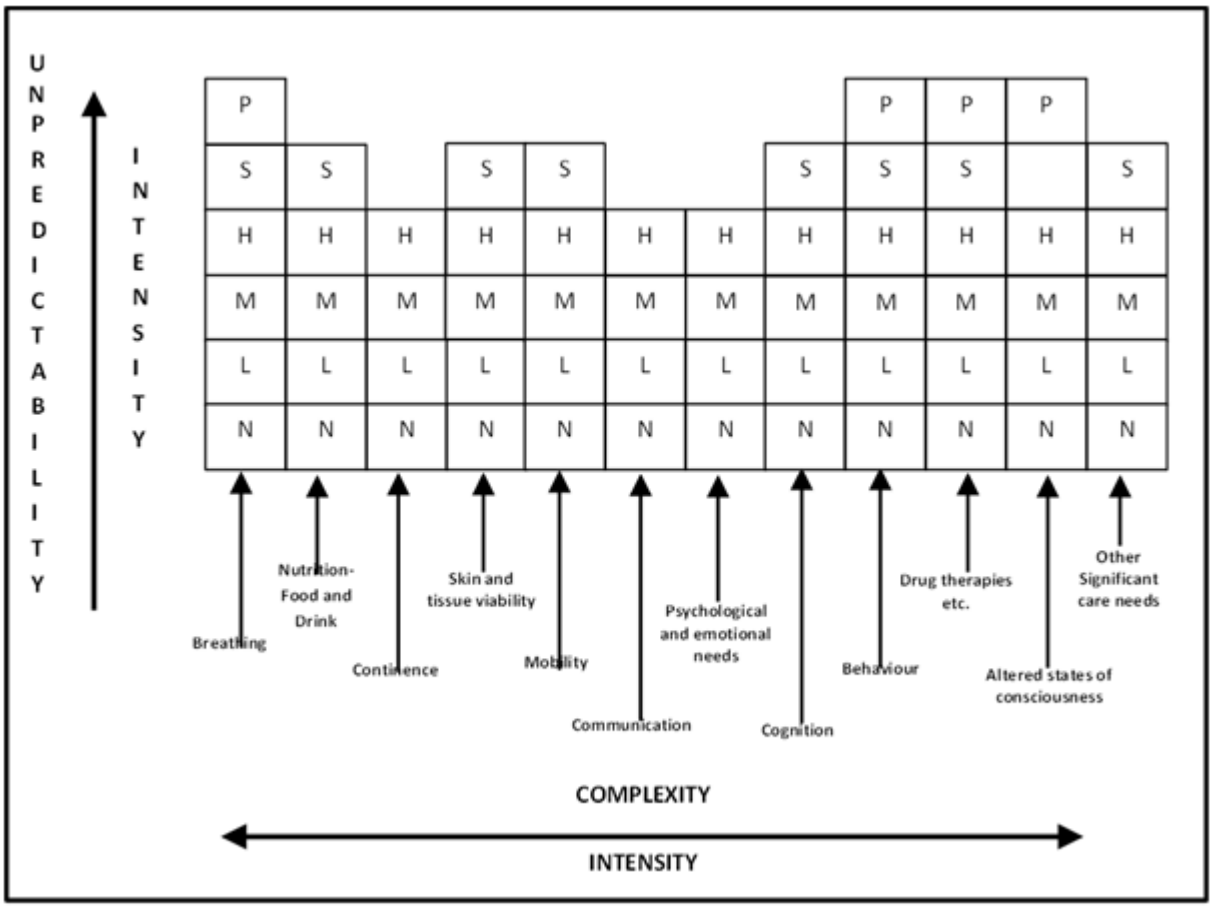


Figure 1 How the different care domains are divided into levels of need.

138. In certain cases, an individual may have particular needs that are not easily categorised by the care domains described here. In such circumstances, it is the responsibility of the MDT to determine the extent and type of the need and to take that need into account (and record it in the 12th care domain) when recommending whether a person has a primary health need.

139. Where deterioration can be reasonably anticipated to take place in the near future, this should also be taken into account, in order to avoid the need for unnecessary or repeat assessments.

140. When considering what evidence is needed to support completion of the DST, a proportionate approach should always be taken. This is further explained in Practice Guidance note 34.

141. Although the tool supports the process of determining eligibility, and ensures consistent and comprehensive consideration of an individual's needs, it cannot directly determine eligibility. Indicative guidelines as to threshold are set out in the tool (for example, if one area of need is at Priority level, then this demonstrates a primary health need), but these are not to be viewed prescriptively. Professional judgement should be exercised in all cases to ensure that the individual's overall level of need is correctly determined. The tool is to aid decision-making in terms of

whether the nature, complexity, intensity or unpredictability of a person's needs are such that the individual has a primary health need (refer to Practice Guidance note 34).

Well-managed needs

142. The decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on NHS Continuing Healthcare eligibility.

143. An example of the application of the well-managed needs principle might occur in the context of the behaviour domain where an individual's support plan includes support/interventions to manage challenging behaviour, which is successful in that there are no recorded incidents which indicate a risk to themselves, others or property. In this situation, the individual may have needs that are well-managed and if so, these should be recorded and taken into account in the eligibility decision.

144. In applying the principle of well-managed need, consideration should be given to the fact that specialist care providers may not routinely produce detailed recording of the extent to which a need is managed. It may be necessary to ask the provider to complete a detailed diary over a suitable period of time to demonstrate the nature and frequency of the needs and interventions, and their effectiveness.

145. Care should be taken when applying this principle. Sometimes needs may appear to be exacerbated because the individual is currently in an inappropriate environment rather than because they require a particular type or level of support – if they move to a different environment and their needs reduce this does not necessarily mean that the need is now 'well-managed', the need may actually be reduced or no longer exist.

146. It is not intended that this principle should be applied in such a way that well-controlled conditions should be recorded as if medication or other routine care or support was not present (refer to Practice Guidance note 23 for how the well-managed needs principle should be applied). The multi-disciplinary team should give due regard to well-controlled conditions when considering the four characteristics of need and making an eligibility recommendation on primary health need (refer to paragraph 59).

Making the recommendation of eligibility to the CCG

147. The MDT is required to make a recommendation to the CCG as to whether or not the individual has a primary health need, bearing in mind that where the CCG decides

that the individual has a primary health need they are eligible for NHS Continuing Healthcare (refer to Practice Guidance note 34). In coming to this recommendation the MDT should work collectively using professional judgement.

148. The written recommendation needs to be clear and concise whilst providing sufficient detail to enable the CCG and the individual to understand the underlying rationale for the recommendation.

149. The recommendation regarding eligibility for NHS Continuing Healthcare 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 provided in paragraphs 54-66 of the National Framework.
- 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 (with reference to paragraphs 54-66 of this National Framework). 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.

150. Where an MDT recommends an individual is not eligible for NHS Continuing Healthcare, a clear rationale that considers the four key characteristics must still be provided. This must be based on the primary health need test, as set out in paragraph 58. Care planning for those individuals with ongoing needs, including the consideration of need for NHS-funded Nursing Care, will still be necessary.

151. If an MDT is unable to reach agreement on the recommendation this should be clearly recorded. Please refer to Practice Guidance note 21 and 28 for further information on the process to be followed by the MDT and Practice Guidance note 34 on what to do if MDT members disagree on domain levels. Please also see paragraphs 208-215 on interagency disagreements and disputes.

152. Where an individual and/or their representative expresses concern about any aspect of the MDT or DST process, the CCG coordinator should discuss this matter with them and seek to resolve their concerns. Where the concerns remain unresolved, these should be noted within the DST so that they can be brought to the attention of the CCG making the final decision.

Decision-making on eligibility for NHS Continuing Healthcare by the CCG

153. CCGs are responsible for decision making regarding NHS Continuing Healthcare eligibility, based on the recommendation made by the multidisciplinary team in accordance with the process set out in this National Framework. Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed.

154. CCGs should ensure consistency and quality of decision making. The CCG may ask a multidisciplinary team to carry out further work on a Decision Support Tool (DST) if it is not completed fully or if there is a significant lack of consistency between the evidence recorded in the DST and the recommendation made. However, the CCG should not refer a case back, or decide not to accept a recommendation, simply because the multidisciplinary team has made a recommendation that differs from the one that those who are involved in making the final decision would have made, based on the same evidence.

155. CCGs should not make decisions in the absence of recommendations on eligibility from the multidisciplinary team, except where exceptional circumstances require an urgent decision to be made (refer to Practice Guidance note 39).

156. CCGs may choose to verify the multidisciplinary team's recommendation in a number of different ways. It is expected that whether the verification is done by an individual or by a panel, this process should not be used as a gate-keeping function or for financial control. A decision not to accept the multidisciplinary team's recommendation should never be made by one person acting unilaterally. The final eligibility decision should be independent of budgetary constraints, and finance officers should not be part of a decision-making process.

157. CCGs should be aware of cases that have indicated circumstances in which eligibility for NHS Continuing Healthcare should have been determined, and where such an outcome would be expected if the same facts were considered in an assessment for NHS Continuing Healthcare under the National Framework (e.g. Coughlan (refer to Annex B) or those cases in the Health Service Ombudsman's report[1] on NHS funding for the long-term care of older and disabled people). However, they should be wary of trying to draw generalisations about eligibility for NHS Continuing Healthcare from the limited information they may have about those cases. There is no substitute for a careful and detailed assessment of the needs of the individual whose eligibility is in question.

[1] The Parliamentary and Health Service Ombudsman, NHS funding for long term care 2002 -2003

158. As part of their responsibility to ensure consistent application of the National Framework, a CCG may review the pattern of recommendations made by multidisciplinary teams, in order to improve practice. However, this should be carried out separately from taking the decision on eligibility in individual cases. Care must be taken to ensure that any review of the pattern of recommendations supports compliance with the 'primary health need' test set out in this National Framework.

Communicating the eligibility decision to the individual

159. Once the eligibility decision is made by the CCG, the individual should be informed in writing as soon as possible (although this could be preceded by verbal confirmation where appropriate). This written confirmation should include:

- the decision on primary health need, and therefore whether or not the individual is eligible for NHS Continuing Healthcare;
- the reasons for the decision;
- a copy of the completed DST;
- details of who to contact if they wish to seek further clarification; and
- how to request a review of the eligibility decision.

160. Where an individual is not eligible for NHS Continuing Healthcare, the outcome letter may also include, where applicable and appropriate, information regarding NHS-funded Nursing Care or a joint package of care.

161. Where an individual is eligible for NHS Continuing Healthcare, 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 NHS Continuing Healthcare is not indefinite, as needs could change. This should be made clear to the individual and/or their representative.

Timeframe for decision making

162. It is expected that CCGs will normally respond to MDT recommendations within 48 hours (two working days), and that the overall assessment and eligibility decision-making process should, in most cases, not exceed 28 calendar days from the date that the CCG receives the positive Checklist (or, where a Checklist is not used, other notice of potential eligibility) to the eligibility decision being made.

163. In the minority of cases where an assessment of eligibility is being carried out in an acute hospital setting, the process should take far fewer than 28 calendar days if an individual is otherwise ready for discharge.

164. When there are valid and unavoidable reasons for the process taking longer, timescales should be clearly communicated to the person and (where appropriate) their representative(s). An example of this might occur where additional work is required to ensure that the DST and supporting evidence submitted to the CCG accurately reflect the full extent of an individual's needs. It should also be noted that the 28 calendar day timescale does not apply to children and young people in transition to adult services (refer to paragraph 342).

Care planning and delivery

165. Where an individual is eligible for NHS Continuing Healthcare, the CCG is responsible for care planning, commissioning services, and for case management. It is the responsibility of the CCG to plan strategically, specify outcomes and procure services, to manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare The services commissioned must include ongoing case management for all those eligible for NHS Continuing Healthcare, including review and/or reassessment of the individual's needs.

166. CCGs should operate a person-centred approach to all aspects of NHS Continuing Healthcare, using models that maximise personalisation and individual control and that reflect the individual's preferences, as far as possible, including when delivering NHS Continuing Healthcare through a Personal Health Budget, where this is appropriate (refer to paragraphs 296-300).

Case management

167. Once an individual has been found eligible for NHS Continuing Healthcare, the CCG is responsible for their case management, including monitoring the care they receive and arranging regular reviews. CCGs should ensure arrangements are in place for an ongoing case management role for all those eligible for NHS Continuing Healthcare, as well as for the NHS elements of joint packages. This could be through joint arrangements with the local authority, subject to local agreement. Best practice would be for CCGs to assign a named case manager or named of point of contact for anyone in receipt of NHS Continuing Healthcare.

168. The individual should be encouraged to have an active role in their care, be provided with information or signposting to enable informed choices, and supported to make their own decisions.

169. In the context of NHS Continuing Healthcare case management necessarily entails management of the whole package, not just the healthcare aspects. The key elements of case management, which in any given case might be undertaken by more than one professional, include:

a) ensuring that a suitable personalised care plan has been drawn up for, and with, the individual;

b) ensuring that the agreed care and support package continues to meet the individual's assessed health and associated care and support needs and agreed outcomes;

c) where the care plan includes access to non-NHS services, ensuring that the arrangements for these are in place and are working effectively;

d) monitoring the quality of the individual's care and support arrangements and responding to any difficulties/concerns about these in a timely manner;

e) acting as a link person to coordinate services for the individual;

f) ensuring that any changes in the person's needs are addressed;

g) initiating/undertaking reviews as described in paragraphs 181-191.

170. Where an individual who is in receipt of NHS Continuing Healthcare becomes the subject of a safeguarding concern, this must be addressed by the responsible CCG using the local safeguarding procedures (i.e. where the individual is currently living). CCGs are reminded of their duties under the Care Act 2014 to co-operate with the local authority and local authorities are reminded of their responsibilities to make enquiries and also their responsibility to ensure, where appropriate, that an individual subject to a safeguarding enquiry has access to independent advocacy.

Care planning

171. The care planning process is central to the commissioning and provision of care to meet an individual's needs. Responsibility for care planning lies with the CCG.

172. Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health and associated care and support needs. The CCG has responsibility for ensuring this is the case, and determining what the appropriate package should be. In doing so, the CCG should have due regard to the individual's wishes and preferred outcomes. Although the CCG is not bound by the views of the local authority on what services the individual requires, any local authority assessment under the Care Act 2014 will be important in identifying the individual's needs and in some cases the options for meeting them. Whichever mechanism is used for meeting an individual's assessed needs, the approach taken should be in line with the principles of personalisation (refer to paragraphs 296-300).

173. Care planning for needs to be met under NHS Continuing Healthcare should not be carried out in isolation from care planning to meet other needs, and, wherever possible, a single, integrated and personalised care plan should be developed.

Commissioning and provision

174. CCGs should take a strategic as well as an individual approach to fulfilling their NHS Continuing Healthcare commissioning responsibilities. CCGs may wish to commission NHS-funded care from a wide range of providers, in order to secure high-quality services that meet the individual's assessed needs and offer value for money. To help inform this approach, CCGs should have an understanding of the market costs for care and support within the relevant local area. As part of any joint commissioning strategy that may be in place CCGs and local authorities should work in partnership, and share information (where appropriate) to enable them to commission better, innovative and cost-effective outcomes that promote the wellbeing of their populations.

175. As with all service contracts, commissioners are responsible for monitoring quality, access and patient experience within the context of provider performance. This is particularly important in this instance, as ultimate responsibility for arranging and monitoring the services required to meet the assessed needs of those who qualify for NHS Continuing Healthcare rests with the CCG. They should take into account the role and areas of focus of the Care Quality Commission and, where relevant, local authority commissioners, of the relevant provider's services to avoid duplication and to support the mutual development of an overall picture of each provider's performance.

176. CCGs should ensure clarity regarding the services being commissioned from providers, bearing in mind that those in receipt of NHS Continuing Healthcare continue to be entitled to access the full range of primary, community, secondary and other health services. The services that a provider of NHS Continuing Healthcare-funded services is expected to supply should be clearly set out in the service specification or contract between the provider and the CCG.

177. The starting point for agreeing the package and the setting where NHS Continuing Healthcare services are to be provided should be the individual's preferences. In some situations a model of support preferred by individuals will be more expensive than other options. CCGs can take comparative costs and value for money into account when determining the model of support to be provided, but should consider the following factors when doing so:

    a) The cost comparison has to be on the basis of the genuine costs of alternative models. A comparison with the cost of supporting an individual in a care home should be based on the actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care home cost.

    b) Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual's assessed needs and agreed desired outcomes. For example, individuals can

sometimes be described as needing 24-hour care when what is meant is that they need ready access to support and/or supervision. CCGs should consider whether models such as assistive technology could meet some of these needs. Where individuals are assessed as requiring nursing care, CCGs should identify whether their needs require the actual presence of a nurse at all times or whether the needs are for qualified nursing staff or specific tasks or to provide overall supervision. The willingness of family members to supplement support should also be taken into account, although no pressure should be put on them to offer such support. CCGs should not make assumptions about any individual, group or community being available to care for family members.

c) Cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment (see the Gunter case in Practice Guidance note 46).

178. Unnecessary changes of provider or of care package should not take place purely because the responsible commissioner has changed from a CCG to a local authority (or vice versa).

179. To support a personalised approach to commissioning, CCGs should take into account relevant national policy and guidance, referring to the NHS-England website[1].

180. NHS care is free at the point of delivery. The funding provided by CCGs in NHS Continuing Healthcare packages should be sufficient to meet the needs identified in the care plan. Therefore it is not permissible for individuals to be asked to make any payments towards meeting their assessed needs.

[1] NHS England website: personalisation

NHS Continuing Healthcare Reviews (at three and 12 months)

Purpose and frequency of reviews

181. Where an individual has been found eligible for NHS Continuing Healthcare, a review should be undertaken within three months of the eligibility decision being made. After this, further reviews should be undertaken on at least an annual basis, although some individuals will require more frequent review in line with clinical judgement and changing needs.

182. Bearing in mind the minimum standards set out above, a guiding principle is that the frequency, format and attendance at reviews should be proportionate to the situation in question in order to ensure that time and resources are used effectively.

183. These reviews should primarily focus on whether the care plan or arrangements remain appropriate to meet the individual's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility.

184. It is expected that the most recently completed Decision Support Tool (DST) will normally be available at the review and should be used as a point of reference to identify any potential change in needs. Where there is clear evidence of a change in needs to such an extent that it may impact on the individual's eligibility for NHS Continuing Healthcare, then the CCG should arrange a full reassessment of eligibility for NHS Continuing Healthcare.

185. Where reassessment of eligibility for NHS Continuing Healthcare is required, a new DST must be completed by a properly constituted multidisciplinary team (MDT), as set out in this National Framework. Where appropriate, comparison should be made to the information provided in the previous DST. CCGs are reminded that they must (in so far as is reasonably practicable) consult with the local authority before making an NHS Continuing Healthcare eligibility decision, including any re-assessment of eligibility. This duty is normally discharged by the involvement of the local authority in the MDT process, as set out in the Assessment of Eligibility section of this National Framework. CCGs should ensure an individual's needs continue to be met during this reassessment of eligibility process.

Role of the local authority in reviews

186. If the local authority is responsible for any part of the care, both the CCG and the local authority will have a requirement to review needs and the service provided.

In such circumstances, it would be beneficial for them to conduct a joint review where practicable.

187. Even if all the services are currently the responsibility of the NHS, it may sometimes be beneficial for the review to be held jointly by the NHS and the local authority where there is an indication of a possible need for a care and support assessment as part of the review process.

Well-managed needs and reviews

188. When undertaking NHS Continuing Healthcare reviews, care must be taken not to misinterpret a situation where the individual's care needs are being well-managed as being a reduction in their actual day-to-day care needs. This may be particularly relevant where the individual has a progressive illness or condition, although it is recognised that with some progressive conditions care needs can reduce over time. More information on well-managed needs can be found in the Assessment of Eligibility section in this National Framework.

Outcomes of an NHS Continuing Healthcare review

189. The outcome of an NHS Continuing Healthcare review will determine whether:

a) the individual's needs are being met appropriately, and

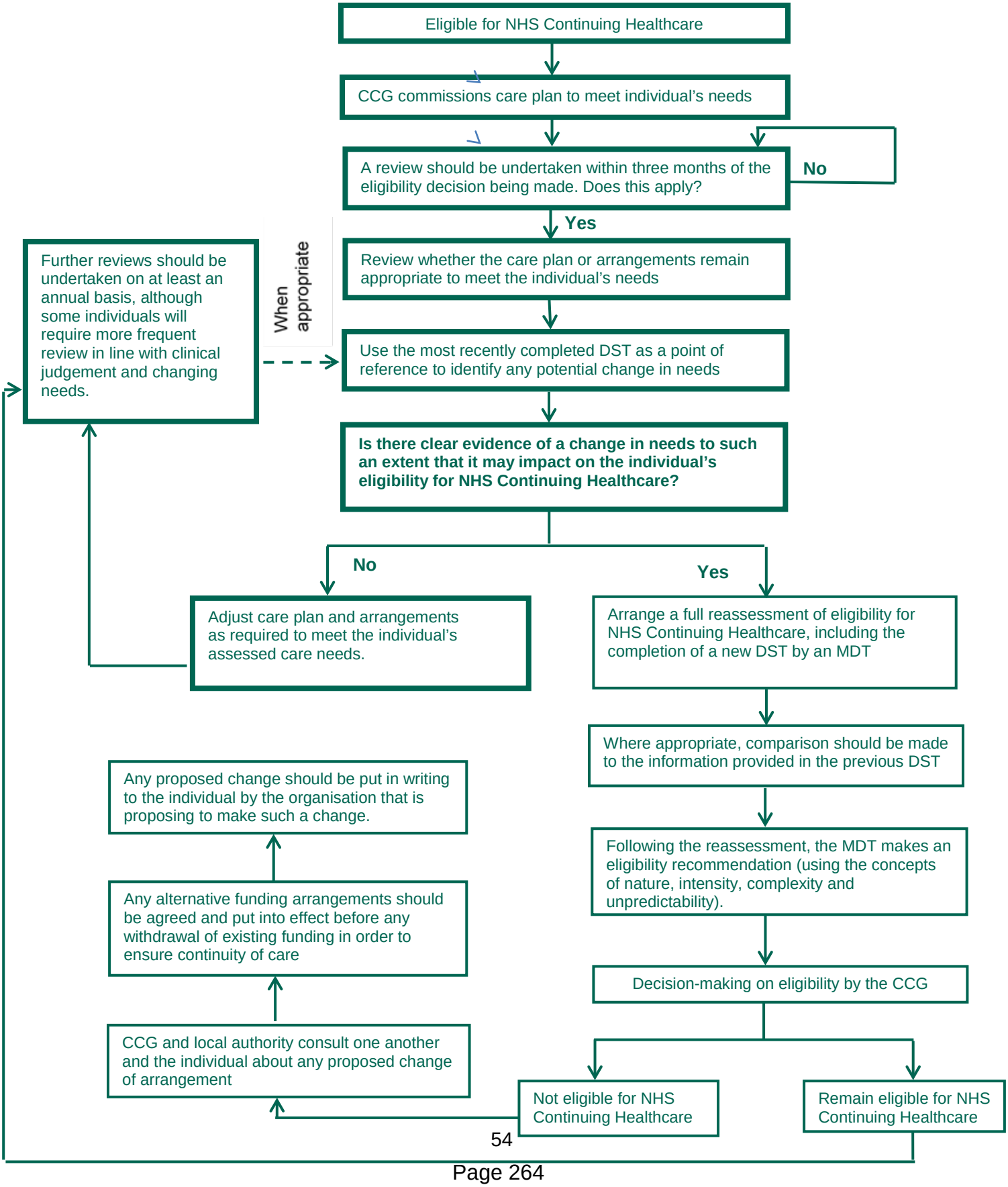
b) whether eligibility should be reconsidered through reassessment for NHS Continuing Healthcare.

190. It is a core principle that neither a CCG nor a local authority should 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, 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, in order to ensure continuity of care. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If agreement between the local authority and the NHS cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding and care management responsibilities should remain in place until the dispute has been resolved. There is a separate disputes procedure for when the individual disagrees with the decision (refer to paragraphs 192-207).

191. The risks and benefits to the individual of a change of location or support (including funding) should be considered carefully before any move or change is confirmed. Neither the CCG nor the local authority should unilaterally withdraw from funding of an existing package until there has been appropriate reassessment and agreement on future funding responsibilities and any

alternative funding arrangements have been put into effect. Further details on responsibilities during changes (including approaches to disputes) are set out in Annex E.

Figure 2: Flow diagram for 3 months 12 month reviews of NHS Continuing Healthcare



Individual Requests for a Review of an Eligibility Decision

192. The formal responsibility for informing individuals of the decision about eligibility for NHS Continuing Healthcare and of their right to request a review lies with that CCG with which the individual is a patient for the purposes of NHS Continuing Healthcare, in line with current legislation.

193. The CCG should give clear reasons for its decision on whether or not an individual has a primary health need. The CCG should set out the basis on which the decision of eligibility was made. The CCG should also explain the arrangements, and timescales, for dealing with a request to review an eligibility decision where the individual or their representative disagrees with it.

Local resolution

194. Where an individual or their representative asks the CCG to review the eligibility decision, this should be addressed through the local resolution procedure, which is normally expected to resolve the matter. CCGs should deal with requests for review in a timely manner. For guidance on this issue please refer to NHS England website.

195. All CCGs must have an NHS Continuing Healthcare local resolution process. They should therefore develop, deliver and publish a local resolution process that is fair, transparent, includes timescales and takes account of the following guidelines:

a) There should be an attempt to resolve any concerns initially through an informal two-way meaningful discussion between the CCG representative and the individual and/or their representative. There should be a written summary of this for both parties. The discussion should be an opportunity for the individual or their representative to receive clarification of anything they have not understood. The CCG should explain how it has arrived at the decision regarding eligibility, including reference to the completed DST and primary health need assessment. Where required this should also be an opportunity for the individual or their representative to provide any further information that had not been considered.

b) Where a formal meeting involving the individual and/or their representative is required, this should involve someone with the authority to decide next steps on behalf of the CCG (e.g. to request further reports, or seek further clarification/reconsideration by the MDT). The individual should be able to put forward the reasons why they remain dissatisfied with the CCG's decision.

There should be a full written record of the formal meeting for both parties. The CCG will agree next steps with the individual or their representative.

c) Following the formal meeting and outcome of the next steps, the CCG will either uphold or change the original eligibility decision.

d) A key principle of the local resolution process is that, as far as possible, if the CCG does not change the original decision, the individual or their representative has had a clear and comprehensive explanation of the rationale for the CCG decision.

f) Where individuals wish to move straight to a formal meeting this should be considered. CCGs should use every opportunity to learn from these meetings, and should consider how they share their learning with other CCGs.

g) CCGs may choose to prioritise cases for individuals currently in receipt of care.

Independent review

196. Where it has not been possible to resolve the matter through the local resolution procedure, the individual may apply to NHS England for an independent review of the decision, if they are dissatisfied with:

- the decision regarding eligibility for NHS Continuing Healthcare; or
- the procedure followed by the CCG in reaching its decision as to the person's eligibility for NHS Continuing Healthcare.

197. When NHS England receives a request for an independent review they should contact the relevant CCG to establish what efforts have been made to achieve local resolution and the outcome. NHS England can consider asking CCGs to attempt further local resolution prior to the independent review. If using local processes would cause undue delay, NHS England has the discretion to agree that the matter should proceed direct to an independent review, without completion of the local resolution process.

198. Where NHS England, rather than a CCG, has taken an eligibility decision which is subsequently disputed by the individual, NHS England must ensure that, in organising a review of that decision, it makes appropriate arrangements as regards the manner in which it organises this review so as to avoid any conflict of interest.

199. The key elements involved in considering requests for independent reviews of NHS Continuing Healthcare eligibility include:

- scrutiny of all available and appropriate evidence as described in the Local Resolution section;

- a full record of deliberations of relevant panel meetings, made available to all parties (subject to any legal restrictions on sharing such documentation); and
- clear and evidenced written conclusions on the process followed by the NHS body and also on the individual's eligibility for NHS Continuing Healthcare, together with appropriate recommendations on actions to be taken. This should include the appropriate rationale related to this guidance.

200. NHS England is responsible[1] for convening independent review panels consisting of:

- An independent chair (appointed by NHS England);
- A CCG representative (who is not from the CCG that made the decision which is the subject of the review);
- A local authority Social Services representative (who is not from a local authority where all or part of the CCG involved in the decision is located).

201. All parties involved should be able to view and comment on all evidence to be considered under the relevant disputes procedure (subject to any legal restrictions on sharing such documentation). Where written records or other evidence are requested, the CCG making the request should ensure that those providing the evidence are aware that it will be made available to those involved in the independent review panel. Where, in exceptional circumstances, those providing written records place any restrictions on their availability to all parties, the position should be discussed with the chair of the relevant disputes resolution body. The chair should consider the most appropriate way forward to ensure that all parties can play a full and informed role in the process.

202. Independent review panels have a scrutiny and reviewing role. It is therefore not necessary for any party to be legally represented at independent review panel hearings, although individuals may choose to be represented by family, advocates, advice services or others in a similar role if they wish.

203. The role of the independent review panel is advisory, but its recommendations should be accepted by NHS England (and subsequently by the CCG) in all but exceptional circumstances (see Annex D). The individual's rights under the existing NHS and social services complaints procedures remain unaltered by the above.

204. Following an independent review panel, if the original decision is upheld but there is still a challenge the individual has the right to make a complaint to the Parliamentary and Health Service Ombudsman.

205. On some occasions, NHS England may receive requests for an independent review or other challenge from a close relative, friend or other representative who does not have lasting power of attorney (LPA) or deputy status. Where the individual has capacity, the CCG should ask them whether this request is in

accordance with their instructions, and where they do not have capacity, a ‘best interests’ process should be used to consider whether to proceed with the request for an independent review or other challenge.

206. NHS England does have the right to decide in any individual case not to convene an independent review panel. It is expected that such a decision will be confined to those cases where the individual falls well outside the eligibility criteria, as set out in the standing rules, or where the case is very clearly not appropriate for the independent review panel to consider (see Annex D). Before taking such a decision, NHS England should seek the advice of an independent review chair who may require independent clinical advice. In such cases where a decision not to convene an independent review panel is made the individual, their family or carer should receive a clear written explanation of the basis for this decision, together with a reminder of their rights under the NHS complaints procedure.

207. CCGs should consider publishing local processes and timescales for responding to complaints and concerns relating to NHS Continuing Healthcare on issues that fall outside of the independent review panel process.

Inter-agency disputes

Disputes between local authorities and CCGs

208. A fundamental principle is for CCGs and local authorities to minimise the need to invoke formal inter-agency dispute resolution procedures by, for example:

a) all parties following the guidance set out in this National Framework;

b) agreeing and following local protocols and/or processes which make clear how the CCG discharges its duty to consult with the local authority (refer to paragraph 21) and how the local authority discharges its duty to co-operate with the CCG (refer to paragraphs 25-30);

c) developing a culture of genuine partnership working in all aspects of NHS Continuing Healthcare;

d) ensuring that eligibility decisions are based on thorough, accurate and evidence-based assessments of the individuals' needs;

e) always keeping the individual at the heart of the process and ensuring a person-centred approach to decision-making;

f) always attempting to resolve inter-agency disagreements at an early and preferably informal stage;

g) dealing with genuine disagreements between practitioners in a professional manner without drawing the individual concerned into the debate in order to gain support for one professional's position or the other;

h) ensuring practitioners in health and social care receive high-quality joint training (i.e. health and social care) which gives consistent messages about the correct application of the National Framework.

Individuals must never be left without appropriate support while disputes between statutory bodies about funding responsibilities are resolved.

209. CCGs and local authorities in each local area must agree a local disputes resolution process to resolve cases where there is a dispute between them about:

- a decision as to eligibility for NHS Continuing Healthcare, or
- where an individual is not eligible for NHS Continuing Healthcare, the contribution of a CCG or local authority to a joint package of care for that person, or
- the operation of refunds guidance (see Annex E).

210. When developing and agreeing local inter-agency disagreement and dispute resolution protocols, CCGs and local authorities should ensure that they encompass the following elements:

- A brief summary of principles including a commitment to work in partnership and in a person-centred way.
- The CCG duty to consult with the local authority (refer to paragraph 21) and the local authority duty to co-operate with the CCG (refer to paragraphs 25-30). This should include arrangements for situations where the local authority has not been involved in the MDT and in formulating the recommendation.
- An 'informal' stage at operational level whereby disagreements regarding the correct eligibility recommendation can be resolved – this might, for example, involve consultation with relevant managers immediately following the MDT meeting to see whether agreement can be reached. This stage might include seeking further information/clarification on the facts of the case or on the correct interpretation of the National Framework.
- A formal stage of resolving disagreements regarding eligibility recommendations involving managers and/or practitioners who have delegated authority to attempt resolution of the disagreement and can make eligibility decisions. This stage could involve referral to an inter-agency NHS Continuing Healthcare panel.
- If the dispute remains unresolved, the dispute resolution agreement may provide further stages of escalation to more senior managers within the respective organisations.
- A final stage involving independent arbitration. This stage should only be invoked as a last resort and should rarely, if ever, be required. It can only be triggered by senior managers within the respective organisations who must agree how the independent arbitration is to be sourced, organised and funded.
- Clear timelines for each stage.
- Agreement as to how the placement and/or package for the individual is to be funded pending the outcome of dispute resolution and arrangements for reimbursement to the agencies involved once the dispute is resolved. Individuals must never be left without appropriate support whilst disputes between statutory bodies about funding responsibility are resolved.
- Arrangements to keep the individual and/or their representative informed throughout the dispute resolution process.
- Arrangements in the event of an individual requesting a review of the eligibility decision made by the CCG.

211. It should be remembered that decisions regarding eligibility for NHS Continuing Healthcare are the responsibility of the CCG, who may choose to make their decision before an inter-agency disagreement has been resolved. In such cases it is possible that the formal dispute resolution process will have to be concluded after the individual has been given a decision by the CCG.

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

Disputes regarding 'responsible commissioner' or 'ordinary residence'

213. In situations where there is a dispute between CCGs regarding responsibility for an individual, then the underlying principle is that there should be no gaps in responsibility as a result. No treatment should be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual's healthcare provision. CCGs should agree interim responsibilities for who funds the package until the dispute is resolved. Where the CCGs are unable to resolve their dispute using current guidance, as a last resort the matter should be referred to NHS England.

214. The Care Act 2014 (sections 39-41), associated regulations[1] and chapter 19 of the Care and Support Statutory Guidance, set out and give guidance on updated rules regarding 'ordinary residence', which is the key concept in determining which local authority is responsible for assessing and addressing the care and support needs of individuals and their carers. As with 'responsible commissioner' guidance a key principle is that individuals should not be left without support whilst any disagreement about which local authority is responsible is resolved.

215. CCGs and local authorities in each local area must agree a local dispute resolution process to resolve cases where there is a dispute between them about eligibility for NHS Continuing Healthcare, about the apportionment of funding in joint funded care/support packages, or about the operation of refunds guidance (see Annex E). Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to local authorities and CCGs in different geographical areas, the dispute resolution process of the responsible CCG should normally be used in order to ensure resolution in a robust and timely manner. This should include agreement on how funding will be provided during the dispute, and arrangements for reimbursement to the agencies involved once

[1] The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014 and The Care and Support (Disputes Between Local Authorities) Regulations 2014

the dispute is resolved. Individuals must never be left without appropriate support whilst disputes between statutory bodies about funding responsibility are resolved.

Fast track

216. There are a number of end-of-life pathways which may be appropriate within local health and care systems and therefore not everyone at the end of their life will be eligible for, or require, NHS Continuing Healthcare. Care planning and commissioning for those with end of life needs should be carried out in an integrated manner, as part of the individual's overall end of life care pathway and taking into account individual preferences. The Government's *End of Life Care Choice Commitment*[1] sets out what everyone should expect from their care at the end of life, and the action being taken to make high quality and personalisation a reality for all.

Fast Track Pathway Tool for NHS Continuing Healthcare

217. Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require 'fast tracking' for immediate provision of NHS Continuing Healthcare.

218. The intention of the Fast Track Pathway is that it should identify individuals who need to access NHS Continuing Healthcare quickly, with minimum delay, and with no requirement to complete a Decision Support Tool (DST). Therefore, the completed Fast Track Pathway Tool, with clear reasons why the individual fulfils the criteria and which clearly evidences that an individual is both rapidly deteriorating and may be entering terminal phase, is in itself sufficient to establish eligibility.

219. In Fast Track cases, Standing Rules[2] state that it is the 'appropriate clinician' who determines that the individual has a primary health need. The CCG must therefore decide that the individual is eligible for NHS Continuing Healthcare and should respond promptly and positively to ensure that the appropriate funding and care arrangements are in place without delay.

220. An 'appropriate clinician' is defined as a person who is:

- responsible for the diagnosis, treatment or care of the individual under the 2006 Act in respect of whom a Fast Track Pathway Tool is being completed; and
- a registered nurse or a registered medical practitioner.

[1] *End of Life Care Choice Commitment*

[2] *Regulation 8 and 13 of the National Health Service Commissioning Board and Clinical Groups (Responsibilities and Standing Rules) Regulations 2012*

221. The ‘appropriate clinician’ should be knowledgeable about the individual’s health needs, diagnosis, treatment or care and be able to provide an assessment of why the individual meets the Fast Track criteria.

222. An ‘appropriate clinician’ can include clinicians employed in voluntary and independent sector organisations that have a specialist role in end of life needs (for example, hospices), provided they are offering services pursuant to the 2006 Act.

223. Others who are not approved clinicians as defined above, but involved in supporting those with end of life needs, (including those in wider voluntary and independent sector organisations) may identify the fact that the individual has needs for which use of the Fast Track Pathway Tool might be appropriate. They should contact the appropriate clinician who is responsible for the diagnosis, care or treatment of the individual and ask for consideration to be given to completion of the Fast Track Pathway Tool.

Completion of the Fast Track Pathway Tool

224. The Fast Track Pathway Tool must only be used when the individual has a rapidly deteriorating condition and may be entering a terminal phase.

225. The Fast Track Pathway Tool replaces the need for a Checklist and DST to be completed. However, a Fast Track Pathway Tool can also be completed after a Checklist if it becomes apparent at that point that the Fast Track criteria are met.

226. The Fast Track Pathway Tool can be used in any setting. This includes where such support is required for individuals who are already in their own home or are in a care home and wish to remain there.

227. The completed Fast Track Pathway Tool should be supported by a prognosis, where available. However, strict time limits that base eligibility on a specified expected length of life remaining should not be imposed:

    - ‘rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining; and
    - ‘may be entering a terminal phase’ is not intended to be restrictive to only those situations where death is imminent.

    It is the responsibility of the appropriate clinician to make a decision based on whether the individual’s needs meet the Fast Track criteria.

228. When completing the Fast Track Pathway Tool clinicians should sensitively explain to the individual that their needs may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review.

229. Also, an individual may currently be demonstrating few symptoms yet the nature of the condition is such that it is clear that rapid deterioration is to be expected in the near future. In order to avoid the need for unnecessary or repeat assessments it may therefore be appropriate to use the Fast Track Pathway Tool now in anticipation of those needs arising and agreeing the responsibilities and actions to be taken once they arise, or to plan an early review date to reconsider the situation. It is the responsibility of the appropriate clinician referring an individual to base their decision on the facts of the individual's case and healthcare needs at the time.

230. It is important to bear in mind that this is not the only way that an individual can qualify for NHS Continuing Healthcare towards the end of their life. The DST asks practitioners to document deterioration (including observed and likely deterioration) in an individual's condition, so that they can take this into account in determining eligibility using the DST. However, this should not be used as a means of circumventing use of the Fast Track Pathway Tool when individuals satisfy the criteria for its use.

231. It is helpful if an indication of how the individual presents in the current setting is included with the Fast Track Pathway Tool, along with the likely progression of the individual's condition, including anticipated deterioration and how and when this may occur. However, CCGs should not require this information to be provided as a prerequisite for establishing entitlement to NHS Continuing Healthcare using the Fast Track Pathway Tool.

232. It is also important for the CCG to know what the individual or their family have been advised about their condition and prognosis and how they have been involved in agreeing the end of life care pathway.

233. If an individual meets the criteria for the use of the Fast Track Pathway Tool then the Tool should be completed even if an individual is already receiving a care package (other than one already fully funded by the NHS) which could still meet their needs. This is important because the individual may at present be funding their own care or the local authority may be funding (and/or charging) when the NHS should now be funding the care in full.

234. The setting where an individual wishes to be supported as they approach the end of their life may be different to their current arrangements (e.g. even though they are currently in a care home setting they may wish to be supported in their family environment).The important issue is that (wherever possible) the individual concerned receives the support they need in their preferred place as soon as reasonably practicable, without having to go through the full process for consideration of NHS Continuing Healthcare eligibility.

235. The overall Fast Track process should be carefully and sensitively explained to the individual and (where appropriate) their representative. Careful decision-making is

essential in order to avoid the undue distress that might result from changes in NHS Continuing Healthcare eligibility within a very short period of time.

CCG responsibilities upon receiving a completed Fast Track Pathway Tool

236. In order to comply with Standing Rules a CCG must accept and immediately action a Fast Track Pathway Tool where the Tool has been properly completed.

237. Exceptionally, there may be circumstances where CCGs receive a completed Tool which appears to show that the individual's condition is not related to the above criteria at all. For example, if a completed Fast Track Pathway Tool states that the person has mental health needs and challenging behaviour but makes no reference to them having a rapidly deteriorating condition which may be entering a terminal phase. In these circumstances, the CCG should urgently ask the relevant clinician to clarify the nature of the person's needs and the reason for the use of the Fast Track Pathway Tool. Where it then becomes clear that the use of the Fast Track Pathway Tool was not appropriate, the clinician should be asked to submit a completed Checklist (if required) for assessment of eligibility through the process outlined in this National Framework.

238. Action should be taken urgently to agree and commission the care package. CCGs should have processes in place to enable such care packages to be commissioned quickly. Given the nature of the needs, this time period should not usually exceed 48 hours from receipt of the completed Fast Track Pathway Tool. CCGs should ensure that they have commissioned sufficient capacity in the care system to ensure that delays in the delivery of care packages are minimal. It is not appropriate for individuals to experience delay in the delivery of their care package while concerns over the use of the Fast Track Pathway Tool are resolved.

239. CCGs should ensure that robust systems are in place to audit and monitor use of the tool and raise any specific concerns with clinicians, teams and organisations, bearing in mind the importance of the Tool being used appropriately and only for the genuine purpose for which it is intended. CCG should consider how the use of the standard NHS contract can support this. Such concerns should be treated as a separate matter from the task of arranging for service provision in the individual case.

Reviews of Fast Track

240. The aim of the Fast Track Pathway Tool is to ensure quick determination of eligibly for NHS Continuing Healthcare and commission an appropriate care package.

241. Once this has happened, it will be important to review an individual's care needs and the effectiveness of the care arrangements. In doing this, there may be certain situations where the needs indicate that it is appropriate to review eligibility for NHS Continuing Healthcare. CCGs should make any decisions about reviewing eligibility in Fast Track cases with sensitivity.

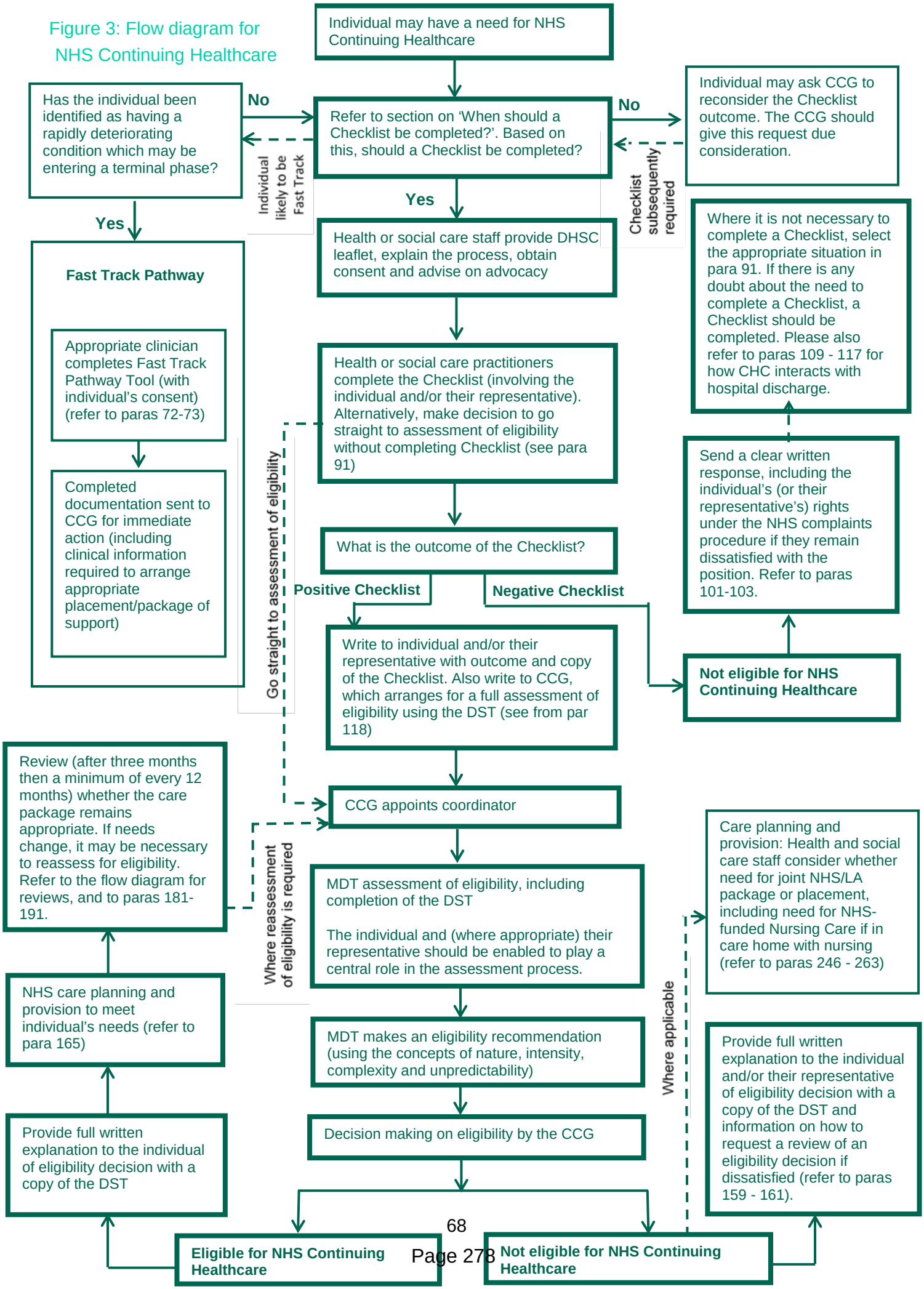
242. Where an individual who is receiving services from use of the Fast Track Pathway Tool is expected to die in the very near future, the CCG should continue to take responsibility for the care package until the end of life.

243. CCGs should monitor care packages to consider when and whether a reassessment of eligibility is appropriate. Where it is apparent that the individual is nearing the end of their life and the original eligibility decision was appropriate it is unlikely that a review of eligibility will be necessary.

244. No individual identified through the Fast Track Pathway Tool who is eligible for NHS Continuing Healthcare should have this funding removed without their eligibility being re-considered through the completion of a DST by a multidisciplinary team (MDT), including this MDT making a recommendation on eligibility for NHS Continuing Healthcare.

245. The individual affected should be notified in writing of any proposed change in funding responsibility. They should be given details of their right to request a review of the decision. Such communications should be conducted in a sensitive, timely and person-centred manner.

Figure 3: Flow diagram for NHS Continuing Healthcare



Joint packages of care, including NHS-funded Nursing Care

NHS-funded Nursing Care

246. NHS-funded Nursing Care is the funding provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible for NHS-funded Nursing Care. Section 22 of the Care Act 2014 prohibits local authorities from providing, or arranging for the provision of, nursing care by a registered nurse, save in the very limited circumstances set out in Section 22 (4).

247. If an individual is not eligible for NHS Continuing Healthcare, the need for care from a registered nurse may need to be determined. An individual is eligible for NHS-funded Nursing Care if:

- the individual has such a need;

and

- it is determined that the individual's overall needs would be most appropriately met in a care home with nursing.

248. The registered nurse[1] input is defined in the following terms:

'Services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse'.

'Nursing care by a registered nurse' covers:

- time spent on nursing care, in the sense of care which can only be provided by a registered nurse, including both direct and indirect nursing time;
- paid breaks;
- time receiving supervision;
- stand-by time; and
- time spent on providing, planning, supervising or delegating the provision of other types of care which in all the circumstances ought to be provided by a registered nurse because they are ancillary to or closely connected with or part and parcel of the nursing care which the nurse has to provide.

[1] Supreme Court judgment, R (on the application of Forge Care Homes Ltd and others) v Cardiff and Vale University Health Board and others (Secretary of State for Health intervening) [2017] UKSC 56

249. Where an individual may have a nursing need a nursing needs assessment, which specifies the day-to-day care and support needs of the individual, should be used to assess whether an individual is eligible for NHS-funded Nursing Care. More information is provided in the NHS-funded Nursing Care best practice guidance.

250. Eligibility for NHS Continuing Healthcare must be considered, and a decision made and recorded (either at the Checklist or DST stage), prior to any decision on eligibility for NHS-funded Nursing Care. For clarity, people who do not require a full assessment of eligibility for NHS Continuing Healthcare can still be eligible for NHS-funded Nursing Care. If an individual has a negative Checklist this simply means that they are not eligible for, and do not require, assessment of eligibility for NHS Continuing Healthcare at this point in time. However, they may require registered nursing in a care home with nursing. The decision regarding this must be based on a nursing needs assessment, which specifies their day-to-day care and support needs and how they meet the criteria outlined above. More on NHS-funded Nursing Care reviews can be found below.

251. Once the need for such care is agreed, the CCG is responsible for paying a flat-rate contribution to the care home with nursing towards registered nursing care costs.

The NHS-funded Nursing Care rate

252. Since 2007, NHS-funded Nursing Care has been based on a single-band rate, set out in the Standing Rules and amended each financial year by the Department of Health and Social Care.

253. Individuals who are in receipt of NHS-funded Nursing Care are entitled to continue to receive this until:

    a) on review, it is determined that they no longer have any need for registered nursing care; or

    b) they are no longer resident in a care home that provides registered nursing care; or

    c) they become eligible for NHS Continuing Healthcare; or

    d) they die.

254. Individuals who were in receipt of the high band of NHS-funded Nursing Care under the three-band system that was in force until 30 September 2007 are entitled to continue on the high band rate subject to a) – d) above. In addition, if on review, it is determined that their needs have changed, so that under the previous three-band system they would have moved onto the medium or low bands, the individual should be moved onto the single rate.

255. The NHS-funded Nursing Care rate is the contribution provided by the NHS to support the provision of 'nursing care by a registered nurse', as defined in paragraphs 247-248 above. This does not include the time spent by non-nursing staff such as care assistants (although it does cover the time spent by the registered nurse in monitoring or supervising care that is delegated to others). Neither does it cover the costs of the wider non-nursing care or accommodation provided for the individual.

256. The Care home provider should set an overall fee level for the provision of care and accommodation. This should include any registered nursing care provided by them. Where a CCG assesses that the resident's needs require the input of a registered nurse they will pay the NHS-funded Nursing Care payment (at the nationally agreed rate) direct to the care home, unless there is an agreement in place for this to be paid via a third party (e.g. a local authority). The balance of the fee will then be paid by the individual, their representative or the local authority unless other contracting arrangements have been agreed.

257. Contracts between individuals and/or local authorities, with providers, should have terms and conditions which are transparent and fair, including setting out what happens if a resident is admitted to hospital or what happens if a resident dies.

NHS-funded Nursing Care reviews

258. When reviewing the need for NHS-funded Nursing Care, potential eligibility for NHS Continuing Healthcare must always be considered. This will normally be achieved by completing a Checklist and where necessary a full assessment for NHS Continuing Healthcare using the DST.

259. However, where:

- a Checklist and/or DST has previously been completed (with the result that the individual was not found eligible for NHS Continuing Healthcare), and
- it is clear that there has been no material change in need

then it will not be necessary to repeat the Checklist and/or DST and this should be recorded. The individual should be informed of this outcome and the reasons for it.

260. Where a new Checklist is completed and indicates that a full assessment of eligibility for NHS Continuing Healthcare is required, then an MDT should complete a DST and follow the normal decision-making process.

261. In order to determine whether there has been a material change in need, the previously completed Checklist or DST should be available at the NHS–funded Nursing Care review. Each of the domains and previously assessed need levels

should be considered as part of the review, in consultation with the person being reviewed and any other relevant people who know the individual who are present.

262. If at the NHS-funded Nursing Care review it is determined that the individual does not require assessment for NHS Continuing Healthcare, they or their representative should be advised of this and provided with a copy of the annotated Checklist or DST which indicates that there has been no material change in their needs. They should be given information explaining how they can request a review of the outcome of the NHS-funded Nursing Care review, should they wish to do so.

Joint packages of health and social care

263. If a person is not eligible for NHS Continuing Healthcare, they may potentially receive a joint package of health and social care. This is where an individual's care or support package is funded by both the NHS and the local authority. This may apply where specific needs have been identified through the DST that are beyond the powers of the local authority to meet on its own. This could be because the specific needs are not of a nature that a local authority could be expected to meet, or because they are not incidental or ancillary to something which the Local Authority would be doing to meet needs under sections 18-20 of the Care Act 2014. It should be noted that joint packages can be provided in any setting.

264. CCGs should work in partnership with their local authority colleagues to agree their respective responsibilities in such cases. These should be identified by considering the needs of the individual. Where there are overlapping powers and responsibilities, a flexible, partnership-based approach should be adopted, including which party will take the lead commissioning role.

265. Apart from NHS-funded Nursing Care, additional health services may also be delivered by existing NHS services or funded by the NHS, if these are identified and agreed as part of an assessment and care plan. The range of services that the NHS is expected to arrange and fund includes, but is not limited to:

- primary healthcare;
- assessment involving doctors and registered nurses;
- rehabilitation/reablement and recovery (where this forms part of an overall package of NHS care, as distinct from intermediate care);
- respite healthcare;
- community health services;
- specialist support for healthcare needs; and

- palliative care and end of life healthcare.

266. Subject to the national eligibility criteria for adult care and support (refer to paragraph 51) and to means testing where appropriate, each local authority is responsible for providing such care and support as can lawfully be provided. More information on this can be found in the section on Legislation in this National Framework.

267. In a joint package of care the CCG and the local authority can each contribute to the package by any one, or more, of the following:

a) delivering direct services to the individual

b) commissioning care/services to support the care package

c) transferring funding between their respective organisations

d) contributing to an integrated personal budget

268. Although the funding for a joint package comes from more than one source it is possible that one provider, or the same worker(s), could provide all the support.

Examples can include:

- an individual in their own home with a package of support comprising both health and social care elements;

- an individual in a care home (with nursing) who has nursing or other health needs, that are beyond the scope of the NHS-funded Nursing Care contribution; or

- an individual in a care home (without nursing) who has some specific health needs requiring skilled intervention or support, that cannot be met by community nursing services and are beyond the power of the local authority to meet.

269. Jointly coordinated CCG and local authority reviews should be considered for any joint package of care in order to maximise effective care and support for the individual.

Further information related to care and support arrangements

Guidance on NHS patients who wish to pay for additional private care

270. The NHS care package provided should meet the individual's health and associated social care needs as identified in their care plan. 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 but the NHS element of the care should always be clearly identified.

271. The decision to purchase additional private care services should always be a voluntary one for the individual. Providers should not require the individual to purchase additional private care services as a condition of providing, or continuing to provide, NHS-funded services to them. The CCG should make this clear when negotiating terms and conditions with the provider.

272. Where an individual advises that they wish to purchase additional private care or services, CCGs should discuss the matter with the individual to seek to identify the reasons for this. If the individual advises that they have concerns that the existing care package is not sufficient or not appropriate to meet their needs, CCGs should offer to review the care package in order to identify whether a different package would more appropriately meet the individual's assessed needs.

273. In March 2009, the Department published *Guidance on NHS patients who wish to pay for additional private care*[1] (referred to below as the 'Additional Private Care Guidance') regarding NHS patients who wish to pay for additional private care, in addition to their NHS care package. Although it is primarily aimed at situations where NHS patients want to buy additional secondary and specialist care services that the NHS does not fund, it contains a set of principles applicable to all NHS services:

a) As affirmed by the NHS Constitution:

- the NHS provides a comprehensive service, available to all;
- access to NHS services is based on clinical need, not an individual's ability to pay; and
- public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

[1] Guidance on NHS patients who wish to pay for additional private care

b) The fact that some NHS patients also receive private care separately should never be used as a means of downgrading or reducing the level of service that the NHS offers. NHS organisations should not withdraw any NHS care simply because a patient chooses to buy additional private care.

c) As overriding rules, 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 an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.

274. There should be as clear a separation as possible between NHS and private care. In the Additional Private Care guidance, 'separation' is described as usually requiring the privately-funded care to take place in a different location and at a different time to the NHS-funded care. However, many individuals eligible for NHS Continuing Healthcare have limitations on their ability to leave their home due to their health needs. Moreover, the majority of the care they receive is often by its nature focused on supporting them within their own home and any additional private care may well also be focused on home-based support. Therefore, although the principle of separation still applies to NHS Continuing Healthcare, a different approach may be necessary. For example, where a person receives 24-hour NHS-funded support by way of a care home package it may not be possible for privately-funded care to be provided at a time that is separate to NHS-funded care. However, in such circumstances, the private care should be delivered by different staff to those involved in delivering the NHS-funded care at the time it takes place and they should not be delivering treatment, care or support identified within the care plan as being part of the NHS-funded service.

275. Based on the above principles, examples of additional private services which might be purchased separately include hairdressing, aromatherapy, beauty treatments and entertainment services.

276. CCGs should seek to ensure that providers are aware of the above principles. Where a provider receives a request for additional privately-funded services from an individual who is funded by NHS Continuing Healthcare they should refer the matter to the CCG for consideration.

277. Although NHS-funded services must never be reduced or downgraded to take account of privately-funded care, the CCG and the organisations delivering NHS-funded care should, wherever appropriate, liaise with those delivering privately-funded care in order to ensure safe and effective coordination between the services provided. Transfers of responsibility between privately-funded and NHS

care should be carried out in a way which avoids putting individuals receiving services at any unnecessary risk. The CCG, the NHS-funded provider and the privately-funded provider should work collaboratively to put in place protocols to ensure effective risk management, timely sharing of information, continuity of care and coordination between NHS-funded and privately-funded care at all times. If different staff are involved in each element of care, these protocols should include arrangements for the safe and effective handover of the patient between those in charge of the NHS care and those in charge of the privately-funded care.

278. CCGs should also be aware that individuals in receipt of NHS Continuing Healthcare continue to be eligible for all other services available to patients of their CCG. In developing or reviewing care packages, CCGs should consider whether other services commissioned or provided by the CCG would help meet the individual's needs.

Higher cost care packages

279. The funding provided by CCGs in NHS Continuing Healthcare packages should be sufficient to meet the needs identified in the care plan, based on the CCG's knowledge of the costs of services for the relevant needs in the locality where they are to be provided.

280. Where an individual indicates a preference for higher-cost accommodation or services, the CCG should liaise with the individual to identify the reasons for their preference.

281. Where an individual's indicated preference is identified by the CCG to be necessary to meet their assessed needs, the CCG should meet this as part of the NHS Continuing Healthcare package. For example, an individual with challenging behaviour may need to have a larger room because it is identified that the behaviour is linked to feeling confined, or it may be agreed that the individual requires a care provider with specialist skills rather than a generic care provider.

282. Where an individual's indicated preference is not an assessed need, it is subject to the criteria outlined in the Additional Private Care guidance above. An example of this might be where an individual would like a larger room which is not related to their needs.

283. In some circumstances individuals become eligible for NHS Continuing Healthcare when they are already resident in care home accommodation for which the fees are higher than the relevant CCG would usually meet for an individual with their needs. This may be where the individual was previously funding their own care or where they were previously funded by a local authority and a third party had contributed to the fees payable. This is permissible under

legislation governing local authority provision but is not permissible under NHS legislation. For this reason, there are some circumstances where a CCG may propose a move to different accommodation or a change in care provision.

284. In such situations, CCGs should consider if there are reasons why they should meet the full cost of the existing care package, notwithstanding that it is at a higher rate. This could include that the frailty, mental health needs or other relevant needs of the individual mean that a move to other accommodation could involve significant risk to their health and well-being.

285. Where an individual in an existing out of area placement becomes eligible for NHS Continuing Healthcare the care package may be of a higher cost than the responsible CCG would usually fund for the person's needs. The CCG should consider whether the cost is reasonable, taking into account the market rates in the locality of the placement. They should also consider whether there are other circumstances that make it reasonable to fund the higher rate. Examples might include: where the location of the placement is close to family members who play an active role in the life of the individual, or where the individual has lived there for many years and it would be significantly detrimental to the individual to move them.

286. CCGs should deal with the above situations with sensitivity and in close liaison with the individuals affected and, where appropriate, their families, the existing service provider and the local authority. Where a CCG is considering moving such an individual because there is no justification for funding a higher cost placement, any decisions on moves to other accommodation or changes in care provider should be taken in full consultation with the individual concerned and put in writing with reasons given. Advocacy support should be provided where this is appropriate. Where the individual concerned lacks mental capacity, decisions about their accommodation must be made in compliance with the Mental Capacity Act 2005. An Independent Mental Capacity Act Advocate (IMCA) must be appointed where the statutory requirements are met.

287. Where the decision is made not to fund the higher cost package, the new accommodation and/or services should reflect the individual's assessed needs as identified in their care plan. This should take into account personal needs such as proximity to family members. Individuals should be provided with a reasonable choice of providers wherever possible.

288. In such cases, a transition care plan should be developed by the existing and new provider which identifies key needs and preferences. This should address how any specific needs and risks will be managed during the transition process. The CCG should keep in regular contact with the new provider and with the individual during the initial weeks of the new services to ensure that the transition has proceeded successfully and to ensure that any issues that arise are being appropriately addressed.

289. Where an individual becomes eligible for NHS Continuing Healthcare and has an existing high-cost care package, CCGs should consider funding the full cost of the existing higher-cost package until a decision is made on whether to meet the higher cost package on an ongoing basis or to arrange an alternative placement.

290. Where an individual wishes to dispute a decision not to pay for higher-cost accommodation, they should do this via the NHS complaints process. The letter from the CCG advising them of the decision should also include details of the complaints process and who to contact if the individual wishes to make a complaint. Refer to Practice Guidance notes 54-55 for two case studies.

Supporting individuals eligible for NHS Continuing Healthcare in their own home

291. Where an individual is eligible for NHS Continuing Healthcare and chooses to live in their own home, the CCG is financially responsible for meeting all assessed health and associated social care needs. This could include: equipment provision (refer to Practice Guidance note 56), routine and incontinence laundry, daily domestic tasks such as food preparation, shopping, washing up, bed-making and support to access community facilities, etc. (including additional support needs for the individual whilst the carer has a break). However, the NHS is not responsible for funding rent, food and normal utility bills.

292. There is a range of everyday household costs that are expected to be covered by personal income or through welfare benefits (e.g. food, rent/mortgage interest, fuel, clothing and other normal household items).

293. Whilst CCGs can take comparative costs and value for money into account, they must not set arbitrary limits on care at home packages based purely on the notional costs of caring for an individual in a home, if this does not represent a personalised approach or an accurate appraisal of the cost of meeting the assessed needs of the individual concerned. Such arbitrary limits are incompatible with personal health budgets which have been developed to enable people to live independently, work or participate in society. For more detail please see below and Practice Guidance note 45.

294. People who are eligible for NHS Continuing Healthcare and who choose to live in their own home may have additional support needs which it may be appropriate for the local authority to address subject to Care Act 2014 provisions and eligibility guidance, e.g. assistance and advice regarding property adaptation (refer to Practice Guidance note 56), support with essential parenting activities, deputyship or appointeeship services, safeguarding concerns, carer support or services required to enable the carer to maintain his/her caring responsibilities (bearing in mind paragraphs 323-330).

295. Where agencies and/or organisations have potentially overlapping powers and responsibilities there should be a discussion between the parties involved. As individual circumstances will differ considerably it is not possible to give hard and fast rules on how best to divide responsibilities in all situations where overlapping powers exist; reference should be made to each agency's statutory responsibilities.

Personal Health Budgets

296. A Personal Health Budget (PHB) is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local CCG. Personal Health Budgets are a means by which an individual can be given more choice and control. It is not new money, but a different way of spending health funding to meet the needs of an individual.

297. Individuals who are eligible for NHS Continuing Healthcare have had a right to have a Personal Health Budget since October 2014. Personal Health Budget Standing Rules require CCGs to provide people eligible for NHS Continuing Healthcare with information about Personal Health Budgets to offer them the option of taking them up, and support to do so.

298. Personal health budgets can be provided in three different ways, or in a combination of these ways:

a) a notional budget held by the commissioner;

b) a budget managed on the individual's behalf by a third party;

c) a cash payment to the individual (a 'direct payment').

299. A wide variety of resources are available via the personal health budgets pages of NHS England's website[1].

300. CCGs and local authorities are encouraged to work closely together with regard to the personalisation of care and support in order to share expertise and develop arrangements that provide for smooth transfers of care where necessary.

[1] NHS England website: Personal Health Budgets

Equipment

301. Where individuals in receipt of NHS Continuing Healthcare require equipment to meet their care needs, there are several routes by which this may be provided:

   a) If the individual is, or will be, supported in a care home setting, the care home may need to provide certain equipment in order to meet regulatory standards or as part of its contract with the CCG. Further details of the regulatory standards can be found on the Care Quality Commission's website[1].

   b) Individuals who are eligible for NHS Continuing Healthcare should have the same access to standard joint equipment services as other people. Therefore, when planning, commissioning and funding joint equipment services CCGs should ensure that the needs of current and future recipients of NHS Continuing Healthcare are taken into account.

   c) Some individuals in receipt of NHS Continuing Healthcare will require bespoke equipment (or other non-bespoke equipment that is not available through routes (a) and (b) above) to meet specific assessed needs. CCGs should make appropriate arrangements to assess and meet these and any subsequent equipment needs that might arise, including responsibility for any essential servicing and repair that might be required for particular items of equipment.

302. CCGs should ensure that there is clarity about which of the above arrangements is applicable in each individual situation, including responsibility for any essential servicing and repair that might be required for particular items of equipment CCGs are reminded of their ability to utilise Personal Health Budgets as a means of meeting equipment needs (including servicing and repair).

303. Where an individual is assessed in a hospital setting as being eligible for NHS Continuing Healthcare, CCGs must have systems in place to minimise delays to discharge due to equipment provision.

Access to other NHS-funded services

304. Those in receipt of NHS Continuing Healthcare continue to be entitled to access to the full range of primary, community, secondary and other health services. The CCG responsible for the individual should be determined in accordance with the principles set out in responsible commissioner guidance. CCGs should ensure that their contracting arrangements with care homes that provide nursing care give clarity on the responsibilities of nurses within the care home and of

[1] www.cqc.org.uk

community nursing services, respectively. No gap in service provision should arise between the two sectors.

Other existing commitments to NHS-funded care

305. Apart from a CCG's responsibilities for NHS Continuing Healthcare and their respective responsibilities under the Mental Health Act 1983, there may be other circumstances when the NHS is expected to take responsibility for a person's long-term care. One example might be people with learning disabilities, where there may be an existing agreement to fund ongoing care for individuals following the closure of long-stay hospitals or campuses. These responsibilities arise independently of a CCG's responsibility to provide NHS Continuing Healthcare, and there should be no assumption that these responsibilities equate to eligibility for NHS Continuing Healthcare or vice versa. Such agreements vary in terms of the commitments they make to fund needs that subsequently arise. Where additional needs do arise, it will be important for the CCG to first check whether there is clarity in such agreements on whether or not they cover responsibilities to meet such needs. If the additional needs fall outside the agreement, CCGs must consider their responsibilities to meet them, in terms both of the CCG's general responsibilities and potential eligibility for NHS Continuing Healthcare.

Advocacy

306. The Mental Capacity Act 2005 made provision for the statutory Independent Mental Capacity Advocate (IMCA) service. Its purpose is to represent and support vulnerable people who lack mental capacity and who are facing important decisions made by the NHS or local authorities, including about serious medical treatment or change of residence – for example, moving to a hospital or care home. An IMCA is normally instructed and consulted where an individual lacks mental capacity in relation to the relevant decision and has no family or friends that are available (or appropriate) to provide independent consultation regarding their best interests. An IMCA must be instructed for specific important decisions, including about the proposed provision of serious medical treatment or the provision of accommodation in a hospital or care home, including a change of accommodation (refer to Practice Guidance notes 9 and 56).

307. Even if an individual does not meet the criteria for use of the IMCA service, and regardless of whether or not they lack capacity, they may wish to be supported by an advocate to help ensure that their views and wishes are represented and taken into account. Any person may choose to have a family member or other person (who should operate independently of local authorities and CCGs) to act as an advocate on their behalf. CCGs should ensure that individuals are made aware of local advocacy and other services that may be able to offer advice and support and, in conjunction with local authority partners, may wish to consider whether there are any joint commissioning opportunities to enhance general advocacy services in their local area.

308. Although not related to the eligibility decision-making process, local authorities have a duty under the Care Act 2014 to promote the well-being of the individual at all times. Where relevant, this includes making arrangements for independent advocacy in relation to safeguarding enquiries relevant to the individual. Please see paragraph 170.

Mental health legislation

Section 117

309. CCGs and local authorities should be familiar with the relevant sections of the Mental Health Act 1983 (as amended).

310. Under section 117 of the Mental Health Act 1983 ('section 117'), CCGs and local authorities have a joint duty to provide after-care services to individuals who have been detained under certain provisions of the Mental Health Act 1983. The duty applies when those individuals cease to be detained and are discharged from hospital (including on Section 17 leave, or under a Community Treatment Order under section 17a) until such time as the CCG and local authority are satisfied that the person is no longer in need of such services. Section 117 is a freestanding duty to provide after-care services to the individual for needs arising from, or related to, their mental disorder. CCGs and local authorities should have in place local policies detailing their respective responsibilities, including funding arrangements.

311. The Care Act 2014 introduced a definition of section 117 after-care services as follows:

'services which have both of the following purposes—

(a) meeting a need arising from or related to the person's mental disorder; and

(b) reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder).'

312. It is important to make a distinction between needs that must be met under section 117 arrangements, and needs to be met under a different arrangement.

313. Responsibility for the provision of section 117 services lies jointly with local authorities and the NHS. Where an individual is eligible for services under section 117 these must be provided under section 117 and not under NHS Continuing Healthcare. It is important for CCGs to be clear in each case whether the individual's needs (or in some cases which elements of the individual's needs) are being funded under section 117, NHS Continuing Healthcare or any other powers.

314. There are no powers to charge for services provided under section 117, regardless of whether they are provided by the NHS or local authorities. Accordingly, the question of whether services should be free NHS services (rather than potentially charged-for social services) does not arise. It is not, therefore, necessary to assess eligibility for NHS Continuing Healthcare if all the

services in question are in fact to be provided as after-care services under section 117.

315. However, a person in receipt of after-care services under section 117 may also have ongoing needs that do not arise from, or are not related to, their mental disorder and that may, therefore, not fall within the scope of section 117. Also a person may be receiving services under section 117 and then develop separate physical health needs (e.g. through a stroke) which may then trigger the need to consider NHS Continuing Healthcare, but only in relation to these separate needs, bearing in mind that NHS Continuing Healthcare must not be used to meet section 117 needs. 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, consideration should be given to the use of the Fast Track Pathway Tool.

316. Local policies should be in place dealing with the approach to section 117 which should include apportionment of financial responsibility having regard to the nature of the services being provided.

317. Local authorities and CCGs may use a variety of different models and tools as a basis for working out how section 117 funding costs should be apportioned. However, where this results in a CCG fully funding a section 117 package this does not constitute NHS Continuing Healthcare.

318. It is preferable for the CCG to have separate budgets for funding section 117 and NHS Continuing Healthcare. Where they are funded from the same budget they still continue to be distinct and separate entitlements.

319. The legislation relating to assessment for NHS-funded Nursing Care contained in the Standing Rules, applies to section 117 individuals as it does to other individuals.

Deprivation of Liberty Safeguards

320. The Mental Capacity Act 2005 contains provisions that apply to an individual who lacks capacity and who, in their best interests, needs to be deprived of their liberty in a care home or hospital, in order for them to receive the necessary care or treatment. In such situations the deprivation of liberty can be authorised using the Deprivation of Liberty Safeguards (DoLS) process set out in the Act. These safeguards are in place in order to ensure that an individual is not deprived of their liberty unlawfully. The fact that an individual who lacks capacity needs to be deprived of his or her liberty in these circumstances does not, in itself, preclude or require consideration of whether that individual is eligible for NHS Continuing Healthcare.

321. Where an individual is in receipt of NHS Continuing Healthcare, and they lack mental capacity to consent to their accommodation, or care and support arrangements, the CCG must ensure that the arrangements they commission are lawful and compliant with the Mental Capacity Act. This means that, where the person is placed in a care home or hospital and they will be subject to restrictions that constitute a deprivation of their liberty, the care provider must request authorisation from the relevant local authority (or in some specific circumstances, the Court of Protection) for this deprivation of liberty. The request for Deprivation of Liberty Safeguards (DoLS) authorisation should be made by the care home or hospital to the local authority before the placement is made.

322. Where the individual who lacks capacity is in receipt of NHS Continuing Healthcare in their own home, including tenancy based accommodation (e.g. supported living), and is subject to restrictions that may constitute a deprivation of liberty, the deprivation of liberty cannot be authorised using the Deprivation of Liberty Safeguards (DoLS) process, instead authorisation must be obtained from the Court of Protection. In these circumstances, because the CCG is the primary funding authority, it is responsible for applying to the Court of Protection for this authorisation and should seek their own legal advice for this reason. The CCG is responsible for its own associated legal costs, but is not responsible for the legal costs of the individual concerned. However, the CCG should ensure that the individual has access to legal advice in their own right.

Carers

323. The important role played by carers is recognised by both central and local government, irrespective of how the cared-for individual has their care funded. CCGs and local authorities have a joint responsibility to identify, and work in partnership with, carers and young carers so that they can be better supported to continue with their caring role, if they are willing and able to do so.

324. A carer is anyone who, usually unpaid, looks after a friend or family member in need of extra help or support with daily living, for example, because of illness, disability or frailty.

325. Healthcare professionals and social care practitioners should be proactive in identifying carers and be sensitive to the level of support they need and desire. This empathetic approach should be reflected in any Checklist and/or full assessment of eligibility for NHS Continuing Healthcare with carers and family members involved where appropriate.

326. When a CCG is supporting a home-based package where the involvement of a family member or friend is an integral part of the care plan, it should agree with the carer the level of support they will provide. It should also undertake an assessment of the carer's ability to continue to care, satisfying themselves that the responsibilities on the carer are appropriate and sustainable, and establish whether there is an 'appearance of need for support', which would mean that the carer should be referred for a carer's assessment (see paragraph 329 below).

327. The CCG may need to provide additional support to care for the individual whilst the carer(s) has a break from his or her caring responsibilities and will need to assure carers of the availability of this support when required. This could take the form of the CCG providing the cared-for person with additional services in their own home or providing the necessary support to enable them to spend a period of time away from home (e.g. a care home). The CCG should also give consideration to meeting any training needs that the carer may have to carry out this role.

328. Carers should have a single point of contact with the CCG to facilitate communication about any aspect of the care and support arrangements. CCGs should also work collaboratively with carers to agree contingency plans should the carer be unexpectedly unable to continue their caring role. This should include information on who to contact out of hours.

329. Consideration should also be given to making a referral for a separate carer's assessment by the relevant local authority. Under the Care Act 2014, all NHS bodies have a reciprocal duty to cooperate with local authorities in exercise of

their respective functions relating to carers[1]. Of particular relevance is the local authority's duty to conduct a carer's assessment 'on the appearance of need for support'[2]. This means that where on the basis of the steps above the CCG believes that there may be a need for support, a referral should be made. This may be particularly relevant where the carer has needs in relation to education, leisure or work (unrelated to their caring role) as these fall outside the scope of NHS Continuing Healthcare but can be addressed through Care Act 2014 provisions.

330. In May 2016, NHS England published *An Integrated Approach to Identifying and Assessing Carer Health and Wellbeing* to help health and social care organisations work together in identifying, assessing and supporting carers[3]. The Children and Families Act 2014[4] also includes duties for the assessment of young carers and parent carers of children under 18.

[1] *Section 6(1)(b) of the Care Act 2014*

[2] *Section 10(1) of the Care Act 2014*

[3] *An Integrated Approach to Identifying and Assessing Carer Health and Wellbeing*

[4] *Children and Families Act 2014*

Transition from child to adult services

331. The National Framework for NHS Continuing Healthcare and the supporting guidance and tools should be used to determine what ongoing care services individuals aged 18 years or over should receive from the NHS.

332. Legislation and the respective responsibilities of the NHS, social care and other services are different in child and adult services. For children and young people, from birth to 18 (i.e. their 18th birthday), needs are assessed against a children's national framework, with a recommendation made to a multi-agency panel[1].

333. The term 'continuing care' has different meanings in child and adult services. For children and young people, continuing care refers to additional health support to that which is routinely available from GP practices, hospitals or in the community, and it can include care jointly commissioned by a local authority and CCG. It is important that young people and their families are helped to understand this and its implications right from the start of transition planning from children into adult services.

334. Eligibility for children's continuing care does not pre-suppose eligibility for NHS Continuing Healthcare.

335. There are a range of sources to support good practice in relation to transition for young people with complex heath needs or disabilities. All transition planning for young people should take full account of the approaches set out in these documents. These documents set out below:

- The NICE quality standard QS140 Transition from children's to adults' services sets out some fundamental principles of assuring an effective transition[2].
- *Transition: moving on well*[3] sets out good practice for health professionals and their partners in transition planning for young people with complex health needs or disabilities.
- *A transition guide for all services*[4] explains how all relevant services should work together with a young person to identify how they can best support that person to achieve their desired outcomes.

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[1] *Children and young people's continuing care national framework*

[2] NICE quality standard QS140 Transition from children's to adults' services

[3] Transition: moving on well

[4] A transition guide for all services

336. CCGs and local authorities should have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a young person who, on reaching adulthood, may have a need for services from the other agency.

337. CCGs should ensure that they are actively involved, with their partners, in the strategic development and oversight of their local transition planning processes, and that their representation includes those who understand and can speak on behalf of adult NHS Continuing Healthcare. CCGs should also ensure that adult NHS Continuing Healthcare is appropriately represented at all transition planning meetings to do with individual young people whose needs suggest that there may be potential eligibility.

338. The needs of a young person, and any future entitlement to adult NHS Continuing Healthcare should be clarified as early as possible in the transition planning process, especially if the young person's needs are likely to remain at a similar level until adulthood.

339. Children's services should identify those young people for whom it is likely that adult NHS Continuing Healthcare will be necessary, and should notify whichever CCG will have responsibility for them as adults. This should occur when a young person reaches the age of 14.

340. This should be followed up by a formal referral for screening to the adult NHS Continuing Healthcare team at the relevant CCG, when the child or young person is 16.

341. As soon as practicable after the young person's 17th birthday, eligibility for adult NHS Continuing Healthcare should be determined in principle by the relevant CCG, so that, wherever applicable, effective packages of care can be commissioned in time for the individual's 18th birthday. In order to do this staff from adult services (who are familiar with the adult NHS Continuing Healthcare National Framework) will need to be involved in both the assessment and care planning to ensure smooth transition to adult services. If needs are likely to change, it may be appropriate to make a provisional decision, and then to recheck it by repeating the process as adulthood approaches.

342. Entitlement to adult NHS Continuing Healthcare should initially be established using the decision-making process set out in this adult National Framework, including the Checklist and the Decision Support Tool. The decision on eligibility should be made using the relevant CCG's usual adult NHS Continuing Healthcare decision-making processes (although the usual 28 calendar day timescale between Checklist and decision does not apply for young people in transition). The health plans and other assessments and plans developed as part

of the transition process will provide key evidence to be considered in the decision-making process. Any entitlement that is identified by means of these processes before a young person reaches adulthood will come into effect on their 18th birthday, subject to any change in their needs. The first review for NHS Continuing Healthcare would then normally take place three months after the person's 18th birthday and thereafter at least annually.

343. Where a young person has been assessed as being eligible for adult NHS Continuing Healthcare when they reach 18 years but lacks the mental capacity to decide about their future accommodation and support arrangements, a best interest decision will have to be made about these issues. This process must be compliant with the 2005 Mental Capacity Act, in particular with regards to consulting relevant people. If there is a significant difference of opinion between the responsible commissioner and the young person's family as to what arrangements would be in their best interests, this needs to be resolved before their 18th birthday. Normal best practice is that such resolution is achieved through open and collaborative discussion between all parties. If there remains disagreement, timely application should be made to the Court of Protection early enough for care and support arrangements to be in place when the young person reaches 18.

344. If a young person who receives children's continuing care has been determined by the relevant CCG not to be eligible for a package of adult NHS Continuing Healthcare in respect of when they reach the age of 18, then they and their parents or guardians – or in the case of looked after children their social worker and Independent Reviewing Officer – should be advised of their non-eligibility and of their right to request an independent review, on the same basis as NHS Continuing Healthcare eligibility decisions regarding adults. The CCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care.

345. Where a young person receives support via a placement outside the CCG's area, it is important that, at an early stage in the transition planning process, there is clear agreement between the CCGs involved as to whom the responsible commissioner presently is, and whether this could potentially change. This should be determined by applying the principles set out in the relevant legislation. All parties with current or future responsibilities should be actively represented in the transition planning process. A dispute or lack of clarity over commissioner responsibilities must not result in a lack of appropriate input into the transition process.

346. Even if a young person is not eligible for adult NHS Continuing Healthcare, they may have certain health needs that are the responsibility of the NHS. In such circumstances, CCGs should continue to play a full role in transition planning for

the young person, and should ensure that appropriate arrangements are in place for services that meet these needs to be commissioned or provided. The focus should always be on the individual's desired outcomes and the support needed to achieve these.

347. Where a child has an Education, Health and Care plan (EHC plan) for special educational needs in addition to a continuing care plan, this may continue up to age 25; the transitional period will provide an opportunity for aligning a review of that EHC plan, and the assessment for NHS Continuing Healthcare.

348. A key aim is to ensure that a consistent package of support is provided during the years before and after the transition to adulthood. The nature of the package may change because the young person's needs or circumstances change. However, it should not change simply because of the move from children's to adult services or because of a change in the organisation with commissioning or funding responsibilities. Where change is necessary, it should be carried out in a planned manner, in full consultation with the young person, bearing the options available through Personal Health Budgets (refer to paragraphs 296-300 of the National Framework). No services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place.

349. The legal responsibilities for child and adult services overlap in certain circumstances. In developing individual transition plans, partners should be clear where such overlaps occur, and the plans should clearly set out who will take responsibility and why. Some local health services for children and young people are only offered up to an age short of adulthood (i.e. 16). CCGs and other partners responsible for children and young people's services should ensure that appropriate services are commissioned to meet needs through to adulthood. A gap in service provision based on age does not mean that adult NHS Continuing Healthcare services acquire early responsibility. Where service gaps are identified, CCGs should consider how to address these as part of their strategic commissioning responsibilities.

Practice Guidance

Leadership and Governance

PG 1 What are the key governance functions of the CCG in relation to NHS Continuing Healthcare?

1.1 CCGs have the lead responsibility for NHS Continuing Healthcare in their locality.

1.2 Paragraph 21 of the National Framework sets out best practice governance responsibilities of CCGs. These are expanded on below.

1.3 Ensuring consistency in the application of the national policy on eligibility for NHS Continuing Healthcare

This may be achieved, for example, through the CCGs:

- monitoring patterns of eligibility decision-making
- using monitoring data to identify and address variations between areas and client groups (including use of the equality monitoring forms)
- peer review of eligibility decisions
- management audits of practice
- developing consistent protocols around completion of the Decision Support Tool (DST)
- working with staff to disseminate learning from the above processes and to identify development issues
- providing effective equality, diversity and human rights training and development, with a particular emphasis on understanding the cultures of the people they are most likely to encounter in their local area.

1.4 Promoting awareness of NHS Continuing Healthcare

This may be achieved, for example, through:

- ensuring that public information is available in appropriate formats and languages at key locations
- providing up to date information on the CCG and LA websites
- providing awareness-raising sessions for staff

- using existing networks to promote better understanding of NHS Continuing Healthcare
- working with independent and/or voluntary organisations to promote awareness.

1.5 Implementing and maintaining good practice

- This may be achieved, for example, through:
- clinical supervision arrangements with staff both individually and as a team
- ensuring that training is jointly developed and delivered with LA partners and tailored to identify and promote good practice
- use of regional meetings to identify and promote good practice and consistency
- use of pathway/process analysis to identify areas for development.

1.6 Ensuring that quality standards are met and sustained

This could, for example, include:

- agreement of quality standards across key agencies
- monitoring contracts for delivery of delegated NHS Continuing Healthcare functions
- use of auditing tools to check process and quality at different stages
- learning from complaints/compliments.

1.7 Providing training and development opportunities for practitioners

The CCG's responsibility is to maintain an oversight as to whether staff across relevant agencies are appropriately trained in relation to NHS Continuing Healthcare, though this does not necessarily mean the CCG has to carry out or fund all the training itself. The CCG's actions could, for example, include:

- providing core training courses on a rolling programme, jointly developed and delivered with other NHS organisations and the local authority
- providing specialist training sessions for coordinators/nurse assessors/social workers and others in NHS Continuing Healthcare roles across organisations
- ensuring training is available for relevant independent sector provider staff
- making training materials available for other organisations to use
- inclusion of NHS Continuing Healthcare in induction training for all relevant staff.

1.8 Identifying and acting on issues arising in the provision of NHS Continuing Healthcare

This could, for example, include:

- systematically reviewing complaints and disputes, including looking for patterns of unlawful discrimination or disproportionate negative impact on individuals, groups and communities
- undertaking ‘root cause analysis’ when a problem arises
- addressing the issues through contract management processes with provider organisations
- using some form of ‘joint solutions group’ with the local authority
- establishing robust risk management systems
- being a ‘learning organisation’ so that the whole team discusses and identifies necessary practice changes.

1.9 Informing commissioning arrangements, both on a strategic and an individual basis

The key to high quality cost-effective care is through robust commissioning and contracting arrangements. Achieving this could, for example, involve:

- use of activity and other monitoring data together with information from individual assessments and joint strategic needs assessments to forecast future patterns of demand
- joint analysis of needs with the local authority through strategic needs analysis processes
- a coordinated approach between the local authority and CCG at all levels of commissioning, brokerage and purchasing to provide a single and coherent interface with the market
- consideration of regional commissioning for cost-effective specialist provision, though care needs to be taken to ensure models that enable personalisation and choice, particularly for socially excluded, vulnerable and hard to reach groups
- liaising with local providers and providing information about likely future demand, possibly through a joint provider forum with the relevant local authority and by having an identified CCG lead for liaison with providers.
- having clear systems in place for the provision of Personal Health Budgets (PHBs).

Legal Context

PG 2 Is there an authoritative definition of 'beyond the responsibility of the local authority'?

2.1 Local authorities have a duty to carry out an assessment of needs where it appears that an individual may have needs for care and support, and a duty to meet eligible needs (subject to means testing). However, local authorities cannot lawfully commission services that are clearly the responsibility of the NHS (such as registered nursing care and services that the NHS has to provide because the individual has a primary health need and is therefore eligible for NHS Continuing Healthcare).

2.2 Whilst there is no legal lower limit to what the NHS can provide, there is a legal limit to nursing and healthcare that can be provided by local authorities. This is a complex area of law. The powers and duties of local authorities derive from statute and case law, including the Coughlan Judgment (refer to Annex B).

2.3 Section 22 (1) of the Care Act 2014 confirms the general limits of local authority responsibility (as clarified in the Coughlan Judgment) stating that the local authority may not meet needs by providing or arranging for the provision of a service or facility that is required to be provided under the NHS Act 2006 unless:

- doing so would be merely incidental or ancillary to doing something else to meet needs under sections 18-20 of the Care Act 2014, and
- the service or facility in question would be of a nature that the local authority could be expected to provide.

2.4 Therefore, whilst local authorities can and do commission care in care homes (with or without nursing) where the person's needs to be met include elements of 'general nursing' which can be provided by healthcare assistants or care assistants, this can only lawfully occur when this 'nursing care' is both incidental or ancillary to the individual's accommodation and of a nature that a local authority can be expected to provide.

2.5 Where a local authority is funding an individual in a care home with nursing who requires registered nursing care, the CCG will be responsible for funding 'NHS-funded Nursing Care', so long as it has first been established that the individual is not eligible for NHS Continuing Healthcare. The Care Act 2014 (section 22(3)) clarifies that a local authority may not meet needs by providing or arranging for the provision of nursing care by a registered nurse (except under very specific circumstances set out in Section 22 (4) of the Care Act 2014).

Primary Health Need

PG 3 When identifying a primary health need, how should the four key characteristics be approached?

3.1 Four characteristics of need – namely 'nature', 'intensity', 'complexity' and 'unpredictability' – 'may help determine whether the 'quality' or 'quantity' of care required is beyond the limit of a local authority's responsibilities, as outlined in the Coughlan case (a summary of the case can be found at Annex B). It is important to remember that each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual's needs.

3.2 It may be helpful for MDTs to think about these characteristics in terms of the sorts of questions that each generates. By the MDT answering these questions they can develop a good understanding of the characteristic in question. The following questions are not an exhaustive list and are not intended to be applied prescriptively.

3.3 **'Nature'** is about the characteristics of both the individual's needs and the interventions required to meet those needs.

Questions that may help to consider this include:

- How does the individual or the practitioner describe the needs (rather than the medical condition leading to them)? What adjectives do they use?
- What is the impact of the need on overall health and well-being?
- What types of interventions are required to meet the need?
- Is there particular knowledge/skill/training required to anticipate and address the need? Could anyone do it without specific training?
- Is the individual's condition deteriorating/improving?
- What would happen if these needs were not met in a timely way?

3.4 **'Intensity'** is about the quantity, severity and continuity of needs.

Questions that may help to consider this include:

- How severe is this need?
- How often is each intervention required?
- For how long is each intervention required?

- How many carers/care workers are required at any one time to meet the needs?
- Does the care relate to needs over several domains?

3.5 **'Complexity'** is about the level of skill/knowledge required to address an individual need or the range of needs and the interface between two or more needs.

Questions that may help to consider this include:

- How difficult is it to manage the need(s)?
- How problematic is it to alleviate the needs and symptoms?
- Are the needs interrelated?
- Do they impact on each other to make the needs even more difficult to address?
- How much knowledge is required to address the need(s)?
- How much skill is required to address the need(s)?
- How does the individual's response to their condition make it more difficult to provide appropriate support?

3.6 **'Unpredictability'** is about the degree to which needs fluctuate and thereby create challenges in managing them. It should be noted that the identification of unpredictable needs does not, of itself, make the needs 'predictable' (i.e. 'predictably unpredictable') and they should therefore be considered as part of this key indicator.

Questions that may help to consider this include:

- Is the individual or those who support him/her able to anticipate when the need(s) might arise?
- Does the level of need often change? Does the level of support often have to change at short notice?
- Is the condition unstable?
- What happens if the need isn't addressed when it arises? How significant are the consequences?
- To what extent is professional knowledge/skill required to respond spontaneously and appropriately?
- What level of monitoring/review is required?

Core Values and Principles

PG 4 What are the key elements of a 'person-centred' approach in NHS Continuing Healthcare?

4.1 The whole process of determining eligibility and planning and delivering services for NHS Continuing Healthcare should be 'person-centred'. This is vital since individuals going through this process will be at a very vulnerable point in their lives. There may well be difficult and significant choices to be made, so empowering individuals at this time is essential. This approach is also at the heart of wider policy on the personalisation of health and social care services (refer to paragraphs 296-300 of the National Framework).

4.2 Despite professional intentions to treat individuals with dignity and respect, the perception of individuals can be that this is not always the case. It is important for practitioners to put themselves in the position of the individual by asking questions like:

- 'How would I feel if this was happening to me?'
- 'Have I really tried to understand what this person wants, and what is important to them now and for the future?'

4.3 There are many elements to a person-centred approach but as a minimum it is necessary to:

a) ensure that the individual and/or their representative concerned is fully and directly involved in the assessment and the decision-making process;

b) take full account of the individual's own views and wishes, ensuring that their perspective is clearly the starting point of every part of the assessment process;

c) address communication and language needs;

d) obtain consent to assessment and sharing of records (where the individual has mental capacity to give this);

e) deal openly with issues of risk;

f) keep the individual (and/or their representative) fully informed.

a), b) and c) are explained further below, d), e) and f) are explained further in later sections of this guidance (refer to Practice Guidance notes 57-58).

a) Ensuring that the individual concerned and/or their representative is fully and directly involved in the assessment and the decision-making process

Individuals being assessed for NHS Continuing Healthcare are frequently facing significant changes in their life. It is essential that a person-centred approach is taken throughout the assessment process. A positive experience of the assessment process that promotes genuine choice and control can empower the person, resulting in a much better outcome.

The DST specifically asks whether the individual was involved in its completion, whether they were offered the opportunity to have a representative and whether the representative attended the DST completion. It also asks for details of the individual's view of their own care/support needs, whether the MDT assessment accurately reflects these and whether they contributed to the assessment. It also asks for the individual's views on the completion of the DST, including their view on the domain levels selected. The provision of advocacy, where appropriate, is an important means of achieving meaningful participation (refer to Practice Guidance note 9 and 57 below). `All reasonable efforts should be made to involve the individual and/or their representative in the assessment process.

b) Taking full account of the individual's own views and wishes, ensuring that their perspective is clearly the starting point of every part of the assessment process

The individual's own views of their needs and their preference as to how they should be met should be documented and given due regard at each stage. Whilst accepting that they are not clinicians, it is important to recognise that some individuals can be experts in managing their own care needs. They should be given as much choice as possible, particularly in the care planning process. Where mental capacity issues impact on an individual's ability to express their views the approaches set out in this guidance should be used, including using family members and others who know the individual well to find out as much as possible on what the individual would want if they were able to express a view.

Where issues arise from needs and risks that may affect the care/support options available, these should be fully discussed with the individual. Care should be taken to avoid indicating any firm conclusions about care/support arrangements until needs have been fully assessed and it is clear what the funding arrangements may be.

c) Addressing communication and language needs

It is important to establish at the outset whether the individual has any particular communication needs and, if so, how these can be addressed. If English is not their first language an interpreter may be required, or if they have a learning disability the use of photographs, pictures or symbols may be helpful to support communication.

Hearing difficulties are often exacerbated where there is background noise (so a quiet room might be needed), and many older people in particular struggle to use any hearing aid they may have. If the individual uses British Sign Language (BSL) it will be necessary to arrange for a BSL interpreter, which may have to be booked well ahead. CCGs should consider the most likely communication needs to arise in the course of assessing for NHS Continuing Healthcare and make ongoing arrangements for appropriate support to be readily accessible. This could be, for example, by having arrangements with identified formal interpreters to be available at short notice.

Preferred methods of communication should be checked with the person or their relatives, friends or representatives in advance. Where a person has specific communication needs such that it takes them longer than most people to express their views, this should be planned into the time allocated to carry out their assessment.

Reasonable adjustments may need to be made (in accordance with the Equalities Act 2010) to enable the individual or their representative to fully participate in the process. For example, if the individual or their representative is not able to take or read written notes it may be considered a reasonable adjustment for them to take an audio recording of a meeting which they can refer to at a later date. However, it is important to be mindful of confidentiality issues and for an explicit agreement to be reached regarding the purpose and use of the recording. This is particularly important when a third party is recording the meeting rather than the individual concerned. In these circumstances either the individual concerned should give consent or, if they lack capacity, a best interest decision should be made by the professional chairing or leading the meeting.

The overall approach to carrying out the assessment is of equal importance in terms of accessibility to the technical arrangements that are put in place. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion naturally progresses, rather than working through an assessment document in a linear fashion. It is important that the person’s own view of their needs is given due regard alongside professional views.

Consent

PG 5 What specific guidance is there in relation to dealing with confidentiality?

General Principles:

5.1 Where the person has mental capacity their informed consent is required before completion of the Checklist and for every stage of the process. It is good practice to seek consent for the whole process at the same time as obtaining consent for the Checklist (i.e. for the individual to also explicitly agree to the MDT sharing assessment information and completing the DST), although it should be made clear to individuals that they can withdraw their consent at any time and it would be good practice to ensure that the person is still consenting at each stage.

Confidentiality: NHS Code of Practice[1] is applicable to decisions on NHS Continuing Healthcare eligibility. The Code states:

'It is extremely important that patients are made aware of information disclosures that must take place in order to provide them with high quality care' … 'whilst patients may understand that information needs to be shared between members of care teams and between different organisations involved in healthcare provision, this may not be the case and the efforts made to inform them should reflect the breadth of the required disclosure. This is particularly important where disclosure extends to non-NHS bodies'

and:

'… Patients generally have the right to object to the use and disclosure of confidential information that identifies them, and need to be made aware of this right. Sometimes, if patients choose to prohibit information being disclosed to other health professionals involved in providing care, it might mean that the care that can be provided is limited and, in extremely rare circumstances, that it is not possible to offer certain treatment options.

'Patients must be informed if their decisions about disclosure have implications for the provision of care or treatment. Clinicians cannot usually treat patients safely, nor

[1] Confidentiality: NHS Code of Practice and Confidentiality: NHS Code of Practice - supplementary guidance: public interest disclosures

provide continuity of care, without having relevant information about a patient's condition and medical history.'

'Where patients have been informed of:

the use and disclosure of their information associated with their healthcare; and

the choices that they have and the implications of choosing to limit how information may be used or shared then explicit consent is not usually required for information disclosures needed to provide that healthcare. Even so, opportunities to check that patients understand what may happen and are content should be taken…'

5.2 When explicit consent is sought from patients, the Code advises that there should be evidence that consent has been given, either by noting this within a patient's health record or by including a consent form signed by the patient.

5.3 When requesting consent to consider an individual's eligibility for NHS Continuing Healthcare, this should also include consent to obtain relevant health and social care records necessary to inform determination of eligibility and also consent for these to be shared appropriately with those involved in the eligibility process. Individuals should be made aware of the range of records which may be disclosed and the range of health and social care professionals who may need to read them. The records that may be required to reach an informed conclusion on eligibility could include those from GPs, hospitals, community health services, LA social care, care homes and domiciliary care/support services.

5.4 Whilst it may not be possible at the outset in every case to indicate the exact records that may be required, individuals should be aware of the range of records that may be requested and explicitly give their consent to this range. A key question to consider is whether a professional receiving a request for access to the individual's records, exercising reasonable care, would be satisfied that the consent supplied by the individual is sufficiently clear and specific for them to be able to release the records. Whilst it is preferable for consent to be recorded in writing, there may be circumstances where an individual is not physically able to provide written evidence of consent but is able to express their consent through verbal or other means. In such cases, the fact that consent has been given should be recorded in the patient's notes and evidence of it made available to other professionals when records are required.

5.5 Individuals should always be given the option to withhold consent to accessing specific records where they wish, or for personal information being shared with particular people or agencies. The implications of withholding consent on the ability of the MDT or CCG to reach an informed decision in eligibility should be explained to the individual. However, they should never be put under pressure to give consent.

Practitioners should respect confidentiality and ensure that information is not shared with third parties where consent has not been given.

Where the individual lacks capacity

5.6 Where the individual lacks mental capacity to consent to sharing personal information with relevant 3rd parties, a decision should be made as to whether sharing the information is in the individual's 'best interests' in accordance with the Mental Capacity Act 2005. Information sharing between professionals regarding a person who lacks capacity which is necessary for the purpose of their care or treatment will normally be in the person's best interest, in which case information can be shared subject to any local information sharing protocol that may be in place. In the context of this National Framework 'for the purpose of care and treatment' is taken to include the assessment of eligibility for NHS Continuing Healthcare.

5.7 Anyone who holds information regarding an individual who lacks mental capacity has a responsibility to act in that person's best interests and this can extend to sharing that information with relevant 3rd parties in appropriate circumstances.

5.8 There are some specific circumstances where information must be shared with a third party e.g. where they have a registered Lasting Power of Attorney (Health and Welfare) or are a court appointed Deputy (Health and Welfare).

5.9 There are also circumstances where it would be acceptable for a third party who is assuming responsibility for acting in a person's best interests (but may not have the formal authority of being an LPA (LPA) (health and welfare) or Court Appointed Deputy (health and welfare) to legitimately request information. In deciding whether to share personal/clinical information regarding an individual who lacks mental capacity with a family member, or anyone purporting to be representing the individual, the information holder must act within the following principles:

- any decision to share information must be in the individual's best interests;
- the information which is shared should only be that which it is necessary in order for the third party to act in the individual's best interests.

5.10 Subject to the above principles, information should not be unreasonably withheld.

5.11 There are a number of situations where a third party may legitimately be given information so long as the above principles are followed. Some common examples include:

- someone making care arrangements who requires information about the individual's needs in order to arrange appropriate support;

- someone with an LPA (property and finance), Deputyship (property and finance) or a registered Enduring Power of Attorney (EPA) seeking to challenge an eligibility decision, or any other person acting in the person's best interests to challenge an eligibility decision.

5.12 If the person lacks capacity, information can be shared where the local authority is satisfied that doing so is in the person's best interests as stated in the Mental Capacity Act 2005.

5.13 One of the key principles behind adult safeguarding work is empowerment: people should be being supported and encouraged to make their own decisions and informed consent. This should be prioritised for the local decision making process.

5.14 Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action, for example because a criminal offence has occurred.

5.15 Because an adult initially refuses the offer of assistance he or she should not therefore be lost to or abandoned by relevant services. The situation should be monitored and the individual informed that she or he can take up the offer of assistance at any time.

PG 6 What are the rules around sharing information in the NHS Continuing Healthcare assessment process?

6.1 The rules governing information sharing are the same for NHS Continuing Healthcare as elsewhere and derive from several acts of Parliament, (including the Data Protection Act 1998, the Access to Health Records Act 1990 and the Mental Capacity Act 2005), the common law duty of confidence, and from a range of national guidance, including the Caldicott Principles. What information can, and should, be shared depends on a number of factors, including:

- Whether the individual concerned is alive or dead, bearing in mind that the records of deceased individuals are still confidential, even after death.

- If alive, whether the individual has capacity to consent to the information being shared. If they do then they should be asked for their consent to share the information and their answer recorded.

- If alive but lacking capacity, whether someone else has legal authority to make welfare decisions on their behalf (e.g. under health and welfare lasting power of attorney or health and welfare court deputy arrangements). If so the person with legal authority can give consent to sharing information on their behalf.

- If alive, lacking capacity and no-one else has authority to make decisions on their behalf, whether sharing information is properly considered to be in the individual's best interests (under the Mental Capacity Act). In the context of NHS Continuing Healthcare it may well be in their best interests for relevant information to be shared. This may include disclosing information to a property and financial affairs deputy or attorney in order for them to carry out their responsibilities, or indeed any other third party who is acting as an advocate for them.

- If the individual concerned is deceased, whether the person requesting information has the proper authority to do so (e.g. the executor of the person's estate or someone who has grant of probate etc.).

- Whether the individual concerned now or in the past has expressly stated that certain information should not be shared

- Whether disclosure of information could lead to any person being put at serious risk of significant harm.

- Whether the records to be shared contain information about a third party (who isn't a professional), in which case this part of the record cannot be shared without some lawful basis for doing so.

- If information has been supplied by a third party (who is not part of the organisation holding the records) then it belongs to that third party and can only be shared by them or with their permission.

6.2 A guiding principle is that where decisions are being made in relation to any person's package of health or social care all pertinent information should be made available, wherever it is possible to do so having regard to the relevant law and guidance.

Capacity

PG 7 What happens if an individual with mental capacity refuses to give consent to being considered for NHS Continuing Healthcare eligibility?

7.1 Apart from the guidance given in this National Framework, The Reference guide[1] to consent for examination or treatment (second edition 2009), although focused on examination and treatment issues contains principles that should also be taken into account when considering a situation where the individual refuses consent to being considered for NHS Continuing Healthcare eligibility.

7.2 If an individual refuses to consent to the completion of a Checklist or NHS Continuing Healthcare assessment it should be clearly explained that this could potentially affect the ability of the NHS and the local authority to provide appropriate services. The reasons for their refusal should be explored. It should be explained that, if they were to consent and if the result was that they were found to be eligible for NHS Continuing Healthcare, the NHS has responsibility for funding the support necessary to meet their assessed health and social care needs. It is important to clearly document the efforts made to resolve the situation, including information and explanations given to the individual and/or their representative (where applicable).

7.3 Every effort should be made to encourage the individual to be considered for eligibility for NHS Continuing Healthcare, dealing with any concerns that they may have about this. For example, their reason for refusing consent could be a concern about losing an existing or potential direct payment arrangement, or that the level of funding available to support them might be reduced. The individual should be advised on what the CCG can do to personalise care/support and give them as much control as possible. Fuller details of approaches on this are in paragraphs 296-300 of the National Framework.

7.4 If a local authority decides that the refusal to consent to an assessment for NHS continuing healthcare means that local authority services can no longer be provided, they should give reasonable notice and clear reasons to the person concerned and give them the opportunity to request a review of the decision or to take it through the complaints process.

7.5 Although refusal of consent only occurs in a minority of cases, CCGs and local authorities should consider developing jointly agreed protocols on the processes to be followed. These should provide clarity regarding approaches such as the use of existing assessments and other information to determine each organisation's responsibilities and the most appropriate way forward. The aim should be for

[1] Reference guide to consent for examination or treatment (second edition)

practitioners to be clear on their responsibilities and how to escalate the case if necessary, and that the individual affected can make an informed decision on future support options as quickly as possible.

PG 8 What if there are concerns that the individual may lack capacity to consent to the completion of a Checklist/DST?

8.1 Where the third party is unable or unwilling to provide evidence of their delegated authority then decision-making responsibility remains with the assessor (although, dependent upon the urgency of the situation, the third party should be given reasonable opportunity to provide the order or LPA if they do not have it with them when requested). It is important to ensure that the assessment and support planning process is not delayed whilst awaiting confirmation of any legal authority that may be in place. Where a person has been appointed as attorney or deputy in relation to the person's property and financial affairs only, they do not have authority to make decisions about health and welfare. If they do have the appropriate authority then the assessment cannot continue if the personal welfare attorney or deputy refuses consent. Under these circumstances if the assessor believes that the deputy/attorney's decision is contrary to the best interests of the person, or would seriously compromise them, consideration should be given to raising this concern through the local Safeguarding Adults procedure. In appropriate circumstances the Court of Protection can overrule the decision or withdraw the welfare decision-making authority from the person.

PG 9 When is it appropriate to involve an Independent Mental Capacity Advocate (IMCA)?

9.1 An IMCA does not routinely need to be appointed in the context of an NHS Continuing Healthcare assessment. However, NHS bodies and LAs have a duty under the Mental Capacity Act 2005 to instruct and consult an IMCA if an individual lacks capacity in relation to, serious medical treatment or a change of accommodation for a certain period (at least 28 calendar days for a hospital admission or a stay of eight weeks in a care home), and has no family or friends that are available (or appropriate) for consultation on their behalf.

9.2 Where an IMCA has been appointed a permanent decision should not be made on the issue (for which they have been appointed) until the IMCA report has been submitted and considered by the decision-maker.

PG 10 Dealing openly with issues of risk

10.1 Assessment of risk is central to providing a holistic multidisciplinary assessment of need. A good risk assessment will include listening and observation, talking to the individual and their carers to identify what risks they see and their proposed response to them in the context of their personal and family circumstances, talking to

other agencies and providers of services and then listing the key risk factors, for example isolation, self-neglect, self-harm or aggression. In considering 'risk' it is important to establish what particular adverse occurrence might happen and to evaluate both the likelihood and the potential impact of this occurrence.

10.2 So long as an individual has mental capacity they are entitled to choose to take risks, even if professionals or other parties consider the decision to be unwise. It is important to work with the person to explain any risks involved and not to make generalised assumptions about these. 'Independence, choice and risk: a guide to best practice in supported decision-making[1]' sets out wider best practice on this issue. The governing principle it states for dealing with independence, choice and risk for all activities surrounding a person's choices about their daily living is: 'People have the right to live their lives to the full as long as that doesn't stop others from doing the same.'

10.3 To put this principle into practice, those supporting individuals have to:

- help people have choice and control over their lives
- recognise that making a choice can involve some risk
- respect people's rights and those of their family carers
- help people understand their responsibilities and the implications of their choices, including any risks
- acknowledge that there will always be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for the person
- continue existing arrangements for safeguarding people.

10.4 The guidance also includes best practice approaches to decision-making on risk issues, including a supported decision tool.

10.5 Where someone lacks the mental capacity to make a decision about a course of action, including one involving any level of risk, they will not be able to give consent. In these circumstances, any decision or action should be made on the basis of what is in the person's best interests, following the requirements in the Mental Capacity Act 2005 and its associated Code of Practice. In some circumstances, the Court of Protection may need to be involved in certain decisions. It should also be borne in mind that just because a person wishes to make an unwise decision, this does not mean in itself that they lack capacity to make the decision.

[1] Independence, choice and risk: a guide to best practice in supported decision-making

Screening for NHS Continuing Healthcare using the Checklist Tool

PG 11 Who needs to be present when a Checklist is completed?

11.1 The individual should be given reasonable notice of the need to undertake the Checklist. What constitutes reasonable notice depends upon the circumstances of the individual case. In an acute hospital setting or where an urgent decision is needed, notice may only be a day or two days. In a community setting, especially where needs are gradually changing over time, more notice may be appropriate. The amount of notice given should take into account whether the individual wishes to have someone present to act as an advocate for them or represent or support them, and the reasonable notice required by the person providing that support. It is the responsibility of the person completing the Checklist or coordinating the discharge process to make the individual aware that they can have an advocate or other support (such as a family member, friend or carer) present and of the local arrangements for advocacy support.

11.2 The individual themselves should normally be given the opportunity to be present at the completion of the Checklist, together with any representative in accordance with the above.

PG 12 What information needs to be given to the individual when completing a Checklist?

12.1 The individual and/or their representative should be advised in advance of the need to complete the Checklist and the reasons for this. The Department of Health and Social Care (DHSC) patient information leaflet on NHS Continuing Healthcare should be given to the individual. Opportunity should be given for an explanation of the NHS Continuing Healthcare process to the patient and for dealing with any questions about it. It should be made clear that completion of the Checklist does not indicate likelihood that they will be eligible for NHS Continuing Healthcare. Whatever the outcome of the Checklist, the individual should be provided with confirmation of this decision as soon as reasonably practicable. The written decision should include the contact details and the complaints process of the CCG in case the individual wishes to challenge the Checklist decision (including any review processes available through the CCG as an alternative to making a complaint). The National Framework sets out how the outcome of the Checklist must be communicated clearly and in writing to the individual or their representative as soon as reasonably practicable, this should include the reasons why the Checklist outcome was reached. Normally this will be achieved by providing a copy of the Checklist (refer to National Framework paragraph 100).

12.2 A copy of the completed Checklist, together with a covering letter giving the appropriate details for challenging the decision, will be sufficient to constitute a

written decision in many circumstances, provided that the completed Checklist or other documentation includes sufficient detail for the individual to understand the reasons why the decision was made. CCGs should consider making the decision available in alternative formats where this is appropriate to the individual's needs.

PG 13 Can registered nurses in care home settings complete a Checklist Tool?

13.1 The care home should contact the relevant CCG NHS Continuing Healthcare team to arrange for a Checklist to be completed. However, where a CCG has an agreed protocol in place with a care home then other arrangements for completion of checklists may apply.

PG 14 Can someone self-refer by completing a Checklist themselves?

14.1 No. If the individual is known to a health or social care practitioner, they could ask that practitioner to complete a Checklist. Alternatively, they should contact their CCG NHS continuing healthcare team to ask for someone to visit to complete the Checklist, or if they already have a care home or support provider, they could ask them to contact the CCG on their behalf. Where the need for a Checklist is brought to the attention of the CCG through these routes it should respond in a timely manner, having regard to the nature of the needs identified. In most circumstances it would be appropriate to complete a Checklist within 14 calendar days of such a request.

PG 15 What should happen once the Checklist has been completed?

15.1 If full assessment of eligibility for NHS Continuing Healthcare is required the Checklist should be sent to the CCG where the individual's GP is registered unless alternative arrangements have been made by the CCG. If the individual does not have a GP, the responsible CCG should be identified using the approaches set out in the relevant legislation. Checklists should be sent in the fastest, but most appropriate and secure way. The use of either internal or external postal systems can delay the receipt of the Checklist and should only be used if no other referral mechanism is available. Each CCG should have appropriate secure arrangements for the receipt of Checklists and these should be publicised to all relevant partners. The CCG will then arrange for a case coordinator to be appointed who will ensure that an MDT (including professionals currently treating or supporting the individual) carries out an assessment and uses this to complete a DST.

15.2 CCGs have the responsibility for ensuring that arrangements are in place so that individuals who are screened out at the Checklist stage are informed of the outcome, are given a copy of the Checklist, are given details of how to seek a review of the outcome by the CCG and are offered the opportunity for their case to be referred to the LA for consideration for social care support. This could be delegated

by agreement to other organisations that have staff completing Checklists but CCGs have the ultimate responsibility.

15.3 Where a Checklist indicates that a referral for assessment of eligibility for NHS Continuing Healthcare is not necessary, it is good practice for the Checklist to still be sent to the relevant CCG for information, as the individual may wish to request the CCG to reconsider the Checklist outcome and the CCG will need a copy of the Checklist in order to do this.

PG 16 Where an individual has been screened using the Checklist and has been found not to require full assessment for NHS Continuing Healthcare, is there a requirement to review this Checklist after 3 months and, following this, on an annual basis?

16.1 No, there is no requirement to review 'negative' Checklists. However, where an individual has been 'screened out' using the Checklist but their needs subsequently change it may, depending on the nature of the changes, be necessary to consider completing a new Checklist to see whether they now require full assessment for NHS Continuing Healthcare. Alternatively a decision could be made to undertake a full assessment for NHS Continuing Healthcare without doing a Checklist if the change in needs clearly warrants this.

16.2 Where an individual has been screened using the Checklist but has been found not to require a full assessment for NHS Continuing Healthcare they should be given a copy of the completed Checklist and informed that if they disagree with the decision not to proceed to full assessment for NHS Continuing Healthcare they may ask the CCG to reconsider this.

16.3 Where an individual who does not require full assessment for NHS Continuing Healthcare nonetheless requires ongoing care and support from health or social care agencies, normal arrangements for such support will apply. However, when undertaking a review of an individual who is currently in receipt of NHS-funded Nursing Care, potential eligibility for NHS Continuing Healthcare must always be considered, by completing a Checklist (unless this has been done before and needs have not changed) and, where necessary, carrying out full consideration using the Decision Support Tool.

When and where to screen and assess eligibility for NHS Continuing Healthcare

PG 17 When should the Checklist be completed if the individual is in the community or in a care setting other than hospital?

17.1 In a community setting or a care setting other than hospital it may be appropriate to complete a Checklist:

- as part of a community care assessment
- at a review of a support package or placement
- when a clinician such as a community nurse, GP or therapist is reviewing a patient's needs
- where there has been a reported change in an individual's care needs, or
- in any circumstance that would suggest potential eligibility for NHS continuing healthcare.

PG 18 When should a Checklist be completed if the individual is in hospital?

18.1 In a hospital setting the Checklist should only be completed (if required) once an individual's acute care and treatment has reached the stage where their needs on discharge are clear. Paragraphs 109-117 of the National Framework highlight the need for practitioners to consider whether the individual would benefit from other NHS-funded care in order to maximise their abilities and provide a clearer view of their likely longer-term needs before consideration of NHS Continuing Healthcare eligibility. This should be considered before completion of the Checklist as well as before completion of the DST.

18.2 In the minority of cases it might be appropriate for both the Checklist and the DST to be completed within the hospital setting but this should only be where it is possible to accurately identify a person's longer-term support needs at that time and there is sufficient time to identify an appropriate placement/ package of care/support that, where practicable, fully takes into account the individual's views and preferences.

18.3 CCGs should ensure that NHS Continuing Healthcare is clearly built into local agreed discharge pathways. This should include identification of the circumstances when NHS Continuing Healthcare assessments and care planning will be carried out in the hospital setting, bearing in mind the guidance set out in paragraphs 109-117 of the National Framework.

18.4 Checklists should not be completed too early in an individual's hospital stay; this could provide an inaccurate portrayal of their needs as the individual could potentially make a further recovery. As far as possible the individual should be ready for safe discharge at the point that a Checklist (if required) is undertaken. It should therefore be completed at the point where wider post-discharge needs are also being assessed. If at any point after a Checklist has been sent to the CCG the individual's needs change such that he/she requires further treatment, the completed Checklist will no longer be relevant and a new Checklist should be undertaken once the treatment has been completed. In some situations an individual's needs might reduce whilst they are still receiving NHS funded care to the extent that a further Checklist indicates that they no longer 'screen in' for a full assessment of eligibility for NHS Continuing Healthcare. The CCG and the individual should be kept fully informed of the changed position. This process will enable the CCG to redirect their resources to where they are most urgently required.

Assessment of eligibility for NHS Continuing Healthcare using the Decision Support Tool

PG 19 Can the national tools be changed?

19.1 No, these are national tools and the content should not be changed, added to or abbreviated in any way. However, CCGs may attach their logo and additional patient identification details if necessary (e.g. adding NHS number, etc.).

19.2 The national tools for NHS Continuing Healthcare include: the Checklist Tool, the Decision Support Tool and the Fast Track Pathway Tool.

PG 20 What is the role of the NHS Continuing Healthcare coordinator(s)?

20.1 The coordination role includes:

- receiving and acting upon a referral for assessment of eligibility for NHS Continuing Healthcare, ensuring appropriate consent has been given
- identifying and securing the involvement of the MDT which will assess the individual's needs and will then use this information to complete the DST. The MDT should usually comprise health and social care staff presently or recently involved in assessing, reviewing, treating or supporting the individual (refer to paragraphs 119-123 of the National Framework)
- supporting MDT members to understand the role they will need to undertake in participating in a multidisciplinary assessment and completing the DST
- helping MDT members to identify whether they will need to undertake an updated or specialist assessment to inform completion of the multidisciplinary assessment
- supporting the person (and those who may be representing them) to play a full role in the eligibility consideration process, including ensuring that they understand the process, they have access to advocacy or other support where required, and organising the overall process in a manner that maximises their ability to participate
- ensuring that there is a clear timetable for the decision-making process, having regard to the expectation that decisions should usually be made within 28 calendar days of the CCG being notified of the need for a full assessment of eligibility for NHS Continuing Healthcare.
- ensuring that the assessment and DST processes are completed in accordance with the requirements in the National Framework and relevant standing rules/regulations.

- acting as an impartial resource to the MDT and the individual on any policy or procedure questions that arise
- ensuring that the MDT's recommendation on eligibility is sent for approval through the relevant local decision-making processes in a timely manner

20.2 Care should be taken by CCGs to ensure an appropriate separation between the coordinator function and those responsible for making a final decision on eligibility for NHS Continuing Healthcare.

PG 21 What are the elements of a good multidisciplinary assessment of needs?

21.1 Assessment in this context is essentially the process of gathering relevant, accurate and up-to-date information about an individual's health and social care needs, and applying professional judgement to decide what this information signifies in relation to those needs. Both information and judgement are required. Simply gathering information will not provide the rationale for any eligibility recommendation; a recommendation that simply provides a judgement without the necessary information will not provide the evidence for any subsequent decision. Assessment documentation should be obtained from any professional involved in the individual's care and should be clear, well-recorded, factually accurate, up to date, signed and dated.

21.2 As a minimum a good quality multidisciplinary assessment of an individual's health and social care needs will be:

- person-centred, making sure that the individual and their representative(s) are fully involved, that their views and aspirations are reflected and that their abilities as well as their difficulties are considered
- proportionate to the situation, i.e. in sufficient depth to enable well-informed judgements to be made but not collecting extraneous information which is unnecessary to these judgements. If appropriate this may simply entail updating existing assessments
- include information from those directly caring for the individual (whether paid or unpaid)
- holistic, looking at the range of their needs from different professional and personal viewpoints, and considering how different needs interact
- taking into account differing professional views and reaching a commonly agreed conclusion if possible
- considerate of the impact of the individual's needs on others
- focused on improved outcomes for the individual

- evidence-based – providing objective evidence for any subjective judgements made
- clear about needs requiring support in order to inform the commissioning of an appropriate care package
- clear about the degree and nature of any risks to the individual (or others), the individual's view on these, and how best to manage the risks.

21.3 Effective assessment processes and documentation are key to making decisions on eligibility for NHS Continuing Healthcare and for commissioning the right care package at the right time and in the right place, so that the individual can move to their preferred place of choice as quickly and safely as possible.

21.4 CCGs and local authorities should consider agreeing joint models of assessment documentation and having regular training or awareness events to support them.

21.5 This will require the gathering and scrutiny of all available and appropriate evidence , whether written or oral, including that from the GP, hospital (nursing, medical, mental health, therapies, etc.), professionals with relevant skills, knowledge and expertise, community nursing services, care home provider, local authority records, assessments, Checklists, DSTs, records of deliberations of MDTs, panels, etc., as well as any information submitted by the individual concerned; compilation of a robust and accurate identification of the care needs; audit of attempts to gather any records said not to be available; involvement of the individual or their representative as far as possible, including the opportunity for them to contribute and to comment on information:

PG 22 What are the potential sources of information/evidence? (NB: this is not an exhaustive list)

- Health needs assessment
- Needs assessment (under the Care Act 2014)
- Nursing assessment
- Individual's own views of their needs and desired outcomes
- Person-centred plan
- Carer's views
- Physiotherapy assessment
- Behavioural assessment

- Speech and Language Therapy (SALT) assessment
- Occupational Therapy assessment
- Care home/home support records
- Current care plan
- 24-hour/48-hour diary indicating needs and interventions (may need to be ‘good day’ and ‘bad day’ if fluctuating needs)
- GP information
- Specialist medical/nursing assessments (e.g. tissue viability nurse, respiratory nurse, dementia nurse, etc.)
- Falls risk assessment
- Standard scales (such as the Waterlow score)
- Psychiatric/community psychiatric nurse assessments

PG 23 How should the well-managed need principle be applied?

23.1 Care should be taken when applying the well-managed need principle. Sometimes needs may appear to be exacerbated because the individual is currently in an inappropriate environment rather than because they require a particular type or level of support – if they move to a different environment and their needs reduce this does not necessarily mean that the need is now ‘well-managed’, the need may actually be reduced or no longer exist. For example, in an acute hospital setting, an individual might feel disoriented or have difficulty sleeping and consequently exhibit more challenging behaviour, but as soon as they are in a care home environment, or their own home, their behaviour may improve without requiring any particular support around these issues.

23.2 Where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain. Similarly, where an individual's skin condition is not aggravated by their incontinence because they are receiving good continence care, it would not be appropriate to weight the Skin domain as if the continence care was not being provided.

PG 24 What is the role of the individual during the multidisciplinary team process?

24.1 The individual or their representative cannot be members of the MDT. However, they should be fully involved in the process and be given every opportunity to contribute to the MDT discussion.

24.2 Once all the information has been gathered (and depending on agreed local protocols) it is acceptable for the MDT to have a discussion without the individual and/or their representative present in order to come to an agreed recommendation. MDTs should be aware that the DST contains a section at the end of the domain tables for the individual and/or the representative to give their views on the completion of the DST that have not already been recorded elsewhere in the document, including whether they agree with the domain levels selected. It also asks for reasons for any disagreement to be recorded. Therefore the MDT meeting should be arranged in a way that enables that individual to give his/her views on the completed domain levels before they leave the meeting.

24.3 If the individual and/or their representative are not present for the part of the meeting where the MDT agrees the recommendation regarding primary health need, the outcome should be communicated to them as soon as possible.

24.4 Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs and, where possible, have recently been involved in the assessment, treatment or care of the individual. MDT members could potentially include:

- nurse assessors
- social care practitioners
- physiotherapists
- occupational therapists
- dieticians/nutritionists
- GPs/consultants/other medical practitioners
- community psychiatric nurses
- ward nurses
- care home/support provider staff
- community nurses
- specialist nurses
- community matrons
- discharge nurses.

This list is not exhaustive but illustrates who may need to be invited to provide evidence regarding an individual's needs so that as accurate and comprehensive picture as possible can be made. It also illustrates the variety of disciplines from which members of the MDT can be drawn.

PG 25 Is the coordinator also a member of the MDT and involved with other members in agreeing the appropriate recommendation regarding eligibility for NHS Continuing Healthcare?

25.1 The role of the 'co-ordinator' in the context of NHS Continuing Healthcare is set out in Practice Guidance note 20. All aspects of the co-ordinator's role are important and part of the role includes 'acting as an impartial resource to the MDT and the individual on any policy or procedure questions that arise'. Some have asked whether this means that the 'co-ordinator' cannot actually be a member of the MDT. If this were the case it would always be necessary to have a minimum of two professionals from different healthcare professions, or one from healthcare and one from social care, in addition to the co-ordinator. It is recognised that in many situations this would raise significant practical difficulties in convening a properly constituted MDT.

25.2 The intention in the National Framework is not to exclude the possibility of a member of the MDT also undertaking the role of co-ordinator, but where the professional concerned has this dual role they should be very clear about their two different functions. The fact that they should, amongst other things, act as an 'impartial resource' relates specifically to advising the MDT on matters of policy and procedure. They can contribute to decision-making on the correct recommendation so long as they encourage debate within the MDT and so long as they record a recommendation which genuinely reflects the view of the whole MDT, not just their own view.

PG 26 What happens if the coordinator is unable to engage relevant professionals to attend an MDT meeting?

26.1 CCGs should not make decisions on eligibility in the absence of an MDT recommendation, unless exceptional circumstances require an urgent decision to be made.

26.2 Apart from ensuring that all the relevant information is collated, it is crucial to have a genuine and meaningful multidisciplinary discussion about the correct recommendation to be made. This should normally involve a face-to-face MDT meeting (including the individual and/or their representative). If a situation arises where a relevant professional is unable or unwilling to attend an MDT meeting every possible effort should be made to ensure their input to the process in another way, such as participating in the MDT meeting as a teleconference call. Where this is not possible then submission of a written assessment or other documentation of views

could be used but this should be the least favoured option. Where professionals use this route, the CCG should explain to them that, whilst their views will be taken into account, the eligibility recommendation will by necessity be made by MDT members physically present or participating by teleconference.

26.3 Care should be taken to ensure that alternative approaches for MDT participation still enable the individual being assessed to fully participate in the process.

26.4 If, even after having followed the above processes, there are still difficulties with the participation of, or obtaining assessment information from, a specific professional, CCGs should consider (in liaison with the individual) whether they have sufficient wider assessment information to reach a full picture of the individual's needs, having regard to the minimum MDT membership set out above. CCGs should record the attempts to secure participation.

26.5 In order to ensure effective MDT decision-making, CCGs should:

- have arrangements in place for coordinators to obtain senior support to secure participation of other practitioners where necessary
- consider agreeing protocols on MDT participation with organisations that frequently have staff who participate in MDTs.

PG 27 Where should an MDT meeting take place?

27.1 An MDT meeting can take place in any setting but should be as near to the individual's location as possible so that they are enabled to be actively involved in the process. Although the acute hospital setting is not an ideal place for MDTs to make a recommendation about eligibility, it may, in some circumstances where the person is an in-patient, be the only available opportunity to have everyone involved in the process. However, wherever possible, it should still be held in a suitable room for the nature of the meeting. Alternatives to the acute hospital setting should be used for MDT meetings wherever possible, e.g. community hospitals, hospices, care homes or the individual's own home may provide suitable settings, depending on the individual's circumstances.

PG 28 What process should be used by MDTs to ensure consistency when completing the DST?

28.1 Whilst local conditions and therefore local processes will vary, the following elements are recommended as being core to achieving consistency:

- The coordinator should gather as much information as possible from professionals involved prior to the MDT meeting taking place, including

agreeing where any new/updated specialist assessments are required prior to the meeting.

- The coordinator (or someone nominated by them) should explain the role of the MDT to the individual in advance of the meeting, together with details of the ways that the individual can participate. Where an individual requests copies of the documentation to be used this should be supplied.
- Information from the process above and any additional evidence should be discussed within the MDT meeting to try to achieve a common understanding of the individual's needs. Where copies of assessments are circulated to MDT members at the meeting, copies should also be made available to the individual if they are present.
- Relevant evidence (and sources) should be recorded in the text boxes preceding each of the domain levels within the DST and this information should be used to identify the level of need within that domain, having regard to the user notes of the DST.
- Depending upon local arrangements the MDT members may decide to reach the final recommendation on eligibility after the individual and/or their representative have left the meeting. However, the National Framework gives clear expectations on the individual's involvement in the wider process. If the MDT is to reach its final recommendation privately it is best practice to give the individual/representative an opportunity before they leave the meeting to state their views.
- Having completed the care domains, the MDT should consider what this information signifies in terms of the nature, complexity, intensity and unpredictability of the individual's needs. It should then agree and record its recommendation, based on these characteristics, providing a rationale which explains why the individual does or does not have a primary health need. It is important that MDT members approach the completion of the DST objectively without any preconceptions that specific conditions or diagnoses do or do not indicate eligibility or fit a particular domain level without reference to the actual needs of the individual (refer to paragraphs 147-152 of the National Framework relating to the completion of the DST and making eligibility recommendations).
- The recommendation should then be presented to the CCG, who should accept this, except in exceptional circumstances. These circumstances could for example include insufficient evidence to make a recommendation or incomplete domains.
- If the CCG does not accept the MDT recommendation (refer to Practice Guidance note 39 for circumstances when this can happen) it should refer the DST back to the MDT identifying the issues to be addressed. The

coordinator for the individual case has a critical role in ensuring that any deficiencies in the MDT assessment and recommendation are fully addressed in order to avoid further delay in decision-making. The coordinator should be satisfied that there is sufficient evidence and a clear rationale to support the recommendation before re-submitting the DST. Once the completed DST has been re-presented to the CCG, the CCG should then accept the recommendation (except in exceptional circumstances). The CCG remains responsible, and accountable for, the final eligibility decision and should avoid repeatedly returning a DST to the MDT.

- The decision should be communicated in writing as soon as possible in an accessible format and language to the individual or their representative so that it is meaningful to them. They should also be sent a copy of the DST and information on how to ask for a review of the decision if the individual is dissatisfied with the outcome.

28.2 This whole process should usually be completed within 28 calendar days. This timescale is measured from the date the CCG receives the completed Checklist indicating the need for full consideration of eligibility (or receives a referral for full consideration in some other acceptable format) to the date that the eligibility decision is made. However, wherever practicable, the process should be completed in a shorter time than this.

PG 29 Are there particular drugs, interventions or conditions which, for consistency, should always translate into a particular scoring or outcome when completing the DST?

29.1 No. For any given domain within the DST, MDT members are required to use their professional judgement to determine the closest fit between what is known about an individual's needs and the relevant domain level descriptors. There is no nationally prescribed set of 'sub-rules' to steer MDT members into allocating particular domain weightings beyond the wording provided in the domain level descriptors. Similarly, because the eligibility criteria for NHS Continuing Healthcare are needs based rather than condition-based, there are no rules which state that an individual with a particular condition must be found eligible (or not) for NHS Continuing Healthcare on the basis of their diagnosis/condition alone.

PG 30 Can associated needs be recorded in more than one domain on the DST?

30.1 Yes, needs associated with a single condition can be reflected in more than one domain. The belief that there is a ‘no double-scoring rule’ is a common misconception. Paragraph 24 of the user notes of the DST makes it clear that the DST is a record of needs and a single condition might give rise to separate needs in

a number of domains. For example an individual with cognitive impairment will have a weighting in the cognition domain and as a result may have associated needs in other domains, all of which should be recorded and weighted in their own right. An individual with a severe cognitive impairment might or might not also exhibit associated challenging behaviour. Therefore, if challenging behaviour exists, recording this in the behaviour domain is necessary in order to give an accurate picture of needs, even though this behaviour might be linked to their cognitive impairment.

PG 31 What is proportionate and reasonable in terms of evidence required to support domain levels and the recommendation in a DST?

31.1 Much will depend on the particular circumstances of the case in question. However, the following points should be borne in mind:

The purpose of evidence in this context is to ensure that there is an accurate picture of the individual's needs, not to convince a court of law that those providing the evidence are telling the truth. Any requirement for additional evidence in support of levels of need should be proportionate and reasonable.

31.2 Having sufficient evidence is not about volume but about how pertinent it is – more is not necessarily better. For example, a précis of incident forms or a chart showing the number of times a particular type of incident/intervention occurred may be more helpful than requiring all the original incident forms or daily records.

31.3 It may be necessary to ask the provider to complete a detailed diary over a suitable period of time to demonstrate the nature and frequency of the needs and interventions, and their effectiveness.

31.4 Oral evidence from carers or relevant professionals should be taken into account where it is pertinent to establishing the levels of need. This should be recorded on the DST by the co-ordinator or other MDT members and given due consideration, bearing in mind other evidence available.

PG 32 What happens if MDT members cannot agree on the levels within the domains of the DST?

32.1 The DST (paragraph 21 of the user notes) advises practitioners to move to the higher level of a domain where agreement cannot be reached but there should be clear reasoned evidence to support this. If practitioners find themselves in this situation they should review the evidence provided around that specific area of need and carefully examine the wording of the relevant DST levels to cross-match the information and see if this provides further clarity. Additional evidence may be sought, although this should not prolong the process unduly. If this does not resolve the situation, the disagreement about the level should be recorded on the DST along

with the reasons for choosing each level and by which practitioner. This information should also be summarised within the recommendation so that the CCG can note this when verifying recommendations.

32.2 The practice of moving to the higher level where there is disagreement should not be used by practitioners to artificially steer individuals towards a decision that they have a primary health need where this is not justified. It is important that this is monitored during the CCG audits of recommendations and processes so that individual practitioners found to be using the 'higher level' practice incorrectly can be identified. Discussion may need to take place with these practitioners and further training may be offered.

32.3 If practitioners are unable to reach agreement, the higher level should be accepted and a note outlining the position included within the recommendation on eligibility. As part of CCGs' governance responsibilities, they should monitor occurrences of this issue. Where regular patterns are identified involving individual teams or practitioners this should be discussed with them and where necessary their organisations to address any practice issues.

PG 33 What happens if the individual or their representative disagrees with any domain level when the DST is completed?

33.1 Whilst the individual and/or their representative should be fully involved in the process and be given every opportunity to contribute to the MDT discussion, the membership of the MDT consists of the practitioners involved (refer to paragraphs 119-123 of the National Framework regarding the composition of the MDT). The approach described in Practice Guidance note 34 applies to disagreements between practitioners and not when an individual or their representative disagrees with individual domain levels chosen in the completion of the DST. However, concerns expressed by individuals and representatives should be fully considered by reviewing the evidence provided. If areas of disagreement remain these should be recorded in the relevant parts of the DST.

PG 34 What does the DST recommendation need to cover?

34.1 The recommendation 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 provided in paragraphs 58-66 of the National Framework.

- 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 (refer to paragraphs 58-66 of the National Framework). 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.

34.2 Although the core responsibility of MDTs is to make a recommendation on eligibility for NHS Continuing Healthcare, the recommendation could also indicate any particular factors to be considered when commissioning/securing the placement or care/support package required to meet the individual's needs (whether or not the individual has a primary health need).

34.3 Where the outcomes of the individual care domains do not obviously indicate a primary health need (e.g. a priority level in one domain or severe levels in two domains being found), but the MDT is using professional judgement to recommend that the individual does nonetheless have a primary health need, it is important to ensure that the rationale for this is clear in the recommendation.

34.4 Where an individual has a deteriorating condition, practitioners need to take this into account in reaching their conclusion on primary health need, considering the approaches set out in paragraphs 229 - 230 of the National Framework, and being mindful of how that condition and the associated needs are going to progress before the next planned review. Where an individual has a deteriorating condition but eligibility for NHS Continuing Healthcare is not presently recommended, consideration should be given to setting an early review date. This should be clearly highlighted in the recommendation to the CCG who should ensure that the review is arranged at the appropriate time.

34.5 The recommendation for eligibility for NHS Continuing Healthcare should not be based upon an individual's specific condition or disease (e.g. stroke, cancer, Alzheimer's disease, dementia, etc.) but on the needs that are identified. Needs that give rise to eligibility can be from any condition or disease. Just because individuals with a particular condition or disease have previously been found to be eligible for NHS continuing healthcare does not mean that every individual with a similar condition or disease will be eligible. Each individual should be assessed in their own right and evidence provided around the range of their needs; the identification of a primary health need should not be prejudged without going through the proper process in each individual case.

34.6 All of the above information should be provided even if the recommendation is that the individual does not have a primary health need. The CCG is responsible for care planning and commissioning all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare, and for the healthcare part of any joint care package. However, it is beneficial if the MDT makes recommendations on the care package to be provided, based on the assessment and any care plan already developed, whether the CCG, LA or both will have responsibilities.

34.7 The written recommendation needs to provide as sufficient detail, but should be clear and concise, to enable the CCG and the individual to understand the rationale behind the recommendation.

34.8 As the individual or their nominated representative should receive a copy of the DST it is important that it is legible, and free from jargon and abbreviations.

34.9 A copy of the completed assessment, DST and other documents should be forwarded to the CCG.

PG 35 How does the DST and primary health need eligibility test apply to people with learning disabilities?

35.1 The DST should be used for all adults who require assessment for NHS Continuing Healthcare, irrespective of their client group/diagnosis. The tool focuses on the individual's needs, not on their diagnosis. Regulations require that the DST is used to inform the decision as to whether an individual has a primary health need, and if the CCG concludes that they do they must be found eligible for NHS Continuing Healthcare.

35.2 In all cases eligibility for NHS Continuing Healthcare should be informed by good quality multidisciplinary assessment. Where the individual has a learning disability it will be important to involve professionals with expertise in learning disability in the assessment process as well as those with expertise in NHS Continuing Healthcare. It will also be important to ensure that the assessment process is person-centred and that family members/carers are fully and appropriately involved.

35.3 The Standing Rules set out how 'primary health need' should be considered in the context of considering eligibility for NHS Continuing Healthcare. Paragraphs 54-66 of the National Framework explain the primary health need test in some detail. It is important to understand that this test is about the balance of needs once all needs have been mapped onto the DST.

35.4 The reasons given for a decision on eligibility should not be based on the:

a) individual's diagnosis;

b) setting of care;

c) ability of the care provider to manage care;

d) use (or not) of NHS-employed staff to provide care;

e) need for/presence of 'specialist staff' in care delivery;

f) the fact that a need is well-managed;

g) the existence of other NHS-funded care; or

h) any other input-related (rather than needs-related) rationale.

35.5 The question is not whether learning disability is a health need, but rather whether the individual concerned, whatever client group he or she may come from, has a 'primary health need'.

35.6 The indicative NHS Continuing Healthcare eligibility threshold levels of need as set out in the user notes apply equally to all individuals irrespective of their condition or diagnosis.

35.7 Previous or current pooled budget, joint funding, Section 75 agreements or legacy funding arrangements and the funding transfer to local authorities in April 2009 do not alter the underlying principles of NHS Continuing Healthcare entitlement.

35.8 The Department made it clear that the funding transfer to local authorities in 2009 was for social care and did not include those eligible for NHS Continuing Healthcare. However this National Framework points out that some historic local agreements relating to particular groups of clients with learning disabilities (for example following hospital/campus closures) can mean that these individuals are not required to be considered separately for NHS Continuing Healthcare.

35.9 It is crucial that the detail of these local agreements are examined in order to clarify whether or not the National Framework applies. It is important to ensure that all adults are treated equitably under the National Framework.

35.10 Some people have concerns about the potential loss of personalisation/control for people with learning disabilities (and other client groups) if their care is commissioned/provided/funded by the NHS. However, CCGs have considerable existing legal powers to maximise choice and control, including the provision of 'personal health budgets'. Anyone in receipt of NHS Continuing Healthcare has the right to have a personal health budget which could potentially include a 'direct payment for healthcare'. These arrangements include individuals with a learning disability and CCGs should ensure that they are aware of current legislation and guidance on this matter.

35.11 Whatever the outcome of the eligibility decision regarding NHS Continuing Healthcare, commissioning should be person-centred and needs-led. Where an individual is eligible for NHS Continuing Healthcare, CCGs have responsibility to ensure that effective case management is commissioned. Consideration should be given as to who is best placed to provide this function, and clear responsibilities agreed. Amongst other options it may be appropriate to secure this from the local authority who may have previous knowledge of the individual concerned or have staff with particular skills and experience to undertake this function on behalf of the CCG.

PG 36 Why is it important to complete the equality monitoring forms with the tools?

36.1 The equality monitoring form is for completion by the individual being assessed, although staff should offer to help them complete it where support is required. The purpose of the equality monitoring form is to help CCGs identify whether individuals from different groups (in terms of disability, ethnicity, etc.) are accessing NHS Continuing Healthcare on an equitable basis, including whether they are being properly identified for potential eligibility at Checklist stage and are being identified for the Fast Track process where appropriate. The equality form should be forwarded to the relevant CCG to enable it to monitor whether the National Framework is being applied equitably in its area. If the CCG identifies any issues for particular groups or communities it should take steps to address these.

Decision-making on eligibility for NHS Continuing Healthcare by the CCG

PG 37 What is the role of the CCG in the decision-making process?

37.1 CCGs are responsible for making the eligibility decision for NHS Continuing Healthcare, based on the recommendation made by the MDT in accordance with the processes set out in this National Framework.

37.2 The role of the CCG decision-making processes, whether by use of a panel or other processes should include:

- verifying and confirming recommendations on eligibility made by the MDT, having regard to the issues in PG41 below;
- agreeing required actions where issues or concerns arise.

37.3 CCG decision-making processes should not have the function of:

- financial gatekeeping
- completing/altering DSTs
- overturning recommendations (although they can refer cases back to an MDT for further work in certain circumstances – refer to Practice Guidance note 39 below).

PG 38 If the CCG uses a panel as part of the overall decision-making process what should its function be and how should it operate?

38.1 Once an MDT has made a recommendation regarding eligibility it is for the CCG to make the final eligibility decision. There is no requirement for CCGs to use a panel as part of their decision-making processes. Where a CCG does use a panel this should not replace the function of the MDT, whose role it is to assess the individual, complete the DST and make a recommendation regarding eligibility. Close working with local authorities is a central part of this National Framework, for example in terms of membership of MDTs and in having local joint processes for resolving disputes. It would be consistent with this overall approach for CCGs to have mechanisms for seeking the views of LA colleagues before making final decisions on NHS Continuing Healthcare eligibility and this could be by the use of a panel. However the formal decision-making responsibility rests with the CCG. Annex F (Local NHS Continuing Healthcare Protocols) contains details of the recommended content of local protocols, including decision-making processes.

38.2 Panels may be used in a selective way to support consistent decision-making. For example this could include panels considering:

- cases which are not recommended as eligible for NHS Continuing Healthcare (for audit purposes or for consideration of possible joint funding)
- cases where there is a disagreement between the CCG and the LA over the recommendation – this could form part of the formal disputes process
- cases where the individual or his/her representative is appealing against the eligibility decision
- a sample of cases where eligibility has been recommended for auditing and learning purposes to improve practice (refer to paragraph 69 of the National Framework and Practice Guidance note 1).

38.3 If a CCG chooses to use a panel arrangement as part of the decision-making process this should not be allowed to delay decision-making. Where relevant expertise is considered essential to the panel the CCG should ensure that staff with such expertise are made available in a timely manner.

PG 39 What are the 'exceptional circumstances' under which a CCG or panel might not accept an MDT recommendation regarding eligibility for NHS continuing healthcare?

39.1 Eligibility recommendations must be led by the practitioners who have met and assessed the individual. Exceptional circumstances where these recommendations may not be accepted by a CCG include:

- where the DST is not completed fully (including where there is no recommendation)
- where there are significant gaps in evidence to support the recommendation
- where there is an obvious mismatch between evidence provided and the recommendation made
- where the recommendation would result in either authority acting unlawfully.

39.2 In such cases the matter should be sent back to the MDT with a full explanation of the relevant matters to be addressed. Where there is an urgent need for care/support to be provided, the CCG (and LA where relevant) should make appropriate interim arrangements.

PG 40 How should CCGs fulfil their duty to make final eligibility decisions for NHS Continuing Healthcare?

40.1 The National Framework and Standing Rules[1] make it clear that CCGs cannot delegate their final decision-making function in relation to eligibility for NHS Continuing Healthcare. CCGs remain legally responsible for all such decisions even where they have authorised another body (such as a Commissioning Support Unit, social enterprise or local authority) to carry out assessment functions on their behalf. CCGs have a number of options as to how to fulfil this responsibility. For example, they might choose to use one, or a combination of, the following:

- appoint (or jointly appoint) an employee (or employees) to work within the organisation carrying out the assessment functions such that this member of staff has authority to make eligibility decisions as an employee of the CCG with clear lines of authority and accountability within the CCG for undertaking this role
- identify an employee (or employees), or Governing Body Member(s), within the CCG to make eligibility decisions regarding NHS Continuing Healthcare having received the completed assessments and recommendations from the organisation carrying out the NHS Continuing Healthcare assessment function on behalf of the CCG
- bearing in mind the guidance in Practice Guidance, use a verification committee or 'panel' as a formal sub-committee of the CCG with delegated responsibility for decision making in relation to NHS Continuing Healthcare eligibility

40.2 Whatever arrangements the CCG chooses it must be remembered that the National Framework places a strong emphasis on the MDT recommendation regarding eligibility for NHS Continuing Healthcare and states that 'Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed. A decision not to accept the recommendation should never be made by one person acting unilaterally (refer to paragraph 156 of the National Framework). Any model for final ratification must respect this requirement and also the requirement that 'the final eligibility decision should be independent of budgetary constraints' (refer to paragraph 156 of the National Framework). It is vital that all arrangements for verifying recommendations and for making the final eligibility decisions are timely and efficient and do not result in delays, particularly where the individual concerned is awaiting transfer of care from an acute hospital setting.

PG 41 Can 'commissioners' sit on panels which scrutinise and ratify eligibility recommendations for NHS Continuing Healthcare?

41.1 The National Framework (paragraph 156) makes it clear that the final decision regarding eligibility for NHS Continuing Healthcare should be independent of budgetary constraints and that 'finance officers' should not be part of a decision-

making panel. The purpose of excluding finance officers is to avoid any perception that eligibility has been influenced by funding considerations.

41.2 CCGs do not have to use a panel arrangement as part of their process for ratifying eligibility recommendations, but if they do the panel should not be used for financial gatekeeping (refer to Practice Guidance note 40).

41.3 Being a budget holder does not automatically mean that a person is a finance officer. Almost everyone working in the NHS or in social care has some responsibility for the proper use of public money. This does not make them ‘finance officers’. The term ‘finance officer’ refers to individuals whose primary role is financial management rather than managing, commissioning or providing services. In a CCG, for example, the Director of Finance is a finance officer and it is probable that most staff who report directly to that Director are also ‘finance officers’.

41.4 The National Framework does not state that 'commissioners' should not be panel members and it is recognised that in many cases it will be commissioning staff (whether from health or social care) who will bring relevant expertise to the decision-making process. However, where panel members, or any officers involved in the ratification process, also have budgetary responsibilities it is very important to be clear that decision-making is based on whether the individual has a 'primary health need’, not on financial considerations.

41.5 As a matter of best practice, and in order to ensure objectivity, where a professional has been involved in making an eligibility recommendation they should not also be involved in ratifying that recommendation.

PG 42 If a person dies whilst awaiting a decision on NHS Continuing Healthcare eligibility, should a decision still be made in respect of eligibility for the period before their death?

42.1 Where an individual received services prior to their death that could have been funded through NHS Continuing Healthcare then the eligibility decision-making process should be completed. Where no such services were provided it is not necessary to continue with the eligibility decision-making process.

42.2 Where a decision is made that the individual would have been eligible for NHS Continuing Healthcare funding then payments should be made in accordance with the guidance on refunds in Annex E of this National Framework.

Care Planning and Delivery

PG 43 How should commissioning be approached for a person eligible for NHS Continuing Healthcare?

43.1 This National Framework sets out a number of responsibilities of CCGs in relation to NHS Continuing Healthcare commissioning, including:

- NHS Continuing Healthcare commissioning involves actions at both strategic and individual levels.
- NHS Continuing Healthcare commissioning actions by CCGs should include strategic planning, specifying outcomes, procuring services, and managing demand and provider performance (including monitoring quality, access and the experience of those in receipt of NHS Continuing Healthcare). In managing the quality and performance of providers and the experiences of those using their services, CCGs should take into account the role and areas of focus of the Care Quality Commission and, where relevant, local authority commissioners of the relevant provider's services in order to avoid duplication and to support the mutual development of an overall picture of each provider's performance.
- There should be clarity on the roles of commissioners and providers. The services commissioned should include an ongoing case management role as well as the assessment and review of individual needs.
- CCGs should consider commissioning from a wide range of providers in order to secure high quality, value for money services. In exercising this responsibility, CCGs should have regard to the case management role set out in the National Framework 167-170 of ensuring that the care/support package meets the individual's assessed needs and agreed outcomes and is appropriate to achieve the identified intended outcomes in the care plan. To help inform this approach, CCGs should have an understanding of the market costs for care and support within the relevant local area.
- CCGs should commission in partnership with local authorities wherever appropriate.
- CCGs should ensure clarity regarding the services being commissioned from providers, bearing in mind that those in receipt of NHS Continuing Healthcare continue to be entitled to access the full range of primary, community, secondary and other health services. The services that a provider of NHS Continuing Healthcare-funded services is expected to supply should be clearly set out in the contract between the provider and the CCG. CCGs should commission services using models that maximise personalisation and individual control and that reflect the individual's preferences as far as possible. It is particularly important that this approach should be taken when

an individual who was previously in receipt of a local authority direct payment begins to receive NHS continuing healthcare; otherwise they may experience a loss of the control they had previously exercised over their care.

- CCGs are reminded that people in receipt of NHS Continuing Healthcare have a right to have a personal health budget (PHB). For more information please visit the NHS England PHB pages at https://www.england.nhs.uk/personal-health-budgets/

- CCGs and local authorities should operate person-centred commissioning and procurement arrangements, so that unnecessary changes of provider or of care package do not take place purely because the responsible commissioner has changed.

- CCGs should take into account other policies and guidance relevant to the individual's needs.

PG 44 Can a CCG use an external agency to carry out the commissioning of NHS Continuing Healthcare services or for negotiation with providers?

44.1 CCGs hold the statutory responsibility for commissioning NHS services for their populations, including NHS Continuing Healthcare. CCGs may reach arrangements with other organisations to carry out functions on their behalf, they retain statutory responsibility. CCGs can make arrangements with local authorities or other bodies/organisations in relation to NHS Continuing Healthcare commissioning. In order for the local authority to commission NHS Continuing Healthcare on the CCG's behalf, this requires a transfer of appropriate powers using section 75 of the NHS Act 2006. Other arrangements, such as integrated teams of the CCG and local authority staff commissioning for individuals with high support needs in an integrated manner are also possible. In all cases, the CCGs retain ultimate responsibility for NHS Continuing Healthcare commissioning. Any such arrangements should reflect the CCG's responsibilities to fund the assessed health and social care needs of individuals eligible for NHS Continuing Healthcare and that NHS Continuing Healthcare, as with most other NHS services, is free at the point of delivery to the individual.

44.2 CCGs should ensure that there is clarity in arrangements with external organisations on the respective responsibilities of the CCG and of the external organisations in relation to the above roles. The approaches of the external organisation to the functions they carry out on behalf of the CCG should reflect the best practice set out for CCGs in this Practice Guidance and in the National Framework. The external organisation should operate within the CCG's strategic approaches and policies in relation to NHS Continuing Healthcare commissioning, including in relation to the range of providers and the choice available to individuals.

PG 45 Can CCGs take comparative costs and value for money into account when determining the model of support to be provided to an individual?

45.1 Yes, subject to the following guidance and the guidance set out in paragraphs 279-290 of the National Framework. In some situations a model of support preferred by the individual will be more expensive than other options. CCGs can take comparative costs and value for money into account when determining the model of support to be provided, but should consider the following factors when doing so:

- The cost comparison has to be on the basis of the genuine costs of alternative models. A comparison with the cost of supporting a person in a care home should be based on the actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care home cost.
- Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual's assessed needs and agreed desired outcomes. For example, individuals can sometimes be described as needing 24-hour care when what is meant is that they need ready access to support and/or supervision. CCGs should consider whether models such as assistive technology could meet some of these needs. Where individuals are assessed as requiring nursing care, CCGs should identify whether their needs require the actual presence of a nurse at all times or whether the needs are for qualified nursing staff or specific tasks or to provide overall supervision. The willingness of family members to supplement support should also be taken into account, although no pressure should be put on them to offer such support. CCGs should not make assumptions about any individual, group or community being available to care for family members.

Cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment (see the Gunter case in Practice Guidance note 46).

PG 46 Gunter Case

46.1 In the case of Gunter vs. South Western Staffordshire Primary Care Trust (2005), a severely disabled woman wished to continue living with her parents whereas the PCT's preference was for her to move into a care home. Whilst not reaching a final decision on the course of action to be taken, the court found that Article 8 of the European Convention of Human Rights had considerable weight in the decision to be made, that to remove her from her family home was an obvious interference with family life and so must be justified as proportionate. Cost could be taken into account but the improvement in the young woman's condition, the quality of life in her family environment and her express view that she did not want to move

were all important factors which suggested that removing her from her home would require clear justification.

Inter-agency disagreements and disputes

PG 47 What if the dispute crosses CCG/LA borders?

47.1 Where a dispute occurs between a CCG and local authority in different areas (and therefore without a shared disputes resolution agreement) it is recommended that the local process applying to the CCG involved in the case is used. Where a dispute involves two CCGs, it is recommended to use the disputes process for the CCG area where the individual is residing at the outset of the relevant decision-making process. Thus if CCG A had made a placement in CCG B's area, it is CCG A's dispute process that should be used, even if the person is now physically residing in CCG B's area. Both CCGs should be able to play a full and equal role in the dispute resolution. Consideration could be given to identifying an independent person (who is not connected with either CCG) to oversee the resolution of the dispute. CCGs and local authorities should consider agreeing and publishing local processes and timescales for responding to complaints and concerns relating to NHS Continuing Healthcare on issues that fall outside of the independent review panel (IRP) process.

PG 48 What can key agencies do to improve partnership working in relation to NHS Continuing Healthcare?

48.1 NHS Continuing Healthcare can only be delivered successfully through a partnership approach at both organisational and practitioner levels between NHS England, CCGs, LAs, local NHS bodies, and provider organisations. Local protocols covering the areas where agreement is needed on policy and processes relevant to NHS Continuing Healthcare may be helpful in ensuring consistency and developing relationships. Annex G contains guidelines on what could be included in such protocols. Trust between organisations is developed by actions that are trustworthy and transparent, and by an approach that is based on everyone seeking to accurately apply the eligibility criteria rather than seeking to move responsibility to another organisation. Amongst other things good partnership working involves:

- NHS England, CCGs and LAs, as far as possible, adopting similar approaches to the ranges and models of care or support they commission so that there is no perceived advantage or disadvantage to being funded by one agency rather than the other;
- NHS England, CCGs and LAs developing similar approaches to risk and enablement;

- NHS England, CCGs, LAs and providers supporting their staff to adopt creative, flexible approaches that reflect best practice;
- Practitioners across all sectors being supportive, open and honest with one another;
- Practitioners respecting each other's professional judgement, knowledge and experience and working together to obtain the best outcome for the individual;
- Dealing with genuine disagreements between practitioners in a professional manner without inappropriately drawing the individual concerned into the debate in order to gain support for one professional's position or the other;
- Practitioners being clear with each other what services can be commissioned by their respective organisations in order to give accurate information to the individuals concerned.

Examples of good partnership working include:

- the LA and CCG having unified commissioning/contracting arrangements, with one organisation commissioning and/or contracting on behalf of both;
- joint brokerage arrangements between the LA and CCG;
- joint preparation and delivery of training;
- joint arrangements for hospital discharge coordinators funded by the CCG based in acute hospitals to ensure good communication, correct processes and streamlined decision-making;
- reciprocal agreements around 'funding without prejudice';
- joint tendering for domiciliary care;
- Secondment/joint post arrangements whereby social care staff work alongside CCG staff to undertake NHS Continuing Healthcare assessments;
- Arrangements to jointly review those receiving NHS Continuing Healthcare;
- CCGs working with the Transition Team to ensure screening and planning occurs for young people approaching adulthood who may become eligible for NHS Continuing Healthcare;
- Appointment of a social worker within an NHS Continuing Healthcare team;
- Joint funding of advocacy services by CCGs and LAs.

Fast Track Pathway Tool

PG 49 Do individuals need to consent to a Fast Track Pathway Tool being completed?

49.1 Yes, where the individual has capacity their consent is required for the completion of the Fast Track Pathway Tool. The clinician completing the Tool should sensitively seek this, along with consent to share personal information for the purposes of arranging appropriate care. Consent in these circumstances should be in a form which complies with the requirements for explicit consent set out in para 72 of the Framework.

49.2 Where an individual lacks capacity to provide consent, the appropriate clinician should make a 'best interests' decision on whether to complete the Fast Track Pathway Tool in accordance with the Mental Capacity Act 2005. This best interests process should be carried out without delay, having regard to the intention that the tool should enable individuals to be in their preferred place of care as a matter of urgency.

PG 50 How should Fast Track care packages be put in place?

50.1 CCGs who receive significant numbers of Fast Track Pathway Tools could consider having staff dedicated to implementing Fast Track care packages as this will avoid a conflict of time priorities when dealing with non-Fast Track applications. Having dedicated staff could also facilitate close working with end of life care teams. CCGs should also consider wider arrangements that need to be in place to facilitate implementation of packages within 48 hours, such as protocols for the urgent provision of equipment. The CCG coordinator and the referrer should communicate effectively with each other to ensure well-coordinated discharge/support provision arrangements.

Joint packages of care, including NHS-funded Nursing Care

PG 51 In a joint package does the DST define which elements are the responsibility of the NHS and which are the responsibility of social services?

51.1 No. The completed DST will help to indicate the nature and levels of need of an individual, but it does not attribute responsibility for individual elements of a care package. Where a person is not eligible for full NHS Continuing Healthcare the cost of a jointly funded support package is a matter of negotiation between the CCG and the local authority based on the assessed needs of the person and the limits of what a local authority can fund.

51.2 One approach to identifying respective funding responsibilities is to analyse a 24 hour/48 diary of the tasks and interventions required to meet the individual's needs in order to identify which elements are beyond local authority powers, which are areas where both health and social care have power to provide, and which areas which are clearly social care responsibility.

51.3 CCGs and local authorities should agree protocols for dealing with jointly funded packages/placements. Local dispute resolution processes should cover both disputes over joint funding as well as NHS Continuing Healthcare eligibility.

PG 52 How does NHS-funded Nursing Care affect other funding such as from local authorities?

52.1 The fundamental issue here is about how the care home fee is shared between the NHS, the nursing home resident and/or the local authority.

53.2 NHS-funded Nursing Care is a defined contribution towards the cost of registered nursing in a care home. It is set each year at a standard rate.

52.3 The Care home provider should set an overall fee level for the provision of care and accommodation. This should include any registered nursing care provided by them. Where a CCG assesses that the resident's needs require the input of a registered nurse they will pay the NHS-funded Nursing Care payment (at the nationally agreed rate) direct to the care home, unless there is an agreement in place for this to be paid via a third party (e.g. a local authority). The balance of the fee will then be paid by the individual, their representative or the local authority unless other contracting arrangements have been agreed.

PG 53 Is there a national template for assessing NHS-funded Nursing Care?

53.1 Yes, Annex A of the NHS-funded Nursing Care Practice Guide contains a template for recording nursing care needs. This template is for use in those situations where the individual has not already had a full MDT assessment with a DST completed (i.e. the individual has had a Checklist completed but this did not indicate the need for a full assessment for NHS Continuing Healthcare).

53.2 Where a full MDT assessment and DST have been completed there should be sufficient information to determine the need for NHS-funded Nursing Care.

Further Information related to care and support arrangements

PG 54 Case study 1: Paying for additional services

54.1 Eileen lives in a care home as part of a care package funded via NHS Continuing Healthcare. She has significant difficulties in leaving the care home due to mobility needs. Her care plan identifies that she requires physiotherapy weekly which she receives from a physiotherapist employed by the CCG. Eileen considers that she wishes to purchase an additional session of physiotherapy weekly.

54.2 The CCG review her care plan and consider that one physiotherapy session a week is sufficient to meet her needs. Eileen decides that she would nevertheless like to purchase an additional session. She makes arrangements with a private physiotherapist for this purpose.

54.3 With Eileen's permission, the NHS and privately-funded physiotherapists liaise to ensure compatible approaches to the treatment that they will give, ensuring that the NHS treatment continues to be fully provided by the NHS physiotherapist. This is set out in a care plan agreed with Eileen.

PG 55 Case study 2: Paying for additional services

55.1 John receives a support package funded via NHS Continuing Healthcare in his own home. The package is delivered by care workers from a private agency engaged by the NHS who visit to provide support every four hours. John considers that support should be provided more often and asks the CCG to increase the visits to every two hours. The CCG review John's support package and agree that more frequent support is needed during the evenings. They increase the frequency to every two hours each evening. However the CCG consider that four hourly visits are still appropriate during the daytime.

55.2 John still wishes to have additional support during the day and arranges with the same care provider to purchase additional visits every two hours. The CCG liaise with John and the care provider to develop mutual clarity on the additional support to be provided in the privately-funded visits as opposed to those provided in the NHS-funded visits. This is set out in a care plan agreed between the CCG, the care provider and John. The arrangements also include a single set of daily notes completed by the care provider's staff as a record of each visit so that, regardless of whether the most recent visit was NHS funded or privately funded, there is effective communication on John's current needs for the next staff who visit.

PG 56 Who is responsible for equipment and adaptations if an individual is eligible for NHS Continuing Healthcare and is in their own home?

56.1 Where an individual is eligible for NHS Continuing Healthcare the CCG has a responsibility to meet the individual's assessed nursing, healthcare, personal care and associated social care needs. It may well be that the provision of equipment and/or adaptations is identified as being an appropriate way to meet some of these needs.

56.2 Those in receipt of NHS Continuing Healthcare should have access to local joint equipment services on the same basis as any other person. Local agreements on the funding of joint equipment services should take into account the fact that the NHS has specific responsibilities for meeting the support needs of those eligible for NHS Continuing Healthcare. Some individuals will require bespoke equipment (and/or specialist or other non-bespoke equipment that is not available through joint equipment services) to meet specific assessed needs identified in their NHS Continuing Healthcare care plan. CCGs should make appropriate arrangements to assess for and meet these needs.

56.3 Disabled Facilities Grants (DFGs)[1] may be available from local housing authorities towards the cost of housing adaptations that are necessary to enable a person to remain living in their home (or to make a new home appropriately accessible). DFGs are means-tested and are administered by the housing authority which has to decide whether the proposed adaptation is reasonable and practicable. Under the relevant legislation[2] the housing authority is required to consult with the Local Authority as to whether the adaptation is necessary and appropriate for the individual in question, but this does not necessarily mean that the local authority is required to undertake an occupational therapy assessment for this purpose. Because CCGs are responsible for meeting the needs of those eligible for NHS Continuing Healthcare, the local authority might reasonably rely on information from the CCG in order to provide advice rather than undertake its own separate assessment for this purpose. A duty to assess under the Care Act 2014 is not triggered in these circumstances (but the request may indicate the need for the CCG to carry out a review of the individual's NHS Continuing Healthcare support plan).

56.4 The CCG retains responsibility for deciding with the individual how their needs will be met, including in situations where property adaptation is assessed as an appropriate option. DFGs are means tested and the individual might not be entitled to a grant or the grant might not cover the full cost of the adaptation. CCGs are reminded that in such circumstances they must give consideration to the option of funding the adaptation if this is a cost effective solution. Housing authorities, CCGs and local authority social services authorities all have powers to provide additional

[1] Disabled Facilities Grant

[2] The Housing Grants, Construction and Regeneration Act 1996

support where appropriate. Further details can be found in the guidance *Delivering Housing Adaptations for Disabled People; A Detailed Guide to Related Legislation, Guidance and Good Practice (2013*)[1]. This guidance encourages the above bodies, together with home improvement agencies and registered social landlords, to work together locally on integrated adaptations services. Whether or not such integrated services are in place, CCGs should have clear arrangements with partners setting out how the adaptation needs of those eligible for NHS Continuing Healthcare should be met, including referral processes and funding responsibilities.

56.5 CCGs should be aware of their responsibilities and powers to meet housing-related needs for those eligible for NHS Continuing Healthcare:

a) CCGs have a general responsibility under section 3(1)(e) of the NHS Act 2006 to provide such after-care services and facilities as it considers appropriate as part of the health service for those who have suffered from illness.

b) NHS England has responsibility for arranging, under section 3B(1) of the NHS Act 2006 and under Standing Rules Regulations, secondary care and community services for serving members of the armed forces and their families, and prisoners, as part of the health service to such an extent as it considers necessary to meet all reasonable requirements.

c) CCGs may make payments in connection with the provision of housing to housing authorities, social landlords, voluntary organisations and certain other bodies under sections 256 and 257 of the above Act.

d) CCGs also have a more general power to make payments to local authorities towards expenditure incurred by the local authority in connection with the performance of any local authority function that has an effect on the health of any individual, has an effect on any NHS function, is affected by any NHS function or are connected with any NHS function.

e) Housing can form part of wider partnership arrangements under section 75 of the above Act.

56.6 Local authorities should be aware that they may continue to have responsibilities under the Care Act 2014 to those in receipt of NHS Continuing Healthcare. Local authorities cannot lawfully meet needs by providing or arranging services that are legally the responsibility of the NHS. Therefore, in deciding what

[1] *A Detailed Guide to Related Legislation, Guidance and Good Practice (2013*

services to provide or arrange the local authority will need to take into account services that are the responsibility of the NHS to provide or arrange, either as NHS Continuing Healthcare or as other NHS services. They may also continue to have some responsibilities for those in their own homes eligible for NHS Continuing Healthcare where the services needed are not ones that the Secretary of State requires the NHS to provide.

56.7 When an assessment is required for a minor housing adaptation or the provision of equipment for an individual receiving NHS Continuing Healthcare funding, the CCG is responsible for ensuring that the assessment is undertaken and, where appropriate, the adaptation or equipment is provided.

56.8 Whilst local authorities and CCGs have some overlapping powers and responsibilities in relation to supporting individuals eligible for NHS Continuing Healthcare in their own home, a reasonable division of responsibility should be negotiated locally. In doing this, CCGs should be mindful that their responsibility under NHS Continuing Healthcare involves meeting both health and social care needs based on those identified through the MDT assessment. Therefore, whilst local authorities and CCGs have overlapping powers, in determining responsibilities in an individual case, CCGs should first consider whether the responsibility to meet a specific need lies with them as part of their NHS Continuing Healthcare responsibilities. Local authorities should be mindful of the types of support that they may provide in such situations as outlined in paragraphs 291-295 of the National Framework.

Advocacy

PG 57 Whose responsibility is it to provide advocacy for individuals going through the eligibility decision-making process?

57.1 Any individual is entitled to nominate a person to represent their views or speak on their behalf and this could be a family member, friend or peer, a local advocacy service or someone independent who is willing to undertake an advocacy role. It is not appropriate for either a local authority or NHS member of staff to act as a formal advocate in this sense as there could be a conflict of interest, although staff should always seek to explain the individual's views alongside their own. Local authorities and CCGs may have varying arrangements to fund advocacy services in their locality, some being jointly funded whereas others are funded by a single agency or rely on voluntary contributions.

57.2 In addition to the provision of advocacy under the Mental Health Act and the Mental Capacity Act, the Care Act 2014 introduced new responsibilities on local authorities to arrange independent advocacy for individuals undergoing certain processes including a care and support assessment and planning under the Care Act 2014 where:

> a) that individual would otherwise have substantial difficulty in understanding relevant information, retaining information, using or weighing information or communicating their views, wishes and feelings and
>
> b) there is currently no appropriate individual available to support and represent the person for the purpose of facilitating their involvement.

57.3 However, whilst there is no specific statutory provision for independent advocacy for people being assessed for NHS Continuing Healthcare, where an individual is being assessed by the local authority, and their needs indicate that a joint assessment is required for NHS Continuing Healthcare, the local authority is under a duty to consider the individual's need for an advocate to support their involvement in that assessment[1]. These Care Act 2014 requirements do not mean that local authorities have a general responsibility for the provision or funding of independent advocacy where individuals are being assessed for NHS Continuing Healthcare.

[1] Paragraph 7.21, 7.22, 7.8, Care and support statutory guidance

57.4 Whilst CCGs do not have a statutory requirement to provide advocacy services, they should consider planning strategically together with their local authority partners regarding statutory and non-statutory advocacy services in their locality, bearing in mind the needs of those being considered for NHS Continuing Healthcare as well as the needs of those requiring support through the care and support assessment and planning process. For advocacy in relation to independent review panels (IRPs), CCGs should ensure that there are agreed protocols as to how the provision of advocates will operate and the circumstances in which they may be made available. CCGs could link such protocols with the strategic development of advocacy services discussed above.

PG 58 Do individuals need to have legal representation during the NHS Continuing Healthcare eligibility process?

58.1 No, although individuals are free to choose whether they wish to have an advocate present, and to choose who this advocate is. This National Framework (supported by Standing Rules Regulations and Care Act 2014 Regulations) sets out a national system for determining eligibility for NHS Continuing Healthcare. The eligibility process is focused around assessing an individual's needs in the context of the National Framework rather than being a legal or adversarial process.

58.2 If the individual chooses to have a legally qualified person to act as their advocate, that person would be acting with the same status as any other advocate nominated by the individual concerned. The MDT process is fundamentally about identifying the individual's needs and how these relate to the National Framework. Health and social care practitioners should be confident of their knowledge and skill in dealing with most queries that arise about the MDT process and the appropriate completion of the DST. Where wider issues that are not connected with the question of eligibility are raised by advocates (such as legal questions) they should, if appropriate, be asked to raise these separately with the CCG outside the MDT meeting.

Annex A: Glossary

Assessment notice

A notice given by the responsible NHS body to the local authority where the NHS body considers it unsafe to discharge a hospital patient unless arrangements are made for that person's care and support needs.

Assessment of eligibility for NHS Continuing Healthcare

The assessment process used by a multidisciplinary team to make a recommendation regarding eligibility for NHS Continuing Healthcare. The assessment of eligibility requires the completion of the Decision Support Tool in order to arrive at an eligibility recommendation.

Assessment of needs

The collection and evaluation of a range of relevant information relating to an individual's needs.

Care

Support provided to individuals to enable them to live as independently as possible, including anything done to help a person live with ill health, disability, physical frailty or a learning difficulty and to participate as fully as possible in social activities. This encompasses health and social care.

Care package

A combination of care and support and other services designed to meet an individual's assessed needs.

Care plan

A document recording the reason why care and support and other services are being provided, what they are, and the intended outcomes.

Care planning

A process based on an assessment of an individual's needs that involves working with the individual to identify the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Carer

A carer is anyone who, usually unpaid, looks after a friend or family member in need of extra help or support with daily living, for example, because of illness, disability or frailty.

Clinical Commissioning Group (CCG)

CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. References to CCG in this National Framework include any person or body authorised by the CCG to exercise any of its functions on its behalf in relation to NHS Continuing Healthcare. Where a CCG delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework. The CCG cannot delegate its final decision-making function in relation to eligibility decisions, and remains legally responsible for all eligibility decisions made (in accordance with Standing Rules[1]).

Commissioning

Commissioning is the process of specifying and procuring services for individuals and the local population, and involves translating their aspirations and needs into services that:

- deliver the best possible health and well-being outcomes, including promoting equality;
- provide the best possible health and social care provision; and
- achieve this with the best use of available resources and best value for the local population.

Coordinator

A person(s) who coordinates the NHS Continuing Healthcare eligibility assessment process. Refer to Practice Guidance note 20.

End-of-life care

Care that helps 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 management of pain and other symptoms, and provision of psychological, social, spiritual and practical support.

Local authority social services

Local authorities are statutory bodies responsible for a wide range of public services in specified geographic area, including social services. Individually and in partnership with other agencies, local authority social services departments provide a wide range of care and support for people who are in need and meet nationally specified eligibility criteria for care and support.

Long-term conditions

Those conditions that cannot, at present, be cured, but may be controlled by medication and other therapies.

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 set out in section 2 of the Mental Capacity Act 2005: *a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a 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'*.

Multidisciplinary

'Multidisciplinary' refers to when professionals from different disciplines (such as social work, nursing and occupational therapy etc) work together to assess and/or address the holistic needs of an individual, in order to improve delivery of care.

Multidisciplinary team

In the context of assessing eligibility for NHS Continuing Healthcare, a multidisciplinary team (MDT) is a team of at least two professionals, usually from both the health and the social care disciplines. It does not refer only to an existing multidisciplinary team, such as an ongoing team based in a hospital ward. It should include those who have an up-to-date knowledge of the individual's needs, potential and aspirations. Refer to paragraphs 119-123 of the National Framework.

NHS Continuing Healthcare

A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual has a 'primary health need'. It can be provided in any setting. Where a person lives in their own home, it means that the NHS funds all the care and support that is required to meet their assessed health and care needs. Such care may be provided either within or outside the person's home, as appropriate to their assessment and care plan. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the person's accommodation, board and care.

NHS England

NHS England is the name given to what is legally known as the National Health Service Commissioning Board. References to NHS England in this National Framework include any person or body authorised by NHS England to exercise any

of its functions on its behalf in relation to NHS Continuing Healthcare. Where NHS England delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework.

NHS-funded Nursing Care

Funding provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible. It exists because Section 22 of the Care Act 2014 prohibits local authorities from providing, or arranging for the provision of nursing care by a registered nurse, save in the very limited circumstances set out in Section 22 (4). Since 2007 NHS-funded Nursing Care has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS Continuing Healthcare before a decision is reached about the need for NHS-funded Nursing Care.

Palliative care

Palliative care is the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.

Personal health budget

A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local NHS. It isn't new money, but a different way of spending health funding to meet the needs of an individual. Personal health budgets are one way to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs.

Personalised

The term used to describe care and services received by a person that are individualised and tailored to their needs and preferences. Wherever possible, it involves the individual having choice and control over the care and support they receive.

Registered nurse

A nurse registered with the Nursing and Midwifery Council.

Rehabilitation

A programme of therapy and re-enablement designed to maximise independence and minimise the effects of disability or illness.

Representative

Any friend, carer or family member who is supporting the individual in the process as well as anyone acting in a more formal capacity (e.g. welfare deputy or power of attorney, or an organisation representing the individual).

Specialist assessment

An assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care, e.g. stroke, cardiac care, bereavement counselling.

Annex B: The Coughlan Judgment

R v North and East Devon Health Authority, ex parte Pamela Coughlan

1. Pamela Coughlan was seriously injured in a road traffic accident in 1971. Until 1993, she received NHS care in Newcourt Hospital. When the Exeter Health Authority wished to close that hospital and move Miss Coughlan and other individuals to a new NHS facility at Mardon House, the individuals were promised that Mardon House would be their home for life.

2. In October 1998, the successor health authority (North and East Devon Health Authority) decided to withdraw services from Mardon House, close that facility, and transfer the care of Miss Coughlan and other disabled individuals to the local authority (LA) social services. Miss Coughlan and the other residents did not wish to move out of Mardon House and argued that the decision to close it was a breach of the promise that it would be their home for life, and was therefore unlawful.

3. The arguments on the closure of Mardon House raised other legal points about the respective responsibilities of the health service and the social services for nursing care. The Court of Appeal's judgement on this aspect has heavily influenced the development of continuing care policies and the National Framework. The relevant law relating to NHS Continuing Healthcare has since been updated with the introduction of the Care Act 2014 (which replaced the National Assistance Act and other Acts of parliament). However, the key relevant points made in this judgement, in the context of the law at the time, were as follows:

    - The NHS does not have sole responsibility for all nursing care. LAs can provide nursing services under section 21 of the National Assistance Act 1948, so long as the nursing care services are capable of being properly classified as part of the social services' responsibilities.

    - No precise legal line can be drawn between those nursing services that can be provided by an LA and those that cannot: the distinction between those services that can and cannot be provided by an LA is one of degree, and will depend on a careful appraisal of the facts of an individual case.

    - As a very general indication as to the limit of LA provision, if the nursing services are:

        a) merely incidental or ancillary to the provision of the accommodation that an LA is under a duty to provide, pursuant to section 21; and

        b) of a nature that an authority whose primary responsibility is to provide social services, can be expected to provide

then such nursing services can be provided under section 21 of the National Assistance Act 1948.

- By virtue of section 21(8) of the National Assistance Act 1948, an LA is also excluded from providing services when the NHS has, in fact, decided to provide those services.

- The services that can appropriately be treated as responsibilities of an LA under section 21 may evolve with the changing standards of society.

- Where a person's primary need is a health need, the responsibility is that of the NHS, even when the individual has been placed in a home by an LA.

- An assessment of whether a person has a primary health need should involve consideration not only of the nature and quality of the services required, but also of the quantity or continuity of such services.

- The duty of clinical commissioning groups under section 3 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), is limited to providing the services identified, to the extent that they consider necessary to meet all reasonable requirements.

- In respect of Ms Coughlan, her needs were clearly of a scale beyond the scope of LA services.

Annex C: The Grogan Judgment

R v Bexley NHS Care Trust, ex parte Grogan

1. Maureen Grogan had multiple sclerosis, dependent oedema with the risk of ulcers breaking out, was doubly incontinent, a wheelchair user requiring two people for transfer, and had some cognitive impairment. After the death of her husband, her health deteriorated and she had a number of falls. Following admission to hospital with a dislocated shoulder, it was decided that she was unable to live independently and she was transferred direct to a care home that provided nursing care.

2. Subsequent assessments indicated that (under the then local criteria dated December 2002) Mrs Grogan's condition was such that she did not qualify for fully funded NHS continuing healthcare. It was initially determined that she was in the medium band of NHS-funded Nursing Care. By and large, she remained in this band, although one determination placed her in the high band from April to October 2004. Mrs Grogan argued that the decision to deny her full NHS funding was unlawful, since the eligibility criteria put in place by South East London NHS CB were contrary to the judgement in the Coughlan case (refer to Annex B). She also submitted that the level of nursing needs identified in the Registered Nursing Care Contribution (RNCC) medium and high bandings (in which she had been placed) indicated a primary need for healthcare that should be met by the NHS.

3. Key relevant points from the Grogan judgement include:
   - In assessing whether Mrs Grogan was entitled to NHS continuing healthcare, the care trust did not have in place – and did not apply –criteria which properly identified the test or approach to be followed in deciding whether her primary need was a health need.

   - The court identified the fact that there can be an overlap, or a gap, between social care and NHS provision, depending on the test, or tests, applied. The court accepted, as had been submitted by the Secretary of State, that the extent of her duties was governed by NHS legislation, not the upper limits of local authority lawful provision, and that therefore there was a potential in law for a gap between what the Secretary of State provided and those 'health services' that the local authority could 'lawfully' supply.

   - If the policy of the Secretary of State was that there should be no gap, then, when applying the primary health need approach, this should be considered against the limits of social services lawful provision, not just by reference to a 'primary health need'.

   4. The trust's decision that Mrs Grogan did not qualify for NHS continuing healthcare was set aside, and the question of her entitlement to NHS continuing healthcare was remitted to the trust for further consideration.

   5. There was no finding, or other indication, that Mrs Grogan in fact met the criteria for NHS continuing healthcare.

Annex D: Independent Review Panel Procedures

The purpose and scope of independent review panels

1. Standing Rules[1] require NHS England to maintain independent review panels (IRPs).

2. An IRP's key tasks are, at the request of NHS England, to conduct a review of the following:

   a) the primary health need decision by a CCG; or

   b) the procedure followed by a CCG in reaching a decision as to that person's eligibility for NHS continuing healthcare

   and to make a recommendation to NHS England in the light of its findings on the above matters.

3. An IRP should not proceed if it is discovered that the individual has not previously received a comprehensive assessment of needs and a determination of their eligibility for NHS Continuing Healthcare, including use of the Decision Support Tool or the Fast Track Pathway Tool, as appropriate. Where an IRP request is received in such circumstances, NHS England should refer the case to the relevant CCG and ask for an assessment of needs and a determination of the individual's eligibility for NHS continuing healthcare to be carried out, if it appears that there may be a need for such care.

4. The IRP procedure does not apply where individuals, their families or any carer wish to challenge:

   - the content of the eligibility criteria;
   - the type and location of any offer of NHS-funded continuing care services;
   - the content of any alternative care package that they have been offered;
   - their treatment or any other aspect of the services they are receiving or have received (this would properly be dealt with through the complaints procedure).

5. The IRP should apply the key principles for dispute resolution processes, as set out in paragraphs 196-207 of the National Framework.

6. Individuals (and their carer and/or representative, where appropriate) should be given clear information about the IRP procedure, the situations it does and does not cover, and how it operates locally. Advocates should be provided where this will support the individual through the review process. NHS England and CCGs

should ensure that there are agreed protocols as to how the provision of advocates will operate and the circumstances in which they are to be made available.

7. It is particularly important that, before an IRP is convened, all appropriate steps have been taken by the relevant CCG to resolve the case informally, in discussion with the NHS England where necessary. NHS England should have a named contact, who is the first port of call for queries from partner organisations for the relevant locality.

8. If the case cannot be resolved by local resolution (or local resolution will cause undue delay), the individual (or their representative) may ask the NHS England to arrange an IRP to review the case with regard to the matters listed in paragraph 2 above. Before doing so, NHS England should ensure that none of the circumstances listed at paragraphs 3 and 4 of this annex apply. If any of them are applicable, NHS England should contact the individual and advise them of the appropriate routes for dealing with these matters. If the case nevertheless has some issues that fall within an IRP's responsibilities, the IRP should proceed, but should only deal with the relevant matters.

9. NHS England should designate individuals to maintain the review procedure and to give advice to IRPs and to the parties involved on the content of the requirements of the National Framework and the associated tools, as well as on any procedural issues.

10. Clear and timely communication is very important. NHS England should develop and publish timescales for the hearing of IRP cases.

11. NHS England does have the right to decide in any individual case not to convene an IRP. It is expected that such a decision will be confined to those cases where the individual falls well outside the eligibility criteria, or where the case is very clearly not appropriate for the IRP to consider. Before taking such a decision, NHS England should seek the advice of the chair of the IRP, who may require independent clinical advice. In all cases where a decision not to convene an IRP is made, NHS England should give the individual, their family or carer a written explanation of the basis of its decision, together with a reminder of their rights under the NHS complaints procedure.

12. No individual should be left without appropriate support while they await the outcome of the review. The eligibility decision that has been made is effective while the independent review is awaited. This does not preclude review of eligibility in the meantime by the CCG, using the process set out in paragraphs 181-185 of the National Framework, if the individual's needs change or if the time for the next scheduled review of the individual has arrived. Please see Appendix E for guidance on responsibilities when a decision on NHS Continuing Healthcare eligibility is awaited or is disputed.

Establishment and operation of the panels

13. IRP chairs should be selected by the NHS England, following an open recruitment process. Those chosen should have a clear understanding of the IRP's purpose and be able to communicate this to the individual, their family and any carers concerned. On the basis of the evidence received and the advice given at the IRP, the chair should be able to determine, in consultation with other IRP members, whether eligibility criteria have been correctly applied. The chair should have the capacity to make balanced decisions in sometimes difficult circumstances, while taking a sympathetic view of the concerns of individuals, their family and any carers.

14. Selection of the right people as chairs – people who are capable of gaining the confidence of all parties – will be a crucial factor in the success of the IRP. Current NHS staff, board members of NHS organisations, LA staff and LA elected members should not be considered but people who have formerly held such a position are eligible. NHS England is advised to involve lay people in the selection process.

15. The appointment of representatives from CCGs and LAs will be on the basis of the nomination of those organisations. They should take account of professional and other skills that are relevant to the work of the IRP. The chair and members of an IRP should receive reasonable expenses.

16. The members of the IRP should meet to consider individual cases. A designated NHS England representative should be responsible for ensuring that the relevant information has been received from the CCG before the IRP. The IRP should also have access to the views of key parties involved in the case, including the individual, his or her family and any carer, health and social services staff, and any other relevant bodies or individuals. It will be open to key parties to put their views in writing or to attend. If parties attend, they should be given the opportunity to hear the submissions of other parties and to ask them questions.

17. An individual may have a representative present to speak on his or her behalf if they so choose, or if they are unable to, or have difficulty in presenting their own views. This role may be undertaken by a relative or carer or advocate acting on the individual's behalf. The IRP should be satisfied that any person acting on behalf of the individual accurately represents their views, and that the representative's interests or wishes do not conflict with those of the individual. The IRP should respect confidentiality at all times.

18. The IRP will require access to independent clinical advice, which should take account of the range of medical, nursing and therapy needs involved in each case. Such arrangements should avoid any obvious conflicts of interest between the individual clinician(s) giving the advice and the organisation(s) from which the individual has been receiving care. The chair of the relevant IRP should consider in advance of the hearing whether, bearing in mind the nature of the case, the evidence supplied and the role of the clinical adviser set out in paragraph 19 below, there is a need for the panel to access independent clinical advice, and

whether this should be in the form of attendance at the hearing or of the clinician supplying written advice.

19. It is the role of the clinical adviser to advise the IRP on the original clinical judgements and on how those judgements relate to the National Framework. It is not the adviser's role to provide a second opinion on the clinical diagnosis, management or prognosis of the individual.

20. An IRP may ask all parties to withdraw while it deliberates and agrees its recommendations. Where appropriate, an IRP may ask an NHS England representative and/or the clinical adviser to be present to give advice. NHS England may also be represented in order to keep a record of deliberations.

21. In reaching a view on whether the CCG followed the correct process and whether it correctly applied the eligibility criteria, the range of recommendations made by the IRP for consideration by the CCG could include:
    a) that the case should be reconsidered by NHS England or the CCG, addressing identified deficiencies in the process used or in the application of the eligibility criteria; or
    b) that, on the evidence submitted, when compared to the eligibility criteria, the individual should or should not be considered to have a primary health need.

22. A full record should be made of the IRP hearing, including details of those present and their role, the issues and evidence considered, the conclusions and recommendations reached by the IRP, and the reasons for them. A copy of this should be sent by NHS England to all parties.

23. The recommendations of an IRP should be accepted by NHS England in all but exceptional circumstances.

24. If NHS England decides, in exceptional circumstances, not to accept an IRP recommendation in an individual case, it should explain this in writing to the individual, the CCG and the chair of the IRP, including its reasons for not accepting it.

25. In all cases, the NHS England should communicate the outcome of the review, with its reasons, to the individual and the CCG.

26. A CCG should accept the recommendations of the IRP, as forwarded by the NHS England, in all but exceptional circumstances. If a CCG decides, in exceptional circumstances, not to accept an IRP recommendation in an individual case, it should explain this in writing to the individual and NHS England, including its reasons. If NHS England or CCG does not accept the recommendations, and if the individual is dissatisfied with this, the matter should be pursued through the NHS complaints procedure.

27. NHS England or the CCG, as appropriate, should ensure that the individual is informed in writing of their right to use the NHS complaints procedure in such circumstances.

Annex E: Guidance on responsibilities when a decision on NHS Continuing Healthcare eligibility is awaited or is disputed

1. This guidance sets out the approach to be taken by CCGs and local authorities (LAs) in three situations:

   a) where there is a need for health or care and support to be provided to an individual during the period in which a decision on eligibility for NHS Continuing Healthcare is awaited, in a case that does not involve hospital discharge (refer to paragraphs 109-115 of the National Framework).

   b) where a CCG has unjustifiably taken longer than 28 calendar days to reach a decision on eligibility for NHS Continuing Healthcare; or

   c) where, as a result of an individual disputing an NHS Continuing Healthcare eligibility decision, the CCG has revised its decision.

<u>a) Where care needs to be provided whilst a decision on NHS continuing healthcare is awaited, in a case that does not involve hospital discharge</u>

2. A person only becomes eligible for NHS continuing healthcare once a decision on eligibility has been made by a CCG, informed by a completed Decision Support Tool or Fast Track Pathway Tool. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment.

3. If, at the time of referral for an NHS Continuing Healthcare assessment, the individual is already receiving ongoing care and support funded by a CCG, or a local authority, or both, those arrangements should continue until the CCG makes its decision on eligibility for NHS Continuing Healthcare, subject to any urgent adjustments needed to meet the changed needs of the individual. In considering such adjustments, local authorities and CCGs should have regard to the limitations of their statutory powers.

4. Some health needs fall within the powers of both CCGs and local authorities to meet. However where:

   i) a local authority is providing services during the period in which an NHC Continuing Healthcare eligibility decision is awaited; and
   ii) it is identified that the individual has some health needs that are **not** within the power of a local authority to meet (regardless of the eventual outcome of the NHS Continuing Healthcare eligibility decision); and
   iii) those health needs have to be met before the decision on eligibility is made;

the CCG should consider its responsibilities under the NHS Act to provide such health services to such extent as it considers necessary to meet all reasonable requirements. NHS England or the CCG should therefore consider whether the individual's health needs are such that it would be appropriate to make services available to help meet them in advance of the NHS Continuing Healthcare eligibility decision.

5. Where an individual is not already in receipt of ongoing care and support from the local authority or CCG (or both), they may have urgent health or care and support needs which need to be met during the period in which the NHS Continuing Healthcare eligibility decision is awaited, for example because previous private arrangements are no longer sustainable or there were not previously any care needs requiring support. Where there are urgent healthcare needs to be met, these should be assessed by the relevant healthcare professional.

6. Where the individual appears to be in need of care and support, the local authority should assess the individual's eligibility for these under section 9 of the Care Act 2014.

7. If, in carrying out a needs assessment (under the Care Act 2014), it appears to the local authority that the individual may be eligible for NHS Continuing Healthcare the local authority must refer the individual to the CCG. The CCG must then take steps to ensure that an assessment of eligibility for NHS Continuing Healthcare is carried out. The local authority and CCG should jointly agree actions to be taken in the light of their statutory responsibilities until the outcome of the NHS Continuing Healthcare eligibility decision making process is known. No individual should be left without appropriate support because statutory bodies are unable to agree on respective responsibilities.

b) <u>Where the CCG has unjustifiably taken longer than 28 calendar days to reach a decision on eligibility for NHS continuing healthcare</u>

8. Decision-making on eligibility for NHS Continuing Healthcare should, in most cases, take no longer than 28 calendar days from the CCG (or organisation acting on behalf of the CCG) being notified of the need for assessment of eligibility for NHS Continuing Healthcare e.g. an appropriately completed positive Checklist, or other notification that an assessment of eligibility is required.

9. When
   i) the CCG makes a decision that a person is eligible for NHS continuing healthcare; and
   ii) it has taken more than 28 calendar days to reach this decision; and
   iii) a local authority or the individual has funded services whilst awaiting the decision;

   the CCG should, having regard to the approaches set out in paragraphs 11 to 13 below, refund directly to the individual or the local authority, the costs of the services from day 29 of the period that starts on the date of receipt of a completed Checklist (or where no Checklist is used, other notification of potential

eligibility for NHS Continuing Healthcare), and ends on the date that the decision was made. This period is referred to below as the "period of unreasonable delay". The refund should be made unless the CCG can demonstrate that the delay is reasonable as it is due to circumstances beyond the CCG's control, which could include:

i) evidence (such as assessments or care records) essential for reaching a decision on eligibility has been requested from a third party and there has been delay in receiving these records from them;
ii) the individual or their representatives have been asked for essential information or evidence or for participation in the process and there has been a delay in receiving a response from them;
iii) there has been a delay in convening a multidisciplinary team due to the lack of availability of a non-CCG practitioner whose attendance is key to determining eligibility and it is not practicable for them to give their input by alternative means such as written communication or by telephone.

10. In all of the above and other circumstances, the CCG should make all reasonable efforts to ensure the required information or participation is made available in accordance with the 28 calendar days timeframe. This should include developing protocols with services likely to be regularly involved in NHS Continuing Healthcare eligibility processes that reflect the need for information in accordance with the within 28 calendar days timeframe. Where the CCG commissions the service from another organisation from which information or participation is regularly required, it may be appropriate to consider placing such expectations within the specification for the relevant service.

11. CCGs and LAs should be aware of the requirements of the Standing Rules[1] and Directions to local authorities[5] for the CCG to consult the relevant local authority, wherever reasonably practicable, before making a decision on NHS continuing healthcare eligibility and for the local authority, wherever reasonably practicable, to provide advice and assistance to the relevant CCG.

12. Where unreasonable delay has occurred and it is an LA that has funded services during the interim period, the CCG should refund the local authority the costs of the care package that it has incurred during the period of unreasonable delay. The CCG can use its powers under section 256 of the NHS Act to make such payments. The amount to be refunded to the local authority should be based on the gross cost of the services provided. Where an individual has been required to make financial contributions to the local authority as a result of an assessment of their resources under the Care Act 2014, the above approach should be adopted rather than the CCG refunding such contributions directly to the individual as the refund of contributions is a matter between the local authority and the individual. Where a CCG makes a gross cost refund, the local authority should refund any financial contributions made to it by the individual in the light of the fact that it has been refunded on a gross basis, including interest.

13. Where a CCG has unreasonably delayed reaching its decision on eligibility for NHS Continuing Healthcare, and the individual has arranged and paid for services directly during the interim period, the CCG should make an ex-gratia

payment in respect of the period of unreasonable delay.

14. Such payments would need to be made in accordance with the guidance for ex-gratia payments set out in Managing Public Money[1]. This sets out that, where public services organisations have caused injustice or hardship, they should provide remedies that, as far as reasonably possible, restore the wronged party to the position that they would have been in had matters been carried out correctly. This guidance sets out other issues to be considered and CCGs should take these into account in reaching their decision.

c) Where, as a result of an individual disputing an NHS continuing healthcare eligibility decision, a CCG has revised its decision

15. When a CCG has made a decision on NHS Continuing Healthcare eligibility, then that decision remains in effect until the CCG revises the decision. This National Framework sets out that IRPs make recommendations but that these recommendations should be accepted by NHS England and the CCG in all but exceptional circumstances. Where a CCG accepts an IRP recommendation on NHS Continuing Healthcare eligibility, it is in effect revising its previous decision in the light of that recommendation.

16. Where:
    i) a local authority has provided care and support to an individual in circumstances where a CCG has decided that the individual is not eligible for NHS continuing healthcare, and

    ii) the individual disputes the decision that they are not eligible for NHS Continuing Healthcare and the CCG's decision is later revised (including where the revised decision is as a result of an IRP recommendation),

    the CCG should refund the local authority the costs of the care package. This should be based on the gross care package costs that the local authority has incurred from the date of the decision that the individual was not eligible for NHS Continuing Healthcare (or earlier, if that decision was unreasonably delayed – see the previous section) until the date that the revised decision comes into effect. The CCG can use its powers under section 256 of the NHS Act to make such payments. Where the local authority has collected an assessed charge from the individual, the refund from the CCG should include interest on that amount so that this can be reimbursed to the individual (see paragraph 17 below)

17. Where a CCG makes such a refund, the local authority should refund any financial contributions made to it by the individual (with interest) in the light of the fact that it has been refunded on this basis.

18. Where:
    i) no local authority has provided care and support to an individual in

[1] Managing Public Money

circumstances where a CCG has decided that the individual is not eligible for NHS Continuing Healthcare, and

ii) the individual has arranged and paid for such services him or herself; and

iii) the individual disputes the decision that they are not eligible for NHS Continuing Healthcare and a CCG's decision is later revised (including where the revised decision is as a result of an IRP recommendation),

the CCG should make an ex-gratia payment directly to the individual. When the CCG has revised its decision, whether as a result of an IRP process or not, this is a recognition that the original decision, or the process leading up to the decision, was incorrect. An ex-gratia payment would be to remedy any injustice or hardship suffered by the individual as a result of the incorrect decision. The CCG should take into account the Managing Public Money guidance as explained above.

Disputes

19. It is important that CCGs and LAs have clear jointly agreed local processes for resolving any disputes that arise between them on the issues covered in this guidance. The Standing Rules and Directions to local authorities require CCGs and LAs to have an agreed local process for resolving disputes between them on issues relating to eligibility for NHS continuing healthcare and for the NHS elements of joint packages. CCGs and LAs could extend the remit of their local disputes process to include disputes over refunds. Whatever disputes process is selected, it is important that it should not simply be a forum for further discussion but includes an identified mechanism for final resolution, such as referring the case to another CCG and LA and agreeing to accept their recommendation.

20. Where an individual disputes a CCG's decision on whether to provide redress to them, or disputes the amount of redress payable, this should be considered through the NHS complaints process.

Annex F: Local NHS Continuing Healthcare Protocols

The following provides a best practice guide for what to include when drawing up and updating local protocols and procedures regarding NHS Continuing Healthcare.

Referrals, Assessments and Recommendations

- A statement about the principles underlying the process to ensure that it is 'person-centred', equitable, culturally sensitive, robust, transparent and lawful. This includes ensuring equitable access to assessment for NHS Continuing Healthcare based on need (not on client group, current funding arrangements, etc.) and using the Checklist as a basis for identifying those who require full assessment to inform completion of the DST.

- Arrangements for ensuring that the individual and their family are kept informed and involved at every stage, including being informed of their right to seek a review if they have reason to believe that an eligibility decision regarding NHS Continuing Healthcare was incorrect.

- Arrangements for obtaining consent (refer to paragraphs 72-73 of the National Framework) to the different stages of the process, and to sharing information, where the individual has capacity to give such consent. Also arrangements for dealing with (probably rare) situations where an individual with capacity refuses consent to assessment of eligibility for NHS Continuing Healthcare.

- Local arrangements for dealing with situations where the individual appears to lack capacity, in order to ensure compliance with the Mental Capacity Act 2005 and the associated Code of Practice, including how to access the IMCA service where the criteria for this are met (refer to paragraphs 306-308 of the National Framework).

- Local arrangements regarding how individuals can access advocacy, advice and information.

- An explanation of who can complete the Checklist (and what training they need beforehand), bearing in mind that the aim is to allow a variety of professionals, in a variety of settings, to refer individuals for a full assessment for NHS Continuing Healthcare. It is for each organisation to decide for itself who are the most appropriate staff to participate in the completion of a Checklist, but these staff should be trained in its use.

- Arrangements to ensure that individuals and/or representatives are informed in writing about the outcome of the Checklist (whether negative or positive), which will normally be achieved by them being given a copy of the completed Checklist. The written information should include what the individual/representative should

do if they are dissatisfied with the Checklist outcome.

- How and in what situations Fast Track arrangements are to operate, including a statement that the Fast Track Pathway Tool (refer to paragraphs 216-245 of the National Framework) is to be completed by an 'appropriate clinician' as defined in the Standing Rules Regulations and is to be acted on by the CCG without delay. It is important to ensure that decision-making around NHS Continuing Healthcare does not in any way compromise the provision of good end of life care or timely discharge from acute hospital.

- Arrangements for the timely provision of care and/or support in fast-track cases, including provision of equipment where necessary.

- The referral process being clear where cases requiring full consideration of eligibility using the DST are to be directed (this may well differ depending on whether the individual concerned is currently in hospital, in a care home or in the community). Clarity on the method of delivery of paperwork is needed to minimise delay but ensure confidentiality.

- An agreement that the key agencies will make staff available to participate in the assessment and decision-making processes, including making staff available to sit on Independent review panels.

- Any specific local arrangements around appointing coordinators, identifying members of the MDT and convening MDT meetings. These arrangements need to ensure that, where appropriate and as far as possible, both NHS and social care colleagues are involved in both the needs assessment (under the Care Act 2014) and eligibility assessment process.

- Arrangements for dealing with people subject to section 117 of the Mental Health Act 1983, with reference to paragraphs 309-319 of the National Framework.

- Clarity on how the NHS Continuing Healthcare process fits with hospital discharge arrangements, with reference to paragraphs 109-115 of the National Framework. These arrangements must reflect the clear emphasis in this National Framework that in the majority of cases it is preferable for eligibility for NHS Continuing Healthcare to be assessed after discharge from hospital when the individual's ongoing needs should be clearer. The assessment process for NHS Continuing Healthcare should not be allowed to delay hospital discharge.

- Arrangements for care and/or support and funding (including 'without prejudice' funding) whilst the decision-making process is carried out, noting that if an individual is identified in the hospital discharge pathway as requiring assessment for NHS Continuing Healthcare then the CCG retains funding responsibility whilst the DST is being completed and the eligibility decision is being made, in accordance with paragraph 106 of the National Framework.

- How transfers of care are to be handled, including effective risk management.

- Arrangements for reviewing:
  - care packages or placements where an individual is in receipt of NHS Continuing Healthcare.
  - Joint packages of care
  - Individuals in receipt of NHS-funded nursing care
- Timeframes for each stage of the process.

Visual representation of the process in flow-charts can often be very helpful.

Decision-making

Arrangements must be in place to ensure that (so far as is reasonably practicable) the local authority's views regarding needs and eligibility are obtained before decisions are made regarding eligibility for NHS Continuing Healthcare. There should be robust arrangements for decision-making between the CCG and the local authority, bearing in mind that the CCG retains responsibility for making eligibility decisions regarding NHS Continuing Healthcare. This may or may not include a panel arrangement, but care should be taken to ensure that panels are not used unnecessarily (refer to Practice Guidance note 38 and 41).

- Terms of reference for panel (where these exist)– purpose of panel, which cases are to be referred, client groups covered, limitations of decision-making powers, bearing in mind that the National Framework states that '*only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed* (refer to paragraph 155 of the National Framework and Practice Guidance note 39).
- Arrangements and process for obtaining the local authority's views where a panel process is not in place.
- Membership and chairing arrangements (some have independent chairs).
- Arrangements for panel members to have sight of case documentation in advance.
- Whether/how the individual and/or their representative is to be involved in the panel arrangements.
- What counts as a quorum.
- Frequency of meetings.
- Access to specialist input/advice.
- Paperwork expected (including DST) to inform discussion.
- Arrangements for recording main points of panel discussion and decisions.

- Clarity on decision-making, voting arrangements (if any), etc. On some panels local authority members have an equal say (which is good practice); others limit local authority involvement to advice from a social care perspective. There is a need to be clear that financial considerations do not influence the decision regarding eligibility for NHS Continuing Healthcare.

- Procedure for dealing with disagreement over eligibility within the panel meetings.

- Local resolution process (refer to paragraphs 194-195 of the National Framework) where an individual or their representative is unhappy with the eligibility decision, with reference to the guidance on local resolution provided in this National Framework.

Dispute Avoidance and Resolution between Agencies

Good communication, effective joint working and mutual respect are key to avoiding unnecessary disputes. Any local protocols should consider:

- Clarity on what counts as a disagreement and what counts as a formal dispute – some protocols include disagreements/disputes at Checklist and DST stage as well as at panel decision-making stage.

- Different levels of dispute resolution – the aim is usually to resolve disputes at practitioner level but most procedures have the option of escalating the dispute through appropriate levels to senior management level where necessary. Some dispute resolution processes include referring the case to a second panel to check the original decision; in some cases there are agreements to refer to a panel in another area. It is important that dispute resolution processes have a clear end, final resolution point.

- What types of dispute are covered – protocols should deal with disputes over NHS Continuing Healthcare eligibility, joint funding arrangements and refunds.

- What paperwork/information is needed at each stage.

- Timescales at each stage of the process.

- Arrangements to ensure individuals get the care or support they need whilst disputes are being resolved, bearing in mind the principle of ‘no unilateral withdrawal of funding’ (refer to paragraph 190 of the National Framework).

- Clarity on what happens over interim or ‘without prejudice’ funding – including over any backdating arrangements for reimbursing costs and how charging the service user will be handled in a variety of possible situations, having regard to the approaches set out in Annex E above.

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Dated **2022**

WORCESTERSHIRE COUNTY COUNCIL

and

NHS HEREFORDSHIRE AND WORCESTERSHIRE CLINICAL COMMISSIONING GROUP

SECTION 75 AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES INCLUDING THE BETTER CARE FUND

Contents

THIS DEED OF AGREEMENT is made on day of 2022

PARTIES

(1) **WORCESTERSHIRE COUNTY COUNCIL of County Hall, Spetchley Road, Worcester WR5 2NP (the "Council"); and**

(2) **NHS HEREFORDSHIRE AND WORCESTERSHIRE CLINICAL COMMISSIONING GROUP of The Coach House, John Comyn Drive, Perdiswell, Worcester WR3 7NS (the "CCG**"),

(each a "**Party**" and together the "**Parties**").

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care, preventative and public health services on behalf of the population of the county of Worcestershire.

(B) The CCG has responsibility for commissioning health services pursuant to the 2006 Act in the counties of Herefordshire and Worcestershire.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. The Partners wish to extend the use of pooled funds to include funding streams from outside of the Better Care Fund.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Parties have agreed to collaborate and to establish a framework through which the Parties can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also a means through which the Parties will pool funds and align budgets as agreed between the Parties.

(F) The aims and benefits of the Parties in entering into this Agreement are to:

i) improve the quality and efficiency of the Services;

ii) meet the National Conditions and Local Objectives, and

iii) make more effective use of resources through the establishment and maintenance of a Pooled Budget for revenue expenditure on the Services.

(G) The Parties are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

(H) The Parties acknowledge that whilst this Agreement is based on a template kindly provided by Bevan Brittan LLP and published on the NHS England website, which refers to the law and guidance in force in August 2014, the Parties have amended this template in accordance with their requirements.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Party means, in the context of Clause 24, the Party whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Annual Budget means the Financial Contributions for the relevant Financial Year agreed between the Parties pursuant to Clause 19.5.

Annual Review shall have the meaning given to it in accordance with Clause 19.1.

Approved Expenditure means any expenditure approved by the Parties in writing or as set out in the Scheme Specification in relation to an Individual Scheme above any Contract Price, Permitted Expenditure or agreed Third Party Costs.

Better Care Fund or BCF means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Parties. BCF is paid directly to the CCG by DfLUHC.

Better Care Fund Plan or BCP means the plan setting out the Parties' proposed use of the Better Care Fund and updated annually in accordance with Clause 19.

Better Care Fund Requirements means any and all requirements on the CCG and Council in relation to the Better Care Fund set out in Law and guidance published by the Department of Health.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, which relates to the powers, duties and responsibilities of the Parties and which must be complied with, implemented or otherwise observed by the Parties.

Commencement Date means 00:01 hrs on 1 April 2021.

Confidential Information means information, data and/or material of any nature which any Party may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Party or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Services Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability.

Data Protection Legislation means all applicable data protection and privacy legislation in force from time to time in the UK including the retained EU law version of the General Data Protection Regulation ((EU) 2016/679) (**UK GDPR**); the Data Protection Act 2018 (**DPA 2018**) (and regulations made thereunder) and the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Party or Parties to the Provider as a consequence of:

(a) breach by either or both of the Parties of an obligation(s) (in whole or in part) under the relevant Services Contract; or

(b) any act or omission of a third party for which either or both of the Parties are, under the terms of the relevant Services Contract, liable to the Provider.

DFG means the Disabled Facilities Grant being funding for capital grants to help meet the cost of adapting property for the needs of a disabled person. DFG is paid directly to the Council by DfLUHC under Section 31 of the Local Government Act 2003 and is subject to grant conditions set out in grant determinations made under that Section.

DfLUHC means the Department for Levelling Up, Housing and Communities.

Financial Contributions means the minimum financial commitments to be made by each Party to the Pooled Budget for each Individual Scheme in any Financial Year as set out in the Annual Budget.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

First Party shall have the meaning given to the term in Clause 26.3.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Party claiming relief.

Functions means the NHS Functions and the Social Care Related Functions.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

IBCF means the Improved Better Care Fund announced in the Spring Budget 2017 being additional funding for social care. IBCF is paid directly to the Council by DfLUHC under Section 31 of the Local Government Act 2003 and is subject to grant conditions set out in grant determinations made under that Section.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes being developed and funded under the Better Care Fund Plan which is agreed by the Parties to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification and "**Scheme**" shall be interpreted accordingly.

Integrated Commissioning means arrangements by which both Parties commission Services in relation to an Individual Scheme on behalf of each other in exercise of both the NHS Functions and Social Care Related Functions through integrated structures.

Integrated Commissioning Executive Officers Group (ICEOG) means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2

Joint (Aligned) Commissioning means a mechanism by which the Parties jointly commission Services. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Party(ies) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Party(ies) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Party commissions Services in relation to an Individual Scheme on behalf of the other Party in exercise of both the NHS Functions and the Social Care Related Functions.

Lead Commissioner means the Party having the function of commissioning Services or part of a Service on behalf of the Parties.

Local Objectives means those objectives set by the parties in respect of Worcestershire.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as amended or replaced from time to time.

National Guidance means any and all guidance in relation to the Better Care Fund as issued from to time to time by NHS England, the Department of Communities and Local Government, the Department of Health, the Local Government Association either collectively or separately.

NHS Functions means those functions listed under Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Scheme Specification.

Non-Recurrent Payments means funding (if any) provided by a Party in respect of the Pooled Budget or to an Individual Scheme in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 9.3.

Overspend means any expenditure in respect of the Pooled Budget in a Financial Year, in relation to an Individual Scheme, which exceeds the total Financial Contributions for that Scheme for that Financial Year which shall be managed in accordance with Clause 11 and Schedule 3

Party means each of the CCG and the Council, and references to "**Parties**" shall be construed accordingly.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Parties have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined under Data Protection Legislation.

Pooled Budget means the budget agreed between the Parties for the purpose of securing the Services or part of them pursuant to this Agreement, made up of the Financial Contributions from the Parties in accordance with the Regulations as set out in the Annual Budget.

Pooled Budget Manager means such proper officer of either Party (which includes a Section 113 / Section 151 Officer) as is nominated by the relevant Party from time to time to manage the Pooled Budget in accordance with this Agreement. As at the Commencement Date, Pooled Fund Manager is the Deputy Chief Finance Officer of the Council who has delegated decision making authority for this responsibility from the Chief Financial Officer.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement (including the Council where the Council is itself a provider of any Services).

Reviewed Pooled Budget means the Pooled Budget for the relevant Financial Year agreed between the Parties pursuant to the Annual Review.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Relevant Party shall have the meaning given to the term in Clause 21.2.

Scheme Manager means the manager of an Individual Scheme as identified in the relevant Scheme Specification.

Scheme Specification means a specification setting out the arrangements and Services for an Individual Scheme agreed by the Parties to be commissioned under this Agreement, a template for which is in Schedule 1.

Services means such health and social care services as agreed from time to time by the Parties as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification and **Service** means any one of them.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Parties in accordance with the relevant Individual Scheme and for the avoidance of doubt the term Services Contract shall include a block contract or care contract.

Service Users means those individuals for whom the Parties have a responsibility to commission the Services.

Social Care Related Functions means those of the social care and public health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Third Party Costs means all such third-party costs (including legal and other professional fees) in respect of each Individual Scheme as a Party reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the ICEOG.

Underspend means any expenditure in respect of the Pooled Budget in a Financial Year for any Individual Scheme which is less than the aggregate value of the Financial Contributions for that Individual Scheme for that Financial Year.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act.

Working Day means 8:00am to 6:00pm any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Parties shall include their respective statutory successors, permitted assignees or transferees, and employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Parties shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

1.13 1.13 All references to BCF shall include reference to IBCF and DFG unless otherwise stated.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date and shall continue until it is terminated in accordance with this Agreement.

2.2 Unless otherwise stated in the relevant Scheme Specification, the duration of the arrangements for each Individual Scheme shall be concurrent with the term of the Agreement as set out in Clause 2.1 unless varied in line with Clause 30 or terminated early in accordance with Clause 21.

2.3 The Parties agree that on and from the Commencement Date this Agreement supersedes all previous arrangements entered into between the Parties under Section 75 of the 2006 Act in relation to the Better Care Fund in Worcestershire. All acts done on and from the Commencement Date in relation to the Better Care Fund shall be deemed to have been done pursuant to the provisions of this Agreement.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the rights and powers, duties, obligations and liabilities of the Parties to each other or to any third parties in the exercise of their respective Functions and obligations (including the Functions); or

3.1.2 any power or duty of the Council to set, administer and recover charges for the provision of any services (including the Services) in the exercise of any Social Care Related Functions.

3.1.3 the Council's power to determine and apply eligibility criteria for the purposes of assessment under the National Health Service and Community Care Act 1990.

3.2 The Parties agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

4 FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Parties will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning;

4.1.4 the establishment of the Pooled Budget,

4.2 In relation to Individual Schemes, the Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Social Care Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions in accordance with the requirements of the Scheme Specifications.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Social Care Related Functions in accordance with the requirements of the Scheme Specifications.

4.4 Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Parties can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Parties.

5.3 The initial Individual Schemes are listed in Part 2 of Schedule 1.

5.4 The Parties shall not enter into a new Individual Scheme unless they are satisfied that the Individual Scheme in question will improve the health and well-being of the Service Users in accordance with this Agreement.

5.5 Where the Parties add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme in the form set out in Part 1 to Schedule 1 (as amended subject to agreement between the Parties) shall be completed and agreed between the Parties.

5.6 The introduction of any Individual Scheme will be:

5.6.1 subject to business case approval by the ICEOG;

5.6.2 subject to any additional constitutional requirements of each Party;

5.6.3 inserted as part of this Agreement in accordance with Clause 30 (Variation); and

5.6.4 reported to the Health and Wellbeing Board, which has strategic oversight of this Agreement.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Parties shall work in cooperation and shall endeavour to ensure that the NHS Functions and Social Care Related Functions are commissioned with all due skill, care and attention.

6.2 Both Parties shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Services Contract.

6.3 Both Parties shall work in cooperation and endeavour to ensure that the relevant Services, as set out in each Scheme Specification, are commissioned within each Party's Financial Contributions in respect of that particular Individual Scheme in each Financial Year.

6.4 The Parties shall comply with the arrangements in respect of any Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

6.5 Each Party shall keep the other Party and the ICEOG regularly informed of the effectiveness of the arrangements including any Overspend or Underspend in the Pooled Fund, in accordance with the provisions of Clause 11 (Risk Share Arrangements, Overspends and Underspends), Schedule 2 (Governance) and Schedule 3 (Financial Schedule - Risk Share, Overspends and Underspends).

6.6 The relevant joint commissioning groups will each report back as required by their respective terms of reference, and as set out in Schedule 2.

6.7 Each Party is committed to developing a joint delivery plan for each Individual Scheme as set out in the relevant Scheme Specification.

Appointment of a Lead Commissioner

6.8 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.8.1 exercise the NHS Functions in conjunction with the Social Care Related Functions (or vice versa) as identified in the relevant Scheme Specification;

6.8.2 commission Services for Service Users who meet the eligibility criteria set out in the relevant Scheme Specification;

6.8.3 contract with Provider(s) for the provision of the Services on terms agreed with the other Party (such approval not to be unreasonably withheld or delayed);

6.8.4 comply with the Law as it applies to both Parties in relation to the Services being commissioned and in particular, but without limitation, ensure that all Services Contracts with care providers require that such element of the Services in any care home (as defined in the Care Standards Act 2000) complies with any national minimum standards under that Act;

6.8.5 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" (as defined in the NHS Standard Form Contract) with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.8.6 undertake performance management and contract monitoring of all Services Contracts;

6.8.7 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.9 The provisions in Schedule 4 (Joint Working Obligations) shall apply where there are Lead Commissioner Arrangements in respect of an Individual Scheme.

Scheme Managers

6.10 In respect of each Individual Scheme, the Lead Commissioner shall appoint or, each Party shall appoint or agree the appointment of the Scheme Manager prior to the commencement of an Individual Scheme.

6.11 The relevant Party shall procure that the Scheme Manager shall in respect of the respective Individual Scheme:

6.11.1 Keep account(s) of all income and expenditure (whether or not Permitted Expenditure) and, where applicable, separately in respect of each Services Contract;

6.11.2 Provide on a monthly basis a summary of all such expenditure in such form as the Pooled Budget Manager shall require for the purposes of complying with its obligations;

6.11.3 Monitor and record compliance by Providers with each Services Contract (including but not limited to measuring performance against KPIs);

6.11.4 Monitor and record any Overspend or Underspend against the Agreed Expenditure; and

6.11.5 Provide any other information or comply with such other reporting requirements as reasonably required by ICEOG from time to time.

7 ESTABLISHMENT OF THE POOLED BUDGET

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Parties have agreed to establish and maintain the Pooled Budget in respect of revenue expenditure on the Individual Schemes.

7.2 The Pooled Budget shall be managed in accordance with the terms of this Agreement.

7.3 It is agreed that monies in respect of the Pooled Budget may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 Third Party Costs;

7.3.3 Approved Expenditure;

("**Permitted Expenditure**")

7.4 The Parties may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Party, subject to approval by the ICEOG.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on any Default Liability unless this is agreed by both Parties.

8 POOLED BUDGET MANAGEMENT

8.1 The Pooled Budget Manager shall have the following duties and responsibilities:

8.1.1 maintaining an overview of all joint financial issues affecting the Parties in relation to the Individual Schemes and the Pooled Budget subject to receiving the relevant information from each Scheme Manager, preparing and submitting to the ICEOG Quarterly reports (or more frequent reports if properly required by the ICEOG) and the Annual Report about the income and expenditure in respect of the Pooled Budget together with such other information as may reasonably be required by the Parties and the Health and Wellbeing Board to monitor the effectiveness of the Pooled Fund. The Parties agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.1.2 preparing and submitting reports to the ICEOG and Health and Wellbeing Board as required by it and any other Council/CCG meeting that is deemed necessary and appropriate by the ICEOG for the discharge of its monitoring obligations.

8.2 In carrying out their responsibilities as provided under Clause 8.1 the Pooled Budget Manager shall have regard to the recommendations of the ICEOG and be accountable to the Parties.

9 FINANCIAL CONTRIBUTIONS AND BALANCING PAYMENTS

9.1 Subject to Clause 9.2, the minimum Financial Contribution of the CCG and the Council in respect of the Pooled Budget for the specified Financial Year of operation of each Individual Scheme shall be as set out in the relevant Annual Budget.

9.2 No provision of this Agreement shall preclude the Parties by mutual agreement making Non-Recurrent Payments. Any such Non-Recurrent Payments agreed by the Parties shall be explicitly recorded in the ICEOG minutes and recorded in any budget statement or financial reports as a separate item.

9.3 The Parties may agree any Approved Expenditure (in addition to Approved Expenditure agreed in a Scheme Specification) through the ICEOG. For the avoidance of doubt, a business case including any corporate spend for such Approved Expenditure shall be approved by the Parties at a quorate ICEOG meeting.

9.4 The CCG shall make equal monthly payments to the Council in respect of the BCF received by the CCG and allocated to the Council under the Annual Budget. Such equal monthly payment shall be adjusted commensurately with any in-year variations agreed between the Parties.

9.5 In respect of IBCF the Council will pay amounts properly due against an invoice raised by the CCG in accordance with the Annual Budget.

9.6 The Parties acknowledge that the DFG grant funding is paid by the Council to third parties in accordance with any agreed budget allocation.

10 NON-FINANCIAL CONTRIBUTIONS

10.1 Each Scheme Specification shall set out non-financial contributions of each Party including staff, premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Services Contracts and the Pooled Budget). The Scheme Specifications shall set out whether these contributions shall be accounted for in respect of the Pooled Budget.

11 RISK SHARE ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Parties have agreed risk share arrangements as set out in Schedule 3, which provide for the allocation of the financial risks relating to Overspend arising within the commissioning of Services in respect of the Pooled Budget.

11.2 ICEOG shall, in conjunction with the Pooled Budget Manager and any reports produced in that regard manage expenditure in respect of the Pooled Budget within the Financial Contributions and shall ensure that expenditure is limited to Permitted Expenditure.

11.3 The Pooled Budget Manager shall notify the ICEOG as soon as reasonably possible of an actual or projected Overspend or Underspend in respect of the Pooled Budget, and where there is an actual Overspend or Underspend the provisions of Schedule 3 shall apply. Such arrangements shall be subject always to the Law and the constitutional documents, Standing Orders and Standing Financial Instructions (or equivalent) of each Party.

11.4 The provisions of Clause 22 shall apply in respect of Overspends and Underspends upon termination of this Agreement or a Scheme Specification.

11.5 In the event that agreement cannot be reached in respect of any matters referred to in this Clause 11 and Schedule 3 the Parties shall follow the dispute procedure as set out in Clause 23.

12 CAPITAL EXPENDITURE

12.1 Subject to Clause 12.2, the Pooled Budget shall not normally be allocated to any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Parties. If a need for capital expenditure is identified this must be agreed by the Parties acting by the ICEOG.

12.2 The Parties agree that capital expenditure may be included in the Pooled Budget where this is in accordance with Better Care Fund requirements and set out in the relevant Scheme Specification. For the avoidance of doubt, this will include capital expenditure using the DFG.

13 VAT AND INVOICING

13.1 The Parties shall agree the treatment of VAT under this Agreement in accordance with any relevant guidance from HM Revenue & Customs and wherever possible in line with the Party responsible for such VAT's policy on the management and dispersal of VAT.

13.2 The Scheme Manager shall check and approve the validity of spend in line with the relevant Services Contract or Permitted Budget set out in the relevant Scheme Specification, and report to the ICEOG as required.

14 AUDIT AND RIGHT OF ACCESS

14.1 Both Parties shall promote a culture of probity and sound financial discipline and control. Each Party shall arrange for the audit of their respective [Individual Schemes] as part of their normal auditing practice and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 29(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998. Both Parties shall comply with each Party's relevant financial reporting timescales and ensure a common approach to financial reporting is in place.

14.2 All internal and external auditors and all other persons authorised by the Parties will be given the right of access to any document, information or explanation they require from any employee or member of either Party in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 The Parties shall agree and maintain appropriate insurance arrangements in respect of all potential liabilities arising from this Agreement. In the case of the CCG, it may arrange alternative cover in accordance with current NHS arrangements administered by the NHS Litigation Authority in lieu of commercial insurance. Each Party shall provide to the other upon request such evidence as that Party may reasonably require to confirm that the insurance arrangements are satisfactory and are in force at all times.

15.2 Each Party ("**Indemnifying Party**") shall indemnify the other Party ("**Indemnified Party**") and its employees and agents against all Losses incurred as a result of or in connection with this Agreement or a Services Contract to the extent that such Losses arise as a result of any negligent or wrongful act, or omission, breach of statutory duty, breach of this Agreement or breach of the relevant Services Contract of the Indemnified Party, its employees or agents, save to the extent that the Indemnifying Party was following the instructions or requests of the Indemnified Party, the Health and Wellbeing Board or the ICEOG.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Party, which may reasonably be considered as likely to give rise to liability under this Clause 15, that Party will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Indemnifying Party specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Indemnifying Party (such consent not to be unreasonably conditioned, withheld or delayed); and

15.3.3 give the Indemnifying Party and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Party and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 For the purposes of the indemnity in Clause 15.2 the expression "agents" shall be deemed to include without limitation any nurse or health professional/social care worker or manager providing services to the Council or the CCG under a contract for services for the Better Care Fund and any person carrying out work for the Council or the CCG under such a contract connected with such of the Council's or the CCG's facilities.

15.5 The Parties acknowledge that the responsibility for specific indemnity cover lies with the Provider relevant to the Services they operate. However, commissioners need to assure themselves that such indemnity cover is in place.

15.6 Each Party shall at all times take all reasonable steps to minimise and mitigate any loss for which it is entitled to bring a claim against the other Party pursuant to this Agreement.

Conduct of Claims

15.7 In respect of the indemnities given in this Clause 15:

15.7.1 the Indemnified Party shall give written notice to the Indemnifying Party as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

15.7.2 the Indemnifying Party shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the Indemnified Party, the Indemnifying Party shall consult with the Indemnified Party about the conduct and/or settlement of such claims and proceedings and shall at all times keep the Indemnified Party informed of all material matters; and

15.7.3 the Indemnifying and Indemnified Parties shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Parties will at all times comply with Law and ensure good corporate governance in respect of each Party (including the Parties' respective constitutional documents, Standing Orders and Standing Financial Instructions).

16.2 The Council is subject to the duty of best value under the Local Government Act 1999 (“**Best Value**”). This Agreement and the operation of the Pooled Budget is therefore subject to the Council's obligations for Best Value and the CCG will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in

clinical care will flourish. This Agreement and the operation of the Pooled Budget are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

16.4 The Parties are committed to an approach to equality and equal opportunities as represented in their respective policies. The Parties will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

16.5 The Services shall be purchased for or provided to the Service Users in accordance with the objectives set out in the Recitals to this Agreement and each Scheme Specification.

16.6 Each Scheme Manager shall implement the bona fide decisions of the ICEOG pursuant to Schedule 2 in respect of an Individual Scheme. For the avoidance of doubt this Agreement does not seek to affect the statutory responsibilities of either Party.

16.7 The ICEOG shall monitor the exercise by the Parties under this Agreement of the Functions in accordance with Schedule 2.

16.8 The report(s) provided by the Council under Schedule 2 will set out the expenditure under this Agreement in relation to the NHS Functions and the Council shall provide such information to the CCG if the CCG requests this from time to time.

16.9 The quarterly report(s) provided by the CCG under Schedule 2 will set out the expenditure under this Agreement in relation to the Social Care Related Functions and the CCG shall provide such information to the Council if the Council requests this from time to time.

17 CONFLICTS OF INTEREST

The Parties shall comply with their respective organisation's Conflicts of Interest Policy for identifying and managing conflicts of interest as referred to in Schedule 6 and as such policies are updated from time to time during the term of this Agreement.

18 GOVERNANCE

18.1 Overall strategic oversight of partnership working between the Parties is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Parties as to any action it considers necessary.

18.2 The Parties have established a multi-agency/stakeholder Integrated Commissioning Executive Officer Group (ICEOG) with membership as set out in Schedule 2. That body will:

18.2.1 implement, deliver and operationally manage the Better Care Fund Plan;

18.2.2 manage the Better Care Fund budget; and

18.2.3 lead, co-ordinate and monitor delivery of the Better Care Fund programme,

as set out in the terms of this Agreement and the terms of reference included at Appendix 1 of Schedule 2.

18.3 Each member of the ICEOG shall be a representative with individual delegated responsibility from the Party employing or appointing them to make decisions which enable that body to carry out its objectives, roles, duties and functions set out in Schedule 2.

18.4 Each Party undertakes to the other that it has secured and will continue to secure internal reporting arrangements to ensure the standards of accountability and probity required by each Party's own statutory duties and organisation are complied with.

18.5 The ICEOG and the CCG Governing Body Board and the Council's Cabinet shall be responsible for the overall approval of the use of funds for Individual Schemes, ensuring compliance with the Better Care Fund Plan.

18.6 A Scheme Specification may set out any additional governance arrangements in respect of the Individual Scheme and (if applicable) how that Individual Scheme is reported to the ICEOG differently to any other Scheme.

18.7 The Parties shall procure that ICEOG shall co-operate with the Pooled Budget Manager in relation to reporting requirements set out in relevant guidance in relation to the Better Care Fund as issued from time to time by NHS England, DfLUHC, the Department of Health and Social Care and/or the Local Government Association.

19 REVIEW

Annual Review

19.1 The Parties shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, the BCP, the Pooled Budget, the Individual Schemes and the provision of the Services within 3 Months of the end of each Financial Year.

19.2 Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

19.3 The Parties shall within 2 Months of each Annual Review jointly prepare an annual report ("**Annual Report**") documenting the matters referred to in this Clause 19. A copy of the Annual Report shall be provided to the ICEOG and also to the Health and Wellbeing Board.

19.4 The Parties acknowledge that the ICEOG shall also undertake regular reviews of the operation of this Agreement in accordance with the terms of reference set out in Schedule 2

Review of Financial Contributions

19.5 The Parties shall use all reasonable endeavours to agree no later than 31st March in any Financial Year their respective Financial Contributions for the following Financial Year and the BCP and Annual Budget shall be agreed and signed by a relevant chief finance officer of each Party.

19.6 The relevant Scheme Specifications will be updated (or deemed to be updated) to reflect the Annual Budget. Where agreement cannot be reached prior to 1 April:

19.6.1 the Annual Budget and the Financial Contributions shall for an interim period commencing on 1 April until the earlier of the date of agreement of the Annual Budget and termination of the Agreement ("Interim Period") be deemed to remain the same as the previous Financial Year;

19.6.2 a Party may give notice to the other Party at any time during the Interim Period that its Financial Contributions are to be reduced provided that (a) it does not result in a financial shortfall to the other Party in respect of any directly related Services Contract and (b) the Party giving the notice provides all reasonable assistance to mitigate the impact of such reduction; and

19.6.3 where any financial shortfall arises during the Interim Period as a result of cost increases outside of the direct control of the Parties (including inflation, staff costs and contractual increases under Service Contracts) the Parties shall either contribute to such shortfall in the proportions stated in the Scheme Specification or agree changes to the relevant Services or Scheme to counter the shortfall. .

19.7 Where the Annual Budget is agreed after 1 April, the effect shall be backdated such that either Party may be required to make a balancing payment (resulting in a positive or negative result) to give retrospective effect to the Annual Budget from 1 April.

19.8 The Parties shall review the operation of the Agreement at each meeting of the ICEOG including confirmation of their respective Financial Contributions for that Financial Year. The Parties may at this time (acting by written agreement of the ICEOG) agree to vary such contributions and the relevant Scheme Specifications and Schedule 3 shall be amended in accordance with Clause 30.

19.9 The Parties shall also use reasonable endeavours in each Financial Year to agree by 1st February a draft budget for the following Financial Year which would usually be based on the budget for the previous Financial Year. Such budget will be finalised once the Parties have agreed their Financial Contributions for the relevant Financial Year in accordance with Clauses 19.5 and 19.8 above.

19.10 Reviews under this clause 19 shall be conducted in good faith and in accordance with the governance arrangements set out in Schedule 2, shall be based upon information to be provided as set out in Schedule 2 and shall take account of:

19.10.1 National Guidance;

19.10.2 reasonable increases for inflation;

19.10.3 any agreed addition or decrease of BCF or the Parties' own funds against any agreed Services and/or outputs;

19.10.4 any commitments under or in connection with any Services Contract; and

19.10.5 any consequential effect to a Party as a result of any changes to any Individual Scheme

and the Parties acknowledge that any decision to reduce a Party's Financial Contribution which may impact on either Party's ability to fund a Service shall comply with the requirements of Clause 30 including consideration of any associated reduction in the Services, taking account of notice periods within the relevant Services Contracts.

20 COMPLAINTS

Each Party's own complaints procedures shall apply to this Agreement. The Parties agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

21 TERMINATION & DEFAULT

21.1 Subject to the requirements of the Law (and in particular the statutory requirements of the Better Care Fund):

21.1.1 this Agreement may be terminated by either Party giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes; and

21.1.2 unless otherwise agreed in the relevant Scheme Specification, each Individual Scheme may be terminated by either Party giving not less than 12 Months' notice in writing or such shorter notice period agreed between the Parties, provided that the Parties ensure that the statutory Better Care Fund requirements continue to be met and for the avoidance of doubt the operation of the Agreement shall continue in respect of the remaining Individual Schemes.

21.2 If a Party ("**Relevant Party**") fails to meet any of its obligations under this Agreement, the other Party may by notice require the Relevant Party to take such reasonable action within a reasonable timescale as the other Party may specify to rectify such failure. Should the Relevant Party fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

21.3 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Parties' rights in respect of any antecedent breach and any terms of this Agreement that expressly or by implication survive termination of this Agreement.

22 EFFECTS OF TERMINATION OR EXPIRY

22.1 In the event that this Agreement is terminated in whole or in part (howsoever terminated) the Parties agree to co-operate to ensure an orderly wind down of their joint activities as set out in this Agreement so as to minimise disruption to all Service Users, carers and staff and subject to the statutory requirements of the Better Care Fund.

22.2 The Council and the CCG shall co-operate to ensure that:

22.2.1 where possible, existing Services Contracts are assigned to the Party with statutory responsibility for the relevant Service Users. Where this is not possible, subject to Clause 22.2.3, the Council and the CCG shall continue to be liable to purchase the Services in accordance with this Agreement for all current Service Users at the date of service of the notice of termination and to fulfil all existing obligations to third parties under any Services Contract until the relevant contracts are terminated; and

22.2.2 the Parties shall continue to operate the Pooled Budget in accordance with this Agreement so far as is necessary to ensure fulfilment of the obligations in sub-Clause 22.2.1; and

22.2.3 the Parties shall remain liable to contribute the proportion of the cost of the Services which either is their proportionate contribution to the relevant Individual Scheme in the current Financial Year or, if such contribution has not at the date of notice of termination yet been confirmed under Clause 19.5, the Party's contribution in the immediately preceding Financial Year represented as a proportion of the aggregate contributions of each Party to the relevant Services in that preceding Financial Year, such liabilities to continue for so long as the Service Users shall require the Services or the obligations to third parties under any Services Contract remain to be fulfilled.

22.3 Upon termination of the Agreement or an Individual Scheme the Parties shall use all reasonable endeavours to agree an apportionment of any Underspend in relation to the Individual Scheme so terminated in a reasonable and equitable manner taking into account the circumstances of and reasons for the Underspend, the consequential effect to any other Individual Scheme and such payments as shall be required to reflect this shall be made from the Pooled Fund to the Parties. Where such agreement cannot be reached within 30 days of termination the Underspend shall be returned to the Parties in proportion to their respective Financial Contributions for that Scheme.

22.4 Upon termination of the Agreement or an Individual Scheme the Parties shall use all reasonable endeavours to agree an apportionment of any Overspend in relation to the Scheme so terminated in a reasonable and equitable manner taking into account the circumstances of and reasons for the Overspend and such payments as shall be required to reflect this shall be made by the Parties to the Pooled Fund. Where such agreement cannot be reached within 30 days of termination the Parties shall meet the Overspend proportionately to their respective Financial Contributions for that Scheme.

22.5 When determining whether there has been an Underspend or Overspend as at the date of termination of this Agreement, all known liabilities in relation to each Individual Scheme should be assessed and quantified and taken into account. In the case of termination of an Individual Scheme, all known liabilities in relation to that Scheme should be assessed and quantified and taken into account.

22.6 The Parties shall continue to be responsible for any liabilities that arise following any payments made pursuant to Clause 22.3 and/or Clause 22.4. Any liabilities that are subsequently quantified shall be apportioned between the Parties on the same basis as an Overspend in accordance with Clause 22.4 and the Parties shall make such payments to each other as shall be required to reflect this.

22.7 Unless agreed otherwise assets purchased from the Pooled Budget will be disposed of by the Party with the responsibility for the Individual Scheme to which those assets relate for the purposes of meeting any of the costs of winding up the Services or where this is not practicable such assets will

be shared proportionately between the Council and the CCG according to their respective Financial Contributions to the relevant Scheme.

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Parties arising out of this Agreement, either Party may serve written notice of the dispute on the other Party, setting out full details of the dispute.

23.2 The Parties shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1 at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Authorised Officer of each Party (or in each case their nominees) shall meet in good faith as soon as possible after the relevant meeting and in any event within fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Parties will attempt to settle such dispute by referring the dispute to the Parties' respective Chief Executive or equivalent, who will endeavour to meet within 28 days of a Party serving notice requiring the same.

23.5 If the dispute remains after the meeting detailed in Clause 23.3 or 23.4 has taken place, then the Parties may attempt to settle such dispute by mediation as follows:

23.5.1 in the case of any financial dispute including those in relation to any Overspends and/or Underspends as referred to in Clause 11 and Schedule 3; by referral to NHS England Midlands and Local Government Association Midlands Region peers for determination; and

23.5.2 in the case of any other dispute, in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Parties.

23.6 To initiate mediation under 23.4.1 or 23.4.2, either Party may give notice in writing (a "Mediation Notice") to the other requesting mediation of the dispute and shall send a copy thereof to NHS England Midlands and Local Government Association Midlands peers, CEDR or the equivalent mediation organisation as agreed by the Parties (as the case may be) asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served (or in the case of mediation of financial issues, such other timescale as NHS England and the Local Government Association shall determine). Neither Party will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Parties). The Parties will co-operate with any person appointed as mediator, providing them with such information and other assistance as they shall require and will pay their costs as they shall determine or in the absence of such determination such costs will be shared equally.

23.7 If the dispute remains after the meeting detailed in Clause 23.3 or 23.4 has taken place may be referred to expert determination by an expert (the **Expert**). The Expert shall be appointed by agreement in writing between the parties, but in the event of a failure to agree within ten Working Days, or if the person appointed is unable or unwilling to act, the Expert shall be appointed by an appropriate professional body relevant to the issue (or any other association that the parties reasonably understand to have replaced it) in relation to a Dispute.

23.8 The Expert shall act on the following basis:

23.8.1 the Expert shall act as an expert and not as an arbitrator and shall act fairly and impartially;

23.8.2 the Expert's determination shall (in the absence of a material failure to follow the agreed procedures, or unless one Party objects prior to the date of the determination) be final and binding on the parties;

23.8.3 the Expert shall decide the procedure to be followed in the determination and shall be requested to make their determination within 30 business days of their appointment or as soon as reasonably practicable thereafter. The parties shall assist and provide the documentation that the Expert requires for the purpose of the determination;

23.8.4 the determination process shall be conducted in private and shall be confidential; and

23.8.5 where the determination is to be final and binding, the Expert shall determine how and by whom the costs of the determination, including their fees and expenses, are to be paid. The fees and expenses of the Expert shall otherwise be borne 50:50 between the Parties.

23.9 Nothing in the procedure set out in this Clause 23 shall in any way affect either Party's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Party shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Party or incur any liability to the other Party for any Losses or damages incurred by that Party to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Party shall notify the other Party as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Party and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Parties shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Party shall have the right to seek to terminate the Agreement under Clause 21.1. For the avoidance of doubt, no compensation shall be payable by either Party as a direct consequence of this Agreement being terminated in these circumstances.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Party receives from another Party (the "**Discloser**") and subject always to the remainder of this Clause 25, each Party (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which'

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Party:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement;

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25; and

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 The Parties agree that they will each cooperate with each other to enable the Party receiving a request for information under the 2000 Act or the 2004 Regulations to respond promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving, and supplying information held, directing requests to the other Party as appropriate and responding to any requests by the Party receiving a request for comments or other assistance.

26.2 Any and all agreements between the Parties as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Party shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

26.3 Each Party ("**First Party**") acknowledges that the other Party will, in responding to a request received under the 2000 Act or the 2004 Regulations, be entitled to provide information relating to this Agreement or which otherwise relates to the First Party.

27 OMBUDSMEN

The Parties will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING AND DATA PROTECTION

28.1 The Parties shall at all times after the commencement of this Agreement:

28.1.1 use their best endeavours to comply with their obligations under the Data Protection Legislation;

28.1.2 cooperate with each other to enable the other Party to meet its obligations under the Data Protection Legislation.

28.2 The Parties shall ensure that at all times throughout the duration of this Agreement there remains in place a policy and procedures for information sharing in order to ensure that:

28.2.1 the Parties comply with any notification requirements under the Data Protection Legislation;

28.2.2 the Parties process information obtained in relation to any Service User in accordance with their obligations under the Data Protection Legislation; and

28.2.3 Providers commissioned pursuant to Individual Schemes have in place appropriate technical and contractual measures to ensure their compliance with the Data Protection Legislation.

28.3 Both Parties shall thereafter comply at all times with such policy and procedures for the duration of this Agreement and indefinitely after its expiry or termination.

28.4 The Parties acknowledge that supporting data sharing protocols and agreements are being developed which will underpin the Better Care Fund Plan and which they will adhere to when sharing information under this Agreement. Wherever the Parties intend to share data, they will consider the type of information to be shared and the purpose for sharing it, and they will enter into the appropriate information sharing agreements as developed between the Parties.

28.5 Each Party shall take such steps as may be practicable to afford the other Party access to information which is reasonably required by the first Party in connection with any of its statutory functions and for any purpose connected with its rights and obligations under this Agreement.

28.6 Each Party must exercise its reasonable endeavours to ensure the accuracy of any data entered into the computer system used in carrying out the Party's obligations under the Agreement.

28.7 So far as is permitted in Law (and each Party shall use all reasonable endeavours to ensure such permission exists) all data held on any computer system operated under this Agreement must immediately on termination of the Agreement be made available on request to the Party with statutory responsibility for the relevant Service Users.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be sent by first class post or electronic mail. The address for service of each Party shall be as set out in Clause 29.3. A notice shall be deemed to have been served if:

29.1.1 posted, at the expiration of forty-eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.2 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Party sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Party in writing:

29.3.1 if to the Council, addressed to: the Strategic Director for People, Worcestershire County Council of County Hall, Spetchley Road, Worcester WR5 2NP

if to the CCG, addressed to the Accountable Officer, NHS Herefordshire And Worcestershire Clinical Commissioning Group of The Coach House, John Comyn Drive, Perdiswell, Worcester WR3 7NS

30 VARIATION

30.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Parties subject to approval by the ICEOG in accordance with Schedule 2 as set out in this Clause.

30.2 Where the Parties agree that there will be:

30.2.1 a new Scheme Specification; or

30.2.2 an amendment to a current Scheme Specification,

the ICEOG shall agree the new or amended Scheme Specification and this must be signed by the Parties. A request to vary an Individual Scheme (which may include a change in the level of Financial Contribution/s) may be made by any Party but will require agreement from both Parties in accordance with the process set out in Clause 30.3. The notice period for any variation unless otherwise agreed by the Parties shall be 3 Months or in line with the notice period for variations within the associated Services Contract/s, whichever is the shortest.

30.3 The following approach shall, unless otherwise agreed, be followed by the ICEOG:

30.3.1 on receipt of a request from one Party to introduce a Scheme Specification for an existing Individual Scheme or vary the Agreement or an Individual Scheme, the ICEOG will first undertake an impact assessment and identify those Services Contracts likely to be affected;

30.3.2 the ICEOG will agree whether those Services Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Services Contract terms and conditions and ensuring that the Party holding the Services Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged;

30.3.3 wherever possible, agreement will be reached to reduce the level of funding in the Services Contract/s in line with any reduction in budget; and

30.3.4 should this not be possible and one Party is left financially disadvantaged as a result of holding a Services Contract for which the budget has been reduced, then the financial risk will, unless otherwise agreed and subject to the exceptions set out in Paragraph 5 of Schedule 3, be shared equally between the Parties.

31 CHANGE IN LAW

31.1 The Parties shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 If at any time during the term of this Agreement a change to the manner in which an Individual Scheme or the Services are commissioned is required as a result of a Change in Law then the provisions outlined in this Clause 31 shall apply.

31.3 The Parties shall jointly investigate the likely impact of the Change in Law on the Services and any other aspect of the Agreement and shall prepare a report in writing, setting out:

31.3.1 the variation proposed;

31.3.2 the date upon which it should take effect;

31.3.3 a statement of whether the variation will result in an increase or decrease in Financial Contributions by reference to the relevant component elements of the Individual Scheme or Services which are subject to the Change in Law;

31.3.4 a statement on the individual responsibilities of the CCG and the Council for any implementation of the variation;

31.3.5 a timetable for implementation of the variation;

31.3.6 a statement of any impact on, and any changes required to the Services; and

31.3.7 the date for expiry of the report.

31.4 The Parties shall confirm in writing their decision to proceed with the proposed variation and shall agree a formal variation in accordance with Clause 30.

31.5 In the event of failure by the Parties to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

Any relaxation, delay or failure of either Party in exercising any right under this Agreement shall not be taken as a waiver of that right and shall not affect the ability of that Party subsequently to exercise that right.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Parties shall not sub-contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Party, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Party's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Parties or render either Party directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Party will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete Agreement between the Parties with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Party.

37.2 Each of the Parties acknowledge and agree that in entering into this Agreement it does not rely on and shall have no remedy in respect of any statement, representation, warranty or understanding (whether negligently or innocently made) of any person (whether party to this Agreement or not) other than as expressly set out in this Agreement.

37.3 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Party unless in writing and signed by a duly authorised officer or representative of the Parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by both Parties shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Parties irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

40 STATUTORY OBLIGATIONS

40.1 The Parties shall in the performance of their obligations under this Agreement comply with all relevant Law and all provisions relating to such matters elsewhere in this Agreement.

40.2 Each Party will note the other Party's current and future obligations under the Data Protection Legislation, the 2000 Act, the Human Rights Act 1998, the Equality Act 2010, S.75 of the 2006 Act and Part 1 of the Local Government Act 1999 (as amended from time to time) and any codes of practice and best practice guidance issued by the European Commission Government and the appropriate enforcement agencies (the **"Specified Legislation**") and shall:

40.2.1 comply with the Specified Legislation in so far as it places obligations upon that Party in the performance of its obligations under this Agreement;

40.2.2 facilitate the other Party's' compliance with its obligations under these provisions and comply with any reasonable requests for that purpose;

40.2.3 act in respect of any person who receives or requests services under this Agreement as if that Party were a public authority for the purpose of the Human Rights Act 1998.

40.3 The Parties shall at all times comply with the requirements of the Health and Safety at Work Act 1974 and of any other Acts pertaining to the health and safety of employees and shall ensure that any contractors carrying out work for any purpose relating to the Agreement likewise comply.

40.4 The Parties shall not in relation to the employment of persons for the purposes of providing the Services or in relation to the provision of the Services to any person unlawfully discriminate against any person contrary to UK legislation relating to discrimination or equality whether in relation to race, gender, religion or belief, disability, age, sexual orientation or otherwise.

41 FAIR DEALINGS

41.1 The Parties recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

IN WITNESS WHEREOF this Agreement has been executed by the Parties as a DEED on the date which first appears in this Agreement

THE CORPORATE SEAL of
WORCESTERSHIRE COUNCIL
was hereunto affixed in the presence of:

Authorised signatory

Signed as a deed on behalf of
NHS HEREFORDSHIRE AND WORCESTERSHIRE
CLINICAL COMMISSIONING GROUP

Authorised signatory

Authorised signatory

Part 1 – Scheme Specification Template

SECTION 75 - Schedule 3 - TEMPLATE			
Scheme name		[Scheme name]	
Lead Commissioning Organisation	Host partner for pooled fund	Scheme Manager	Annual budget
[insert org name]	[insert org name]	[enter officer of host partner]	[enter £]
SCHEME SUMMARY			
Description of the scheme			
Is the scheme within the Better Care Fund? *Yes / No*			
Planned duration of the scheme *Enter start and end date*			
What performance measures / national BCF conditions does this scheme support?	e.g DToC, NEA, Res and Nursing Admissions, 91 day at home following reablement		
Which of the HICM areas does this scheme support?	Early Discharge planning, Systems to monitor patient flow, MDT discharge teams, Homefirst / D2A, 7-day service, Trusted Assessors, Focus on choice, Enhanced health in care homes		
FINANCIAL ARRANGEMENTS			
Financial contributions			
Partner	BCF £	Partner spend not in BCF £	
Worcestershire Council			
Herefordshire & Worcestershire CCG			
TOTAL			
Funding Source for Scheme			
*enter YES under relevant funding source	PASC	DFG	CCG Min Fund	Council Additional Fund	CCG Additional Fund
Funding source*					
Funding flow arrangements			
*enter YES under relevant funding source	Funds retained and spent by lead / host partner	Invoice by WCC to HWCCG and cash transfer	
Funding transfer*			
Financial reporting arrangements for scheme			
*enter YES under relevant control arrangement	Sole control	Lead Commissioner	Joint Commissioner
[Enter scheme host here]			
Statutory reporting by Scheme host			
Statutory reporting by Partner			
CONTRACTUAL ARRANGEMENTS FOR SCHEME			
Contract type:			
The end date of the contract (include details of extension options):			
Are the contract terms agreed by both partners (jointly commissioned contract) or by the lead commissioner:			
What contract management arrangements have been agreed?			
Which partner has responsibility for contract monitoring and performance management?			
What happens if the s75 agreement terminates:			
Can the partner terminate the contract:			
Can the contract be assigned in full / part to the other partner?			
RISK SHARING ARRANGEMENTS FOR SCHEME			
HOW PERFORMANCE OF THE SCHEME IS TO BE MEASURED *Please detail agreed KPIs below*			
Unit of measure	Target / ambition	Report frequency	Report submitted to:
e.g. number of clients supported, reduction in DToC	*full year target*	e.g. monthly / quarterly	e.g. CYP JCG

Part 2: Schedule of Individual Schemes

A/C	Provider	Budget Category	Service
Adults	WCC	ICES	Worcestershire Community Equipment Service
Adults		BCF	Beds for Admission Prevention & Patient flow
Adults		BCF	Onward Care Team
Adults		BCF	Older People Care Act Eligible Services
Adults		BCF	DFCG
Adults		BCF	Growth
Adults		BCF	Community Health Services
Adults	WH&CT	Other Adults	Wheelchairs
Adults	WH&CT	Other Adults	WINN project - mobile OT service
Adults		Other Adults	FNC
Adults		Other Adults	Adult Recovery Services
Adults		Other Adults	Hospital & Rapid Response Assessment
Adults		Other Adults	Carers
Adults		Other Adults	iBCF
Adults		Other Adults	Loneliness Services
Adults		Other Adults	Social Impact Bond
Adults		Other Adults	Suicide Prevention

Adults		Other Adults	Support at home
Adults		Other Adults	Adult weight management services
Adults		Other Adults	NHS Health Checks
Adults		Other Adults	Sexual Health Services (including Out of Area GUM)
Adults		Other Adults	Lifestyle Services
Adults	WH&CT	LD	LD Integrated Teams
Adults		LD	LD Complex cases - TCP
Adults		LD	LD Complex cases - Dowry
Adults		LD	LD Other
Adults		Mental Health	Dementia Post Diagnostic Support
Adults		Mental Health	Dementia services
Adults		Mental Health	General Advocacy
Adults		Mental Health	Mental Capacity Act Training
Adults		Mental Health	Qwell
Adults			S117
			Total Adults Section 75
Children's	WH&CT	Provider Arm (WH&CT)	CAMHS Service
Children's	WH&CT	Provider Arm (WH&CT)	Speech Language & Communication needs (SCLN)

Children's	WH&CT	Provider Arm (WH&CT)	Children's Respite Care (Osbourne court)
Children's	WH&CT	Provider Arm (WH&CT)	Short Breaks - Osbourne Court
Children's	WH&CT	Provider Arm (WH&CT)	Thorne Lodge
Children's	WH&CT	Provider Arm (WH&CT)	Children's special needs CDC
Children's		Voluntary Sector	Worcester Young Carers Project
Children's		Children's Other	Physio Equipment spend
Children's		Children's Other	Children's contribution to the ICES equipment
Children's		Children's Other	Commissioning Team
Children's		Children's Other	0-19s Prevention and Early Intervention Service (Starting Well) incl LAC health Assessments
Children's		Children's Other	Speech and Language therapy Service
Children's		Children's Other	EHWB for schools
Children's		Children's Other	CAMHS Training

SCHEDULE 2– GOVERNANCE

The Parties acknowledge that the governance arrangements set out in this Schedule relate only to the Section 75 Agreement, including the Better Care Fund.

1 Delegated Authority

1.1 The Integrated Commissioning Executive Officers Group (ICEOG) is authorised to make financial commitments and to take other decisions where necessary within the limited delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

1.1.1 authorise commitments which exceed, or are reasonably likely to lead to exceeding, the contributions of the Party to the aggregate contributions of the Party to the Pooled Budget, as laid out in Schedule 3; and

1.1.2 authorise a Lead Commissioner to enter into any Services Contract necessary for the provision of Services under an Individual Scheme.

2 Information and Reports

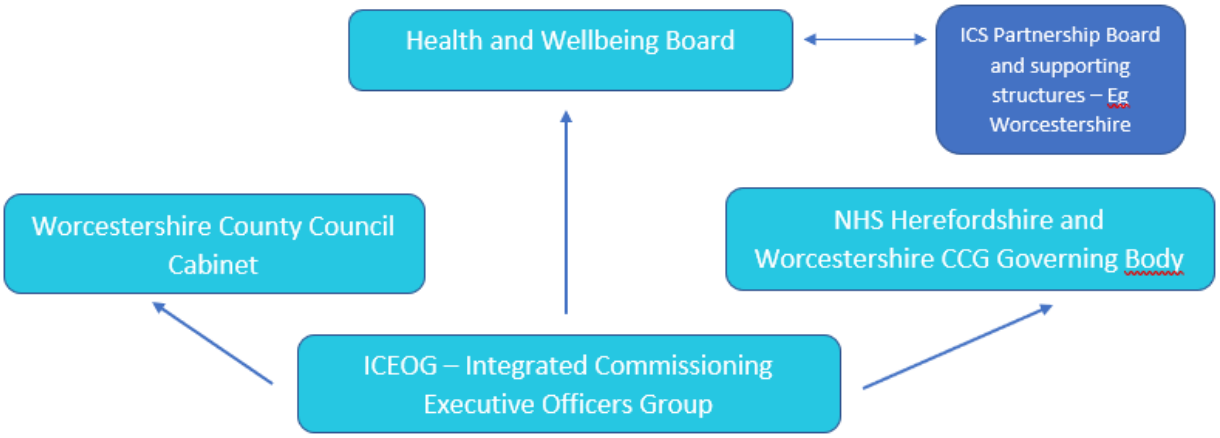
The ICEOG shall receive on a Quarterly basis the financial and activity information as required under the Agreement. In addition it will receive regular reports from each of the Individual Schemes included in the Agreement, as outlined in the Scheme Specifications for each Individual Scheme listed at Schedule 1 (together with any further Schemes, if any, agreed pursuant to this Agreement).

3 Post-termination

The ICEOG shall continue to operate in accordance with this Schedule 2 following any termination of this Agreement for so long as is reasonably necessary to comply with the post termination provisions.

Part 2

Worcestershire's Governance arrangements for the oversight and delivery of the Section 75 Agreement



Integrated Commissioning Executive Officers Group (ICEOG)
The Terms of Reference for the ICEOG describe the role of this group and its relationship to the other key groups that are responsible for the oversight and delivery of the Section 75 Agreement. These Terms of Reference are included below at **Appendix 1.**

Appendix 1

ICEOG TERMS OF REFERENCE

1 Aims

1.1 To progress the integration of NHS, social care, public health and related services for the benefit of Worcestershire residents through:

1.2 The development of strategies that support the integration of care across adults and children's services – in the context of the Integrated Care System, Joint Strategic Needs Assessment, Joint Health and Well-being Strategy, the Children and Young People's Plan and other relevant strategic plans across the Council and CCG

1.3 Ensuring effectiveness, safety and improved experience of services commissioned under the Section 75 (S75) agreement.

1.4 Working within the budgets delegated from partners' governing bodies. The scheme of delegation of the governing bodies through the powers delegated to lead officers (the Director for People, the Director of Public Health, the Director of Children's Services, and the CCG Accountable Officer)

1.5 To support the development of new models of care, focussing specifically upon integration and improvement of health and social care across Worcestershire.

2 2. Membership and representation

2.1 The Executive Officers Group comprises:

2.1.1	Strategic Director for People	Worcestershire County Council
2.1.2	Director of Public Health	Worcestershire County Council
2.1.3	Director of Children's Services/Chief Executive	Worcestershire County Council/Worcestershire Children First
2.1.4	Deputy Chief Finance Officer – Service Finance	Worcestershire County Council
2.1.5	Accountable Officer (Chair)	Herefordshire and Worcestershire CCG
2.1.6	Managing Director – Worcestershire	Herefordshire and Worcestershire CCG
2.1.7	Chief Finance Officer	Herefordshire and Worcestershire CCG
2.1.8	Director of Partnership and Change	Herefordshire and Worcestershire CCG

2.2 In addition the following will attend meetings as required according to the agenda:

2.2.1	Assistant Director for Adult Social Care	Worcestershire County Council
2.2.2	Assistant Director for Commissioning	Worcestershire County Council
2.2.3	Director of Education and Early Help	Worcestershire Children First
2.2.4	Deputy Director of Public Health	Worcestershire County Council

2.2.5 Chief Nursing Officer and Director of Quality Herefordshire and Worcestershire CCG

2.2.6 Relevant finance officers from the County Council and CCG

2.2.7 Other senior managers will be invited to attend as required.

2.3 All members are appointed by virtue of the post or role that they hold. They will therefore remain a member for as long as they fulfil that post or role.

2.4 Members may have named substitutes but someone acting as a substitute for one member cannot also be the substitute for another member. Substitutes will have the same powers and responsibilities as the member they are substituting for.

3 Objectives

Operational Business

3.1 Establish and maintain appropriate integrated commissioning arrangements and review their effectiveness annually.

3.2 Develop and implement appropriate and effective integrated commissioning plans in accordance with the priorities, outcomes and budgets set by the respective governing bodies and the Health and Well-being Board.

3.3 Establish appropriate and rigorous financial accountability mechanisms to ensure that the S75 agreement is fully implemented, and all contributed funds are used effectively for the intended purpose within agreed limits.

3.4 Agree and report against a joint performance management framework, including: monitoring achievement against the BCF standards; contract performance, and quality assurance.

3.5 Identify individual and collective quality, financial and other relevant risks and agree remedial action to address these risks within the scheme of delegation of the governing bodies.

3.6 To oversee financial recovery actions in relation to efficiency programmes

3.7 Support the development and review of the Health and Well-being Strategy and associated plans.

3.8 Support development and implementation of the Worcestershire Better Care Fund plan.

3.9 Ensure that public, patients, service users and carers are given the opportunity to shape how services are organised and provided.

3.10 Ensure that the statutory duties and responsibilities of relevant partners are discharged by integrated commissioned services, including Safeguarding responsibilities in respect of children and vulnerable adults.

3.11 Ensure that all integrated commissioning meets the requirements of the Equality Act and undertake an Equality Impact Assessment for service developments or significant changes.

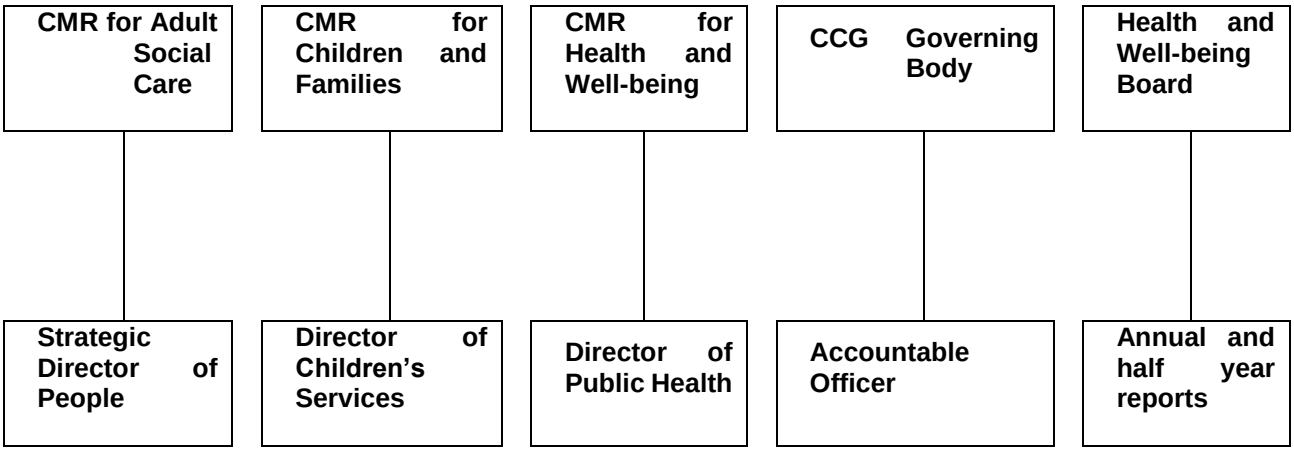
4 Reporting arrangements

4.1 The Strategic Director of People, the Director of Public Health and the Director of Children's Services will keep relevant Cabinet Members and the wider Council informed of any issues requiring their attention that arise from discussions at the Integrated Commissioning Executive Officers Group.

4.2 The Clinical Commissioning Group Accountable Officer will keep the CCG Governing Body informed of any issues requiring their attention that arise from discussions at the Integrated Commissioning Executive Officers Group.

4.3 The Strategic Director of People, the Director of Public Health, the Director of Children's Services and the Accountable Officer will produce a full report for the Health and Well-being Board annually on the Integrated Commissioning Executive Officer's Group, with an interim report half-way through the year.

5 Reporting arrangements



6 Conducting the business of the meetings

6.1 The Integrated Commissioning Executive Officers Group will be serviced from the Adult Services Commissioning Unit (WCC) with support from the CCG.

6.2 Meetings will be held monthly on dates to be agreed in advance or at such other intervals as may be agreed by the members.

6.3 The agenda will be developed by the Assistant Director for Commissioning in discussion with the Chair. (A standard Agenda and forward plan will be developed to ensure that business can be considered in line with the commissioning cycle and governance processes of partner organisations.) A standard format for papers will be used and papers will be clearly identified (for example, as performance report, for information, for decision).

6.4 To be quorate; the Chair, Strategic Director of People, Director of Children's Services or their nominated deputies must be in attendance.

7 Review

7.1 For review by 31st March 2022, or before if required, and at least each anniversary of the Commencement.

SCHEDULE 3– FINANCIAL CONTRIBUTIONS, RISK SHARE AND OVERSPENDS

Unless the context otherwise requires, the defined terms used in this Schedule shall have the same meanings as set out in Clause 1 of the main body of the Agreement.

Pooled Budget and Financial Management

Whilst every effort will be made by the Parties to ensure that the expenditure remains in line with the agreed budget through robust budget management, it is acknowledged that there may be circumstances that lead to either an over or under spend for which both Parties will be sighted on and in agreement with in the month of occurrence.

Pooled Budget Underspends

Underspends are forecast within the financial year, the Integrated Executive Officer Group (ICEOG)* will be fully briefed on the Underspend including the impact on service delivery/anticipated outcomes for both the Individual Scheme and any other Services where applicable.

Following which, ICEOG* will make an informed decision on the management of this variance and document it in the minutes.

Underspends at the end of a financial year can either be carried forward into the next financial year or allocated to Parties. The historic split has been on a 50:50 basis, however, it will be the responsibility of ICEOG* to formally approve and minute this agreement.

Pooled Budget Overspends

Over-spends are forecast within the financial year, the Integrated Executive Officer Group (ICEOG)* will be fully briefed on the Over-spend including the impact on service delivery/anticipated outcomes for both the Individual Scheme and any other Services where applicable.

Following which, ICEOG* will make an informed decision on the management of this variance and document it in the minutes.

These options could include

- agreeing an action plan to facilitate the reduction in expenditure within an agreed timeframe.
- utilisation of Underspends within the Section 75 Agreement to mitigate any Overspend.
- agreement to a proportionate Non-recurrent Payment from each Party based on both/either the overall budget % contribution and/or an informed discussion on the driver of the Overspend.
- the decommissioning of all or any part of the Individual Schemes to which the Overspend relates.

Aligned Budgets

In the case of aligned budgets, financial liability rests with the relevant commissioning Party in full and that Party has the option to recover any Underspend in full, unless otherwise agreed by ICEOG* and respective governing bodies. Overspends on aligned budget also rest with the relevant commissioning Party in full.

*ICEOG – assumed to be quorate.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Commissioner shall notify the other Party if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports - and provide copies of the same.

2 The Lead Commissioner shall provide the other Party with copies of any and all:

2.1 Monthly Activity Reports;

2.2 Scheme Updates;

2.3 Joint Performance Dashboards;

2.4 Remedial Action Plans; and

2.5 Service Quality Performance Report;

3 The Lead Commissioner shall not without the approval of both Parties:

3.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

3.2 vary any Provider Plans (excluding Remedial Action Plans);

3.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

3.4 give any approvals under the Services Contract;

3.5 agree to or propose any variation to the Services Contract (including any Schedule or Appendices);

3.6 suspend all or part of the Services;

3.7 serve any notice to terminate the Services Contract (in whole or in part);

3.8 serve any notice;

3.9 agree (or vary) the terms of a Succession Plan; without the prior approval of the other Party (acting through the Joint Commissioning Board) such approval not to be unreasonably withheld or delayed.

4 The Lead Commissioner shall advise the other Party of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Party as part of that process.

Part 2 – OBLIGATIONS OF THE OTHER PARTY

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 Each Party shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

1.1 resolve disputes pursuant to a Services Contract;

1.2 comply with its obligations pursuant to a Services Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Services Contract;

2 No Party shall unreasonably withhold or delay consent requested by the Lead Commissioner.

3 Each Party (other than the Lead Commissioner) shall:

3.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Services Contract in relation to any information disclosed to the other Parties;

3.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

The ICEOG will receive relevant performance reports at its monthly meetings including:

- Monitoring against delivery of national and local BCF standards
- Monitoring against the performance measures in the relevant Services Contract specification for each Individual Scheme included in this Agreement, as outlined in the Scheme Specifications included at Schedule 1, Part 2.

SCHEDULE 6 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

The Parties shall comply with their respective organisation's Conflicts of Interest Policy for identifying and managing conflicts of interest and as such policies are updated from time to time during the term of this Agreement.

The CCG's policy can be viewed here:

HWCCG Conflicts of Interest Policy

Worcestershire County Council's Code of Conduct can be viewed here:

WCC Code of Conduct

SCHEDULE 7 – INFORMATION GOVERNANCE

1. In relation to the UK Data Protection Regulations, tailored by the Data Protection Act 2018, all Parties confirm that:

   1.1. That their operational policies and procedures are fully compliant

   1.2. That staff are fully and appropriately trained in the requirements of the Regulations and the Act and in their responsibilities to protect personal data and are familiar with the ICO (Information Commissioners Office) guidance on Data Protection, including guidance on Children's Data, Data Sharing and the Age Appropriate Design Code (issued September 2020)

   1.3. That contracts issued and designated service providers are fully compliant as appropriate

   1.4. That in relation to paragraphs 1.1 to 1.3 compliance is regularly reviewed and monitored.

SCHEDULE 8 – BETTER CARE FUND PLAN

BCF 21.22 Narrative Plan Final.docx

Worcestershire HWB V4.xlsx

Cover

Worcestershire Health & Wellbeing Board

Ongoing discussions and meetings have enabled a range of key stakeholders to be involved in the preparation and review of proposals that sit within the BCF plan including Herefordshire & Worcestershire Health & Care Trust, Herefordshire & Worcestershire CCG, Primary Care Networks, Worcestershire Healthwatch, voluntary and community organisations along with Worcestershire council stakeholders.

Engagement and involvement has been through a variety of system and internal meetings, including the Worcestershire Executive Committee, which brings partners together at "Place" level as part of developing the Integrated Care System in Herefordshire and Worcestershire, and through sharing of data and wider documentation.

The BCF guidance 2021-22 sets out national conditions, which are the key requirements for the better care fund plan 2021-22.

a. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
b. NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
c. invest in NHS-commissioned out-of-hospital services
d. a plan for improving outcomes for people being discharged from hospital

The BCF also has key national metrics for 2021-22.

Avoidable admissions to hospital	Unplanned admissions for chronic ambulatory care sensitive conditions
Admissions to residential and care homes	Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes
Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement
Length of stay	Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days or more
Discharge destination	Improving the proportion of people discharged home using data on discharge to their usual place of residence

Executive Summary

The priorities for 2021-22 are:

- Hospital Discharge and Flow
- Development of an Integrated Care System
- Care Market Development
- Management of Social Care Demand

21/22 for Pathway 1 to enable people to be discharged within 24 hours in line with National Discharge Targets. Investment in supporting people to go home and remain at home, should result in reducing admissions to long term care.

2. Sustaining delivery and future model for the Onward Care Team - a multi-disciplinary approach to identify the right discharge pathway and care and support plan to improve length of stay and ensure national hospital discharge targets are achieved.

3. Development of Pathway 3 to reduce the use of care home provision through the creation of an Intensive Rehabilitation and Assessment Unit to support people through bed-based reablement to return home.

4. Development of an Intermediate Care Service which facilitates effective partnership working and the ability to analyse flow across the system and identify opportunities to integrate services where there are benefits to flow and efficiency.

In addition to the main BCF resources and plans, the improved better care fund (iBCF) allocation for Worcestershire Adult Social Care in 2021-22 includes funding to be spent for the following purposes:

a) meeting adult social care needs.
b) reducing pressures on the NHS including seasonal winter pressures.
c) supporting more people to be discharged from hospital when they are ready; and
d) ensuring that the social care provider market is supported

The formal allocation of the iBCF is established as part of the BCF budget setting process, £1m of the total contribution has historically been transferred to the CCG to assist with pressures on the NHS in the relevant areas. The remainder of the grant is used to meet adult social care needs and ensuring that the market is supported, examples of these include:

- Financially supporting the domiciliary care market with the aim to avoid hospital admissions (metric 8.1), and increasing patient flow across the system
- Funding permanent recruitment within the Onward Care Team streamlining hospital discharge and reduce DToC
- Additional investment in the community reablement service with the aim of preventing / delaying admission to long term care or hospital. This supports metric 8.5 (Clients remaining at home after 91 days following hospital discharge).
- Use to fund pressure of externally purchased Pathway 3 placements, whilst long term care planning for clients.

BCF funding is used for key core social care and NHS community services - operational social work, integrated discharge, community health and care services short-term and long-term placements in home care and care homes, and discharge to assess; it is central to the delivery of health and social care in the community.

Worcestershire County Council's People Strategy and transformation programmes, focus on promoting people's independence through high quality community-based support, focussing on individuals' strengths. The focus on strength-based social work is delivered through the Three Conversation Model and development of one Front Door, focussing on prevention though early

targeted advice, information, and support to enable people to remain safely in their own homes for as long as possible.

Key changes since the previous BCF Plan

Overall, the BCF plan remains focussed on supporting hospital discharge but it is evolving to bring in more activities to prevent admissions to hospital and to long-term care placements.

Governance

Worcestershire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reports.

Oversight and responsibility for the BCF is embedded within the Senior Leadership Teams of both the People Directorate within the Council and Herefordshire and Worcestershire Clinical Commissioning Group. In each organisation, this is led by Chief Officers, who are able to maintain the profile of the shared agendas and ensure linkages to wider health and social care commissioning and delivery, with formal governance and decision making via monthly ICEOG.

Overall approach to integration

Joint priorities for 2021-22 include:

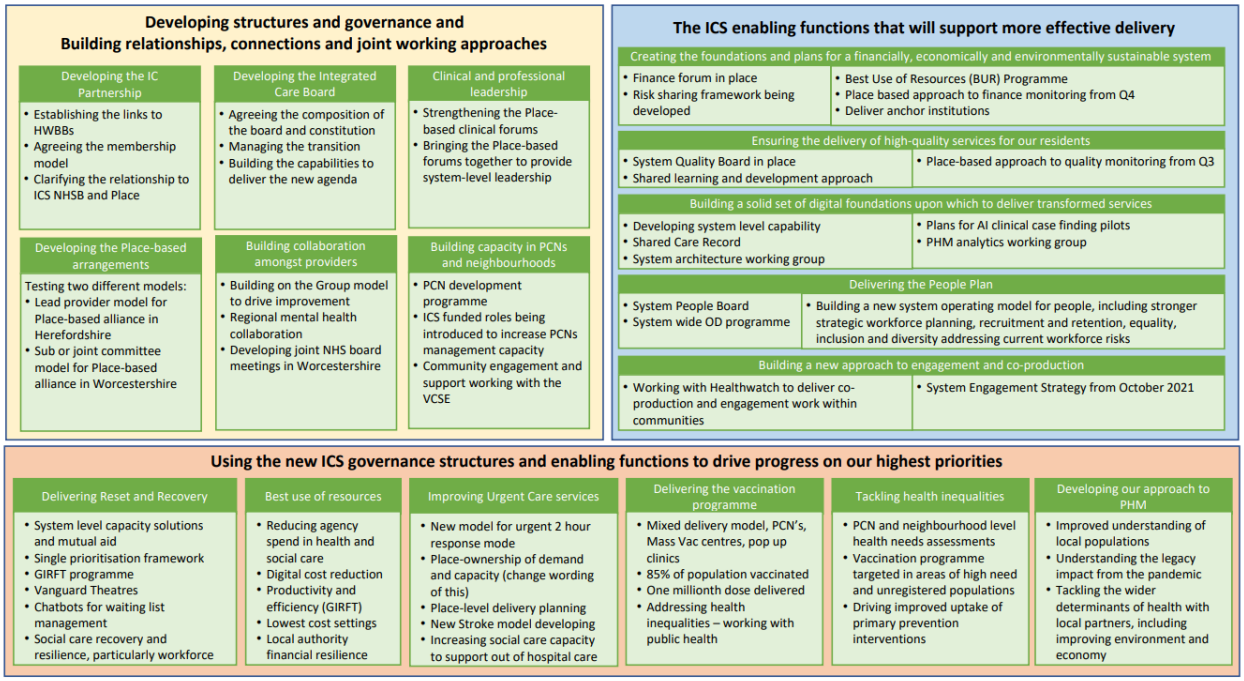
- Adherence to the National Discharge Targets
- Covid recovery
- Admission avoidance and prevention.

The integrated care system (ICS)

The Herefordshire and Worcestershire system has built a strong record of delivery and improvement over the last 3 years. The system has stable leadership across our two places and our primary care networks, with excellent support from our local authority and voluntary sector partners.

Integration has enabled the delivery of a successful COVID vaccination programme, which has proactively targeted reducing health inequalities by working with patient representatives, communities, PCNs, local authorities and NHS providers to increase uptake. By working collectively, it has been possible to develop mutual aid and secure Vanguard Theatres in both counties, which support a Reset and Recovery Programme. With a commitment to improve clinical productivity through implementing 'Getting it right first time' and deliver an ambitious Best Use of Resources programme.

The plan on a page shows a summary of the development plan. The top left section describes the key six strategic development initiatives that will shape the overall operating model for the ICS going forward. The top right describes the enabling functions that are required to support delivery of this operating model and the bottom section is the way in which this new way of working will be used to deliver improved services and outcomes for the local population.



Integrated Equipment.

Worcestershire Council and NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG) have statutory requirement duties under various legislation to provide community equipment for people with an assessed eligible social or health care need.

The Worcestershire Community Equipment Service (WCES) is central to the delivery of the prevention and wellbeing priorities of the council and its partners with changing demand in social and health care, this service continues to evolve to meet the demands of stakeholders.

The service continues to see an increase in both client numbers and overall equipment spend compared to monthly averages in 2020/21. The increase evidences the on-going focus to provide equipment to enable people to remain in their own homes, to reduce the need for the interventions of domiciliary care, care home placements and avoidable hospital admissions, whilst facilitating hospital discharge.

Integration Agenda.

Health and social care partners are committed to working together to provide an integrated approach to support residents of Worcestershire to:

- provide demand management through a strength-based approach and developing models and services that will support independence at home.
- create versatile, cost effective and sustainable services.
- increase and improve services that support complex and challenging behaviours, such as autism or dementia.
- work across health services, children and young people and adult services to integrate our commissioning and market management approach where appropriate.
- invest in early help, prevention, and community services.
- improve and embed mental health and wellbeing in all service design.
- support and develop the health, family support and social care workforce.
- embed technology where it delivers benefits across pathways and services, and
- promote an inclusive customer focus to ensure fair access to services.

Targets

- LOS
- percentage of people who return to their normal place of residence on discharge from acute hospitals
- community hospital targets

The reablement metric of increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, will be further stretched by increasing capacity in the teams, from Oct-21 result is 86.1% against target 82%, with national target of 80%

Key to the successful delivery of the plan are health and social care initiatives to support admission avoidance and timely discharge, including 2-hour response service and investment in pathways, aiming to provide sufficient support in the community to enable people to remain independent in their own homes for longer, thereby reducing hospital admissions and support discharges.

Virtual wards

The system is continuing to develop its approach to virtual wards, using the relationships between NHS providers, including primary care and social care, as well as the growing maturity of PCNs.

Flow and Discharge dashboard

The system is developing a system wide flow and discharge dashboard for Worcestershire that supports ongoing monitoring and identifies areas for improvement, including the development of SHREWD and the Patient Tracker. This will support targeted intervention, both on an operational basis and also through tactical review to adjust resource distribution across the pathways.

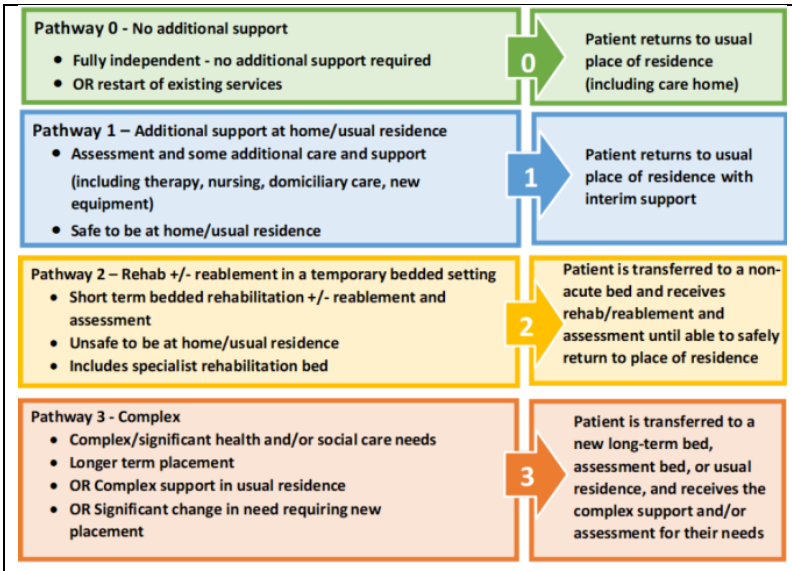
Supporting Discharge (national condition four)

Worcestershire County Council continues to provide a Reablement service which offers therapy-led services aligned with a Reablement model. People are discharged from a hospital setting through a fully integrated discharge team who provide a proportionate assessment in line with the Discharge to Assess (D2A) model. Pathway 1 (Home) being the optimum pathway with a £4m investment to expand this service to enable more people to return home, where safe to do so, and reduce the number of people sent to a bed-based facility.

Provision of a dedicated unit to provide enhanced reablement support to avoid Pathway 3 care home admission. The model developed, and supported by ICEOG, is that Pathway 3 provision will be provided in 21 beds at WCIPU (Worcester City in-patient unit) from December 2021. This means that the Health and Care Trust will be adapting 21 beds at the unit to provide Pathway 3 rather than the more traditional community hospital offer. The remaining 25 beds will remain available as either step up or step-down beds for the local population.

A period of assessment, recovery, re-ablement and rehabilitation will be provided for up to 28 days

Intermediate Care Service – Strengthening integration with health teams has been the aim throughout. Worcestershire is piloting an integrated intermediate care service with a view to a more permanent approach.



Note, to reflect the latest definitions: anyone going home with something (inc. restarts) are PW1 and anyone going to a care home, whether its returning to their usual place of residence or to a new placement will be classified as PW3.

Disabled Facilities Grant (DFG)

The DFG is a capital grant pooled into the BCF to promote joined-up approaches to meeting people's needs to help support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care and strategic use of the DFG can support this. In Worcestershire, this Grant is passported out to the District Councils to meet their statutory housing duties.

Each District Council is responsible for their own Housing Assistance Policy to make local needs and DFG is used in accordance with these policies.

The 6 District Councils and the County Council have jointly procured a Home Improvement Agency. Millbrook Healthcare won the contract for Promoting Independent Living and started to deliver the new Countywide HIA on 1st April 2021. The service covers: -

- information and advice
- housing options
- minor adaptations/handyperson
- making homes healthier
- mandatory Disabled Facilities Grant (DFG)
- OT/Trusted Assessor Development
- Assistive technology
- Able to pay customers

There is a multi-agency Promoting Independence Strategic Group to steer the work and oversee issues within the system

In the first year the contract achieved the following outcomes

Facilitate hospital discharge	6
Prevent hospital admission	1019
Reduce pressure on informal carers	161
Reduce/delay packages of care	620
Reduce/prevent falls	1770
Promote independence	193
Support to remain in own home	219

In 2021/22

We are working with the Health and Care Trust on a recovery plan for the Occupational Therapy input to adaptations following the pandemic.

Work has also commenced to do more detailed work on able to pay customers, with the aim of preventing individuals needing more extensive adaptation, health and care in later life.

Equality and Health inequalities

The system has established an Integrated Care System Inequalities Collaborative which includes senior representation from all partners in our ICS.

All partners are committed to equality and diversity using the scope of the Equality Act 2010 to eliminate unlawful discrimination, advance equality of opportunity and foster good relations, and demonstrate that we are paying 'due regard' in our decision making in the design and delivery of services.

It is not envisaged that the content of this plan will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

It is fundamental that individuals are at the heart of all activities and services. All partnerswill work to ensure all people have access to services, ensuring those people requiring additional support due to, for example a learning disability and/or autism have equal access to services and are supported to be as independent as possible in the community wherever possible.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Worcestershire

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	730.0	730.0	Target set to maintain as a minumum 20/21 levels. Significant investment has been made in improving support in the community to identify those patients at risk of admission and arranging for additional care to mitigate this risk.	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	10.5%	10.5%	Ambition is based on maintaining compliance with national standards (13% - local ambition under 10%) - Current performance is 7.6 - worcs specific and 4.5 H&W board area with respect to over 21 days against a plan of 10%. During 20/21 a variety of schmes have been identified to improve flow from the hospital - including increased investment in pathway 1 care - increasing support by 50%.	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	4.5%	4.5%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	90.0%	Ambition is to achieve targets as defined within the national dicharge requirements service - see above	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	550	629	477	574	CCG and Council Social Care colleagues have agreed additional investment of £4m from the Better Care Fund to increase capacity by 114 more staff to support hospital discharges through Pathway 1 in support of Worcestershire's Home First agenda (ie hospital discharge). As we recruit more UPI workers into our PW1
	Numerator	746	855	656	806	
	Denominator	135,720	135,906	137,439	140,470	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.8%	86.9%	82.1%	Meeting positive outcomes for people has been increasingly challenging due to the impact of COVID pandemic, where the focus has often been on the flow of people out of hospital. Despite this, supporting people leaving hospital with a reablement focus is clearly delivering results. This continued focus on outcomes as
	Numerator	383	385	455	
	Denominator	468	443	554	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.