Torbay and South Devon NHS
NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust Organisational Policy on Choice, Cost and Risks regarding relevant Health and Social Care funded provision

TORBAY COUNCIL

Partners in Care

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1. Introduction

1.1 This Policy describes the way in which Torbay and South Devon NHS Foundation Trust (the Organisation) will make provision for the care of people who have been assessed as eligible for services and support under both relevant health and social care to include Personal Health Budgets for NHS Continuing Healthcare The Policy describes the ways in which the organisation will commission and provide care in a manner that reflects the choice and preferences of individuals but balances the need for the organisation to commission care that is safe and effective and makes best use of the resources available in the community.

1.2 This Policy should be read in conjunction with:

- The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care Guidance ("National Framework Guidance")
- NHS Continuing Healthcare (Responsibilities) Directions 2007 ("2007 Directions")
- Care Act 2014
- NHS England Guidance on the right to have a Personal Health Budget in adult NHS Continuing Healthcare and Children and Young Peoples continuing care.

as amended or replaced from time to time.

1.3 This policy has taken account of existing legal advice, and draws upon relevant legislation and case law.

1.4 The original policy was written with guidance and support by our legal advisors.

2. Context

2.1 **"Continuing Care" is a general term defined as**:

"Care provided over an extended period of time to a person aged 18 or over, to meet physical or mental health needs which have arisen as a result of disability, accident or illness. It may require services from the NHS and/or social care and can be provided in a range of settings. Access to these services is based on assessed need."[1] This includes long term conditions.

2.2 Fully funded **"NHS Continuing Healthcare"** is a term used to describe a package of ongoing care, including accommodation arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need.

[1] National Framework, Paragraph 7

2.3 The term **"Continuing Healthcare"** is used in this policy as an abbreviation for fully funded "NHS Continuing Healthcare"

2.4 **The Care Act 2014** provides a framework for determining eligibility for adult social care.

3. The provision of care and support in health and social care

3.1 "Independence, choice and risk: a guide to best practice in supported decision making" was issued by the Department of Health in response to what people had told them they wanted from health and social care services for the 21st century. People want more opportunities, choice and control over their lives. This will mean risks and accountability will need to be considered if we are to promote a culture of choice that enables responsible, supported decision-making.

3.2 The Care Act 2014 imposes a duty on local authorities (the Organisation) to carry out an assessment of need for community care services with people who appear to them to need such services and then, having regard to that assessment, decide whether those needs call for the provision by them of services. If an individual or their carer refuses to allow the organisation to undertake an assessment of need, the organisation may be unable to provide services. Where there are capacity issues a best interest decision will be made in line with the principles of the Mental Capacity Act 2005.

3.3 The Organisation has a responsibility to promote a comprehensive health service on behalf of the Secretary of State without exceeding its financial allocations – this includes care provision under Continuing Healthcare. Since its designation as an Integrated Care Organisation in October 2015, the Organisation also has responsibility for ensuring the provision of social care in exercising functions delegated by Torbay Council. In providing these services, the Organisation is expected to take account of an individual's choice, but must do so in the context of the responsibilities and issues discussed in this Policy.

3.4 In order to balance individual choice alongside safety and value for money the Organisation has agreed this Policy to support consistency and transparency in the process of decision making for all care provision under Continuing Healthcare, Integrated Personal Commissioning and Care Act 2014 eligibility. The policy sets out to ensure that all such decisions are:

- Where at all possible, co-produced with the individual giving due regard to outcomes which promote independence and empowerment of the individual
- Robust, fair, consistent and transparent
- Based on the objective assessment of the individual's clinical need, safety and best interests

- Involve the individual and their family where possible and appropriate, taking into account the natural support available from family and the wider community
- Take into account the need for the Organisation to allocate its financial resources in the most cost effective way
- Mindful for the safety and appropriateness of care packages to those involved in care delivery and
- Supportive of choice to the extent possible in the light of the above factors.

3.5 If more than one suitable care package is available, the total cost of each package will be considered and assessed for overall cost effectiveness against available resources. Whilst there is no set upper limit on expenditure, the expectation is that arrangements will generally not be made in respect of a particular care package where the costs of that package are 10% or more above the most cost effective care package that has been identified by the Organisation and assessed as able to meet an individual's needs.

3.6 In making any decision on care provision, availability of resources is a legitimate consideration but it must be balanced against the needs of the individual and decisions must be made on a case by case basis taking into account all other relevant considerations. This includes the individuals identified needs and outcomes alongside the issues identified in Paragraph 3.5 and 3.7.

3.7 The Organisation will also take into account the nature and extent of all the individuals' needs, including psychological and social needs and the impact on home and family life of any decision not to fund a particular package of support or care if there is an effective, less expensive alternative. The Organisation will consider the relative cost of different funding options balanced against their relative benefit and relative need for that benefit.

3.8 All placement decisions and any supporting rationale must be thoroughly and appropriately documented. This is particularly important where an agreed package of health and/or social care is 10% or more above the most cost effective care package (as set out in 3.5 and 3.6 above). Decisions on large packages of care as agreed within the Organisations Scheme of Delegation (i.e. at £700 week) should be formally documented on the Complex Care Ratification Form in accordance with the Organisation Scheme of Delegation in line with the Organisation Protocol

3.9 Where a care package is being arranged in exercise of the social care functions delegated to the Organisation by Torbay Council, the Organisation will comply with Appendix A of the Care Act 2014 (Choice of Accommodation). When exercising its NHS functions, the Organisation is not bound by but will act in the spirit of these directions as further described in Appendix A.

3.10 The ability of an individual to augment a care package to meet personal preferences is dependent on whether that package has been arranged by the Organisation in exercise of its social care functions or as a package of Continuing Healthcare. In the context of a social care package, “top ups” are only permitted in the very limited circumstances described in Appendix A. Essentially such arrangements are only permitted where the “top up” does not constitute a subsidy to the core package identified by the Organisation to meet the individual’s needs. The core package must remain fully funded by the NHS as joint funding arrangements are not currently lawful. An individual does, however, have the right to expressly decline NHS services and make their own private arrangements for the total cost of the care. [Please refer to Appendix A for further guidance].

3.11 The Organisation has in place a Complex Care Ratification Panel (CCRP) to discuss and authorise care provision outside of the usual cost of care. The role of this panel will be to ensure there is a robust, equitable process of decision making within the Scheme of Delegation of the Organisation. The Panel will audit the decision making and rationale of care provision costing more than £700 weekly. It is intended that care packages in excess of £1000 weekly will require authorisation by this Panel.

3.12 Care provision in excess of £2000 week must be authorised by the Finance Director (or nominated representative) of the ICO, following the recommendation of the CCRP

4. Provision of care at Home

4.1 Where an individual has a care package provided within their own home the Organisation will need to take into account the following issues and requirements. This is particularly important for individuals who require more complex care:

a) Care must be delivered safely to the individual without undue risk to the individual, people providing the care or other resident members of the household, including children. Safety will be determined by a formal assessment of risk undertaken by an appropriately qualified health or social care professional employed, engaged or commissioned by the Organisation. The risk assessment will include the availability of equipment, the appropriateness of the physical environment and the availability of appropriately trained/untrained carers and/or staff to deliver care whenever it is required

b) The acceptance by the Organisation and each person involved in the individual’s care of any identified risks in providing care and the individual’s acceptance of the risks and potential consequences of receiving care at home. Where an identified risk to the care providers or the individual can be minimised through the actions of the individual, their family and/or carers, these individuals agree to comply with the steps required to minimise such identified risks; must use the Risk Enablement Policy

c) The emotional, physical and psychological needs of the unpaid carers and/or family engaged in supporting the individual will be taken into account. A carers assessment will be offered in all circumstances

d) The individual's General Practitioner agrees to provide primary medical support for those individuals receiving care at home under NHS Continuing Healthcare

e) It is the individual's informed and preferred choice; adherence must be made to the Mental Capacity Act 2005 (see Paragraph 4.2 and 4.3 below)

f) The suitability and availability of alternative arrangements

g) The extent of the individual's needs

h) The cost of providing the care at home in the context of best value and the costs of alternative care

i) The relative cost of providing the package of choice considered against the relative benefit

j) The psychological, social and physical impact on the individual

k) The individual's human rights and the rights of their carers and, where appropriate, any family members. Particularly the right of respect for home and family life

l) The willingness and ability of family members or friends to provide elements of care where this is a necessary and/or desirable part of the support plan and the agreement of these people to that plan.

4.2 If there is uncertainty that an individual has the mental capacity to make an informed choice and could place themselves at risk by requesting a particular care package at home, a mental capacity assessment will be undertaken. When necessary an independent advocate will be offered to support the individual in this process, under the provisions of the Mental Capacity Act 2005.

4.3 If an individual does not have the capacity to make an informed choice on the provision of care, the Organisation will deliver the safest and most cost effective care available based on an assessment of best interests made in conjunction with any advocate, close family member, circle of support or other person/s who should be consulted under the terms of the Mental Capacity Act 2005.

5. Review of needs and care provided by the Organisation

NHS Continuing Healthcare and social care

5.1 All individuals will have their needs reviewed at three months and thereafter on an annual basis or sooner if their needs indicate this is necessary. Individuals with palliative care needs may require care reviews more frequently in response to their medical condition.

5.2 The Care Act 2014 stipulates that reviews for social care should be undertaken on a routine basis, within three months of services being first provided or of major changes to support plans, and after that annually or more frequently if necessary. The guidance also states that: reviews must include a re-assessment of individual needs and be focused on outcomes rather than services.

5.3 Workers should reassess an individual's care needs and review the services that are in place to establish whether agreed outcomes are being achieved. If an individual or their carer refuses to allow a reassessment to take place The Organisation may issue a *Withdrawal of Care Notice* whereby safety of the individual and/or those people involved in providing care is likely to be compromised without such action. Where there are capacity issues a best interest decision will be made in line with the principles of the Mental Capacity Act 2005.

5.4 A review and re-assessment of an individual's needs may result in an increase or decrease in identified needs which may impact on the care and support required. If needs change it may be necessary to discuss and agree changed or alternative packages of care in line with this guidance on choice cost and risk.

5.5 There may be circumstances where an individual declines to accept alternative suitable provision and an appropriate package of support acceptable to both the individual and the Organisation cannot be identified. This may result in the Organisation issuing a *Withdrawal of Care Notice* whereby safety of the individual and/or those people involved in providing care is likely to be compromised without such action.

5.6 If the Organisation becomes aware, via the reassessment process or otherwise, that an action identified under paragraph 4.1 (b) above to reduce an identified risk to either the individual or those providing care has not been observed and such failure may put either party at risk or may significantly increase the cost of the package then the Organisation will take the necessary steps to protect both the individual and those providing care with a view to ensuring safety for all concerned. This may result in the Organisation issuing a *Withdrawal of Care Notice* where safety is likely to be compromised without such action.

5.7 Individuals who do not or no longer meet eligibility for NHS Continuing Healthcare will be considered for eligibility to NHS Funded Nursing Care/ Registered Nurse Care Contribution in accordance with the National Framework Guidance should the individual reside in a registered nursing home.

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5.8 All other NHS health services will continue to be provided at no cost to the individual.

5.9 Individuals who do not or no longer meet eligibility for NHS Continuing Healthcare and continue to have ongoing care needs will be assessed

against the Care Act 2014 eligibility criteria. If a care package agreed under the Care Act 2014 is arranged under social care, the Organisation will undertake a financial assessment to identify the contribution the individual will be required to pay towards the cost of their care provision.

6. Right of appeal

6.1 Individuals are entitled to appeal the outcome of a NHS Continuing Healthcare eligibility decision in accordance with the 2007 Directions and the National Framework Guidance.

6.2 An individual may also appeal a decision made by the Organisation in relation to funding of health or social care provision. In this case the Organisation will follow their appeals process which is currently under review but is intended to cover, actual care provision, funding allocations for individual person centred plans and exceptional treatment.

Appendix A

NHS CONTINUING HEALTH CARE

PRICE CEILINGS AND TOP UPS

In this note, references to the Organisation are references to the Organisation in its capacity as an NHS body. This note does **not** apply to care home placements arranged in exercise of the Organisation's local authority functions.

1 When considering the lawfulness of any first or third party top ups for patients eligible for NHS Continuing Healthcare, the key principles are:

1.1 services provided by the Organisation in exercise of its statutory NHS functions must be free of charge except where an express statutory power to make a charge exists;

1.2 there is no power for the Organisation to make a charge for care provision made in respect of individuals eligible for NHS Continuing Healthcare;

1.3 the Organisation is only obliged to provide services that meet all reasonable requirements. There is no absolute obligation and resources are a consideration;

1.4 an individual has the right to decline NHS services and make their own private care arrangements. This is an "all or nothing" option as joint funding arrangements are not currently lawful.

2 Although resources can be taken into account, it is inappropriate, and potentially unlawful, for the Organisation to use a pre-determined cost ceiling as justification for a blanket policy of refusing to fund placements in more expensive care options. Funding refusals on these grounds should only be made where the Organisation has taken into account the individual circumstances of a case including client need, the level and nature of services to be provided and any Human Rights implications.

3 If a care home is charging fees that are more than the Organisation is, having taken account of the issues mentioned in Paragraph 2, willing to pay for that particular placement (**"Organisation Maximum"**), it would be unlawful for the Organisation to make arrangements to meet this additional cost (**"Excess"**) by either:

3.1 invoicing the patient (or any third party) directly for the **Excess** and using the proceeds to contribute to the placement costs;

3.2 allowing the patient (or any third party) to pay the **Excess** directly to the care home, thereby reducing the sums charged to the Organisation.

4 However, the charging prohibition described in Paragraph 3 only applies to the services that the Organisation is obliged to provide (**"Statutory Services"**). In the context of care home placements this will be limited to the cost of providing accommodation, care and support necessary to meet the assessed needs of the patient (which includes social care needs as these patients are eligible for NHS Continuing Healthcare).

5 If a breakdown of a care home's invoice reveals that any element of their fees is *genuinely* attributable to services that are not **Statutory Services** (**"Additional Services"**), it would be lawful for the Organisation to make (or approve) arrangements through which the patient (or a third party) meets the cost of those **Additional Services**.

6 Arrangements of the nature described in Paragraph 5 carry a high risk of challenge because (i) it can be very difficult in practice to differentiate between **Statutory Services** and **Additional Services** and (ii) the **Excess** is more likely to be attributable to market influences than to genuine **Additional Services**.

7 As a general rule, therefore, the Organisation should only permit patients (or third parties) to make a contributions to any **Excess** where:

7.1 the **Additional Services** are optional, non-essential services which a care home resident has chosen (but was not obliged) to include in their care home package; or

7.2 the **Additional Services** are part of the care home's standard package (i.e. they are not optional in the sense described in Paragraph 7.1 above) but are of a type that would not ordinarily be provided as part of placements made in care homes that can properly meet the needs of a patient but whose fees do not give rise to an **Excess**;

and the Organisation is satisfied that the **Additional Services** are genuinely services that do not fall within its statutory responsibilities and that the **Organisation Maximum** is reasonable given the circumstances of the particular case.

The exception referred to in Paragraph 7.2 should, however, be exercised with caution and should only be relied upon where a suitable alternative placement is available to a patient in a care home charging fees that fall within the **Organisation Maximum**. In deciding what is "suitable" for these purposes, the Organisation should take account of the issues referred to in Paragraph 8 below. Where there is no suitable alternative, a temporary placement may be considered in accordance with Paragraph 9.

8 The Organisation exercising its NHS functions is not subject to specific directions on choice of accommodation unlike local authorities which are subject to the Care Act 2014 "Choice Directions" when making care home placements. Nevertheless, there is a long established emphasis on individual choice in the NHS which means that, whilst the Choice Directions are not strictly binding, they are likely to be regarded as indicative of reasonable practice. When considering the appropriateness of a placement in a less expensive care home or its legitimacy as a genuine "alternative" to the more expensive placement the Organisation should take account of the following:

8.1 The wishes of the individual or their representatives. If these views are not taken into account, there is a risk of challenge under the Human Rights Act 1998 on grounds of a failure to observe the right to respect for private and family life. This risk will be higher where an existing care home arrangement is withdrawn or varied, particularly where this is done primarily on the grounds of resources rather than need;

8.2 the suitability of the alternative arrangements having regard to the individual's assessed needs;

8.3 the availability of alternative care home placements;

8.4 the location of any alternative care homes, in particular, their proximity to the individual's home, family or other support networks;

8.5 where applicable, the potential risk to the individual's health of any withdrawal of or variation to existing arrangements;

8.6 Practical and legal issues associated with an individual who refuses to move (either from hospital, home or an existing care home).

9 If there is no suitable alternative placement available, the Organisation could agree to fully fund a patient in a care home with fees in excess of the **Organisation Maximum** on a temporary basis only. Prior to making such an arrangement, the Organisation should consider the potential health risks likely to be associated with the later transfer between care homes. Such arrangements will also be dependent on the Organisation's ability to agree the terms of a temporary placement with the relevant care home provider.

This guidance follows legal advice provided to the Organisation.