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**Health, Social Services
and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

To: Chief Executives HSC Board, PHA,
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CARE MANAGEMENT, PROVISION OF SERVICES AND CHARGING GUIDANCE

This Circular issued by the Department of Health, Social Services and Public Safety (the Department) provides the Health and Social Care Board (the HSC Board) and Health and Social Care Trusts (HSC Trusts) with updated guidance on:

- the care management process including assessment and case management of health and social care needs;
- provision of services, including placement of service users in residential care homes and nursing homes and the service user's right to a choice of accommodation; and
- charging for personal social services provided in residential care homes and nursing homes.

This Circular replaces Circular: ECCU 3/2006, Care Assessment and Placement Guidance and should be read in conjunction with the legislation and guidance documents listed in **Annex A** and **Annex B**.

Nothing in this guidance absolves the HSC Board or HSC Trusts of their duty to service users and the taxpayer to ensure that quality services are procured and delivered in response to assessed need at a cost that represents best value for money within available resources. It must also be understood that this revised guidance does not reflect any substantive changes to the existing legislative and policy framework.

BACKGROUND

The Department's policy paper, 'People First: Community Care in Northern Ireland for the 1990s'¹ (DHSS) places emphasis on the requirement, "*within available resources, to identify and assess individuals' needs, taking full account of personal preferences (and those of informal carers), and design packages of care best suited to enabling the consumer to live as normal a life as possible*". The 'Review of Community Care - First Report',² (DHSS 2002) reiterated the need to "*make proper assessment of need and good case management the cornerstone of high quality care*".

The central objectives of community care services remain:

- helping people to remain in their own homes, or in as near a domestic environment as possible, for as long as they wish and it is safe and appropriate to do so;
- providing practical support to carers to support them in their caring role; and
- ensuring that residential care, nursing home and hospital care is reserved for those whose needs cannot be met in any other way.

Services must be delivered in ways that appropriately manage risk for service users, carers, staff and the public. It is acknowledged, however, that in some situations, living with an identified risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking (when it is appropriately managed) can be considered to be a positive action. Health and Social Care (HSC) staff need to work in partnership with service users and carers to explore choices, identify and assess risks and agree on how these will be managed and minimised for the benefit of individual service users, carers, families and communities.

UNDERPINNING PRINCIPLES

A number of principles underpin the Department's policy on community care. The care management process should reflect these. In particular, HSC staff should:

¹ *People First* can be accessed at: http://www.dhsspsni.gov.uk/people_first.pdf

² *The Review of Community Care – First Report* can be accessed at: http://www.dhsspsni.gov.uk/review_of_community_care.pdf

- intervene no more than is necessary;
- focus on those at greatest risk;
- ensure that information about the care management process, services and the delivery of care, is proactively publicised in ways which will assist those who may require them; and that this information is 'user-friendly' and kept up-to-date;
- make sure that contact screening and assessment are proportionate to the presenting circumstances and are completed in a way that is timely, effective and efficient;
- respond flexibly and sensitively to the needs of individual service users and their carers;
- treat service users and their carers with respect and dignity;
- encourage and equip service users and carers to play an active part in the assessment, care planning, care plan implementation, monitoring and review processes, including the identification and management of risk;
- seek service users' informed consent to share relevant information in line with best professional and data protection principles and practice;
- focus on enabling people to go on living at home for as long as is safe and appropriate;
- provide a holistic assessment of need which, where appropriate, takes account of physical and mental health; emotional well-being; capacity for the activities of daily living and self care; abilities (including attitudes toward any disability) and lifestyle (including how the day is spent); the contribution of informal carers (so long as they are able, willing and supported to carry on the caring role); social network and support; and housing, finance and environmental factors;
- explore a range of options for care, across agencies and sectors, in order to widen the service user's choice;
- ensure that the provision of practical support to carers is a high priority; and
- integrate and co-ordinate the service user's journey through all parts of the health and social care system.

These principles are not new. It is important, however, that they are consistently and uniformly applied across the region so that the best of current practice becomes the norm that service users, their carers and families can confidently expect.

CARE MANAGEMENT AND CASE MANAGEMENT

For the purposes of this guidance, the term **care management** is used to describe the whole concept which embraces the key functions of:

- case finding, i.e. making information available to the public and service users and carers about the range of services available and potential sources of help;
- screening and determining the level of assessment to be undertaken when a person is referred;
- undertaking a proportionate, person-centred assessment of the individual's needs, having due regard to the needs of carers;
- developing and implementing a care plan and a care package (which may comprise a range of services) to meet identified needs; and
- monitoring, reviewing and adjusting the care plan and care package as required.

The term **case management** is used, as set out in 'People First',³ to describe the activity included within the concept of care management of advocating and co-ordinating services for individuals who have complex or frequently or rapidly changing needs which require a range of support services. In recent years, however, "case management" has become more commonly associated with Long Term Condition management and the term "care management" has tended to be viewed as the activity of co-ordinating a community care package for people with complex or rapidly changing needs. It is the Department's view that both interpretations are captured within the whole concept set out by 'People First'. Where the service user has significant health or clinical care needs, the case manager⁴ is most likely to be a nurse or allied health professional. Where social care needs are predominant the case manager will most likely be a social worker.

The view of the Department is that everyone, regardless of whether their needs are short or long term and whether these are complex or not, has the right to access the care management process and receive appropriate levels of advice and support. Determining the level of assessment to be undertaken is a matter for professional judgement. As a consequence of the screening and preliminary assessment processes, some individuals may not be eligible for services from the HSC Trust. Where this is the case, they should be given advice, in a timely manner, about how to access information relevant to their circumstances such as, for example, benefit entitlements from the Social Security Agency and about the support available from other agencies such as voluntary and community sector organisations.

Where individuals are assessed as being eligible for support and have relatively straightforward needs for a basic service, this will be arranged or provided directly by HSC Trusts. For those persons who, due to the complexity of their needs require a varying range of supports, the provision of services will be planned and co-ordinated by an identified professional within an individual case management approach.

THE NORTHERN IRELAND SINGLE ASSESSMENT TOOL

The Northern Ireland Single Assessment Tool (NISAT), which has been developed and validated, primarily in relation to assessing the needs of older people, supports the exercise of professional judgement in the care management process; and the earliest possible provision of safe and effective health and social care. NISAT is designed to capture the information required for holistic, person-centred assessment. It is structured in component parts and using domains which will be completed according to the level of health and social care needs experienced, from non-complex to complex.

³ People First: Care Management: Guidance on Assessment and the Provision of Community Care, Department of Health and Social Services (Paragraph 2.4) can be accessed at: www.dhsspsni.gov.uk/people_first_-_care_management_-_guidance_on_assessment_and_the_provision_of_community_care.pdf

⁴ Case Manager is taken to include the terms Care Manager, Care Co-ordinator, Lead Professional and, in the context of NISAT, Key Worker

NISAT has three primary components:

- (i) the Contact Screening;
- (ii) the Core Assessment, with prompts to specialist assessment, where necessary; and
- (iii) the Complex Assessment, with prompts to specialist assessment, where necessary.

There are four additional components to be used in conjunction with the primary components of NISAT:

- a Specialist Referral Form;
- a Specialist Summary and Recommendations Form;
- a GP and Medical Practitioner Report; and
- a Carer's Support and Needs Assessment, the need for which could be triggered at any point in the process.

In addition, the Carer's Support and Needs Assessment component of NISAT should also be used as the "stand alone" carer's assessment tool in all Adult Programmes of Care.⁵ It should be noted that the Carers and Direct Payments Act (Northern Ireland) 2002 places a statutory duty on HSC Trusts to:

- (a) make information generally available in its area about a carer's right to an assessment and in such a manner that carers in the HSC Trust's area have access to that information; and
- (b) to inform individual carers, where the HSC Trust is aware that they are providing care, of their right to an assessment.

To facilitate ease of access, a Contents page has been added and the remainder of this circular is set out in three parts, as follows:

PART 1: CARE MANAGEMENT – A DYNAMIC PROCESS;

PART 2: PROVISION OF SERVICES AND COMPLAINTS; and

PART 3: CHARGING FOR PERSONAL SOCIAL SERVICES.

⁵ Circular HSS (ECCU) 2/2009: Regional Carer's Assessment Support and Needs Assessment Tool can be accessed at: <http://www.dhsspsni.gov.uk/eccu2-09.pdf>

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PART 1: CARE MANAGEMENT – A DYNAMIC PROCESS

1. **Care management** is a dynamic process tailored to the circumstances and needs of individuals and their family and community contexts. The process aims to deliver safe and effective health and social care services in the setting which is most appropriate to the person's needs. When a focused assessment has determined the need for services, these should be made available to the individual in a timely manner.
2. The decision to allocate resources must be based on proper assessment. Assessment must therefore be person-centred, taking full account of the individual's context and needs, and proportionate to the presenting circumstances. Where needs are straightforward, the process should facilitate access to support and services arranged, or provided directly, by HSC Trusts in an efficient and effective way. Where needs are varied or more complex and require a range of services which need to be co-ordinated by a single professional, **case management** should be used to ensure effective co-ordination and timely delivery of care and services.

CASE MANAGEMENT – A FOCUSED ACTIVITY

3. **Case management** is:
 - focused on people with **complex**, or **frequently** or **rapidly changing needs** or on people with more straightforward and stable needs but **where services or service providers need to be co-ordinated**; and
 - undertaken by a range of **professionally qualified staff** in social work and health, with appropriate training, skills and experience.
4. Case management should be a focused activity, available for as long as necessary, to support people with a complex single or long term condition, complex social care needs, or rapidly changing needs or people who may require effective co-ordination of a range of services or service providers. It should be available to all service user groups and to carers where effective co-ordination of services or service providers is necessary to sustain their caring role.
5. People who should be considered for case management across all programmes of care and service user groups will include individuals who:
 - are experiencing severe mental or physical incapacity, disability or loss of independence;
 - are at high level of risk;
 - are in need of care and protection;
 - have more straightforward and stable needs but several services and/or service providers require effective co-ordination;
 - have rapidly or frequently changing needs;

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- have complex needs or present challenging behaviour where high level support is necessary or whose care arrangements are at risk of breaking down;
 - may require admission to residential care, nursing home or other long-stay care setting;
 - are being discharged from hospital or other care settings after a period of long-term care;
 - are being discharged following major intervention or serious illness requiring acute hospital care and have complex needs;
 - have a chronic long term condition;
 - are high intensity users of unplanned secondary care; or
 - are highly dependent on the input of a carer(s).
6. This is not an exhaustive list and should be used by HSC Trusts primarily as a guide. All service users with complex needs or whose services need to be co-ordinated are entitled to avail of appropriately directed case management. This also applies to service users who are in a position to cover the full costs of their residential care or nursing home care. The financial circumstances of individuals **should never** be used as a reason for failing to offer access to the care management process.
7. Service users may choose not to avail of case management but this should only be as a result of an explicitly expressed and informed wish to opt out after having been provided with full and appropriate information in a suitable format and at a time convenient for them. The reason for opt-out should be recorded in the service user's case record. The service user should also be advised that he/she can choose to avail of the care management process at a future date. Similarly, residents of residential care homes or nursing homes who did not have initial contact with the HSC can avail of the care management process at any time if they so choose. Homeowners and Trust staff should be alert to this possibility.
8. There are currently different approaches to case management within HSC Trusts. Each HSC Trust should clarify the needs it is seeking to address through case management and then consider how to organise services in order to address those needs. In determining which professional is best placed to lead on the chosen case management approach, HSC Trusts should have regard to the following competences:
- identifying service users at high risk, protecting the vulnerable, promoting health and social well-being, preventing ill-health and tackling social exclusion;
 - leading complex care co-ordination;
 - professional practice and leadership;
 - interagency and partnership working;
 - supporting self care, self management and enabling independence
 - proactively managing complex long term conditions and care situations;
 - managing cognitive impairment and mental well-being and working with disability;
 - advanced clinical and professional practice; and

- managing care at the end of life.

THE CARE MANAGEMENT PROCESS

9. An effective care management process requires certain key functions to be carried out (illustrated in **Annex C**). These may be separated into the following distinct stages:

- Case Finding;
- Screening;
- Assessment of Need;
- Care Planning;
- Managing and Implementing the Care Plan;
- Monitoring implementation of the Care Plan; and
- Review.

Appropriate file records need to be maintained at each stage of the process in line with best practice and Standards for Assessment and Care Management (DHSS 1999).⁶

CASE FINDING

10. Case finding includes **proactively** publicising information about health and social care services and how to access them in an accessible, informative and user friendly manner which will assist those who may require support and/or services. Such information will also enable referring agencies, including General Practitioners (GPs), to make appropriate referrals. HSC Trusts should be innovative in their approach to publishing and making information available to ensure that it reaches as wide an audience as possible. HSC Trusts should positively seek to engage service users and carers, and referring agencies, as appropriate, in the development, monitoring and evaluation of the effectiveness of its communication processes and the usefulness of information provided.

SCREENING

11. Screening is the initial examination of all referrals to determine the most appropriate response. It means collecting and analysing basic information about individuals which is then used to provide or make referrals to appropriate services (where the need is considered to be straightforward) or to professionals where further action or assessment of need is required. Screening may be undertaken by

⁶ *Quality Standards Assessment and Care Management* can be accessed at:
http://www.dhsspsni.gov.uk/quality_standards_-_assessment___care_management.pdf

Good Management, Good Records - Guidelines for Managing Records in Health and Personal Social Services Organisations in Northern Ireland, DHSSPS, December 2004, can be accessed at:
<http://www.dhsspsni.gov.uk/dhs-goodmanagement.pdf>

either a professional or an appropriately trained non-professional member of staff. When completed by the latter, decision making must be documented and “signed off” by a professional.

ASSESSMENT OF NEED

12. Proper, proportionate assessment of need will continue to be the cornerstone of the care management process. Assessment of need is the systematic determination of health and social care needs in a manner which is proportionate to the individual’s presenting circumstances. Assessment should reflect the perceptions and wishes of service users and carers as well as their strengths and preferences. Disagreements should be noted with an outline as to how these are to be resolved/managed. Assessment should always include the identification of risks and a risk management plan. Where appropriate, the assessment should accurately portray the contribution of carers and their needs. It should focus on maximising opportunities for service users to live independently at home, or in as near a domestic environment as possible, for as long as they wish, where this is safe and appropriate.
13. All HSC staff should be aware that assessments carried out before individuals have had time to recuperate or rehabilitate from illness or a stay in hospital will not always be able to accurately determine their potential to improve or their capacity to cope at home. For these reasons, unless there are other compelling factors, decisions about longer-term care should not be made in hospital settings where service users and their carers are at their most vulnerable.
14. HSC Trusts should have arrangements in place for the safe and effective discharge of people from hospital and their transfer between care settings. Discharge and transfer procedures should be agreed between hospital and community services and should be communicated proactively to all staff, service users, or their authorised representatives, as appropriate, and carers. HSC Trusts should ensure that service users and carers, or their individual advocates or representative organisations, are properly involved in drawing up and publicising discharge and transfer procedures which also have due regard for the needs of carers.
15. The NISAT, developed primarily in the context of older people’s needs, provides a validated assessment framework, which may, depending on the presenting needs of individual, involve different levels of assessment, as follows:
 - **CORE ASSESSMENT** - This is the largest and most comprehensive component of NISAT. This level of assessment is undertaken where a holistic overview of a person’s health and social care needs is required. Core assessment, with input from the GP and/or a Medical Practitioner, as required, may be sufficient to fully identify and describe assessed need, formulate a care plan and facilitate the delivery of support and services. If not, it should trigger a specialist (in-depth) assessment or complex assessment where appropriate. Within the core

assessment, there are four main areas of the person's life to be considered, namely:

- past life;
- present life which is captured through ten, appropriately triggered, domains;
- how any difficulties affect quality of life; and
- future goals and wishes.

The Core Assessment may be completed by any health and social care professional regardless of grade or specialism. Decision making must be documented and appropriately "signed off".

- **THE COMPLEX ASSESSMENT** - The complex component of NISAT should be completed to ascertain if the individual requires intensive support services to remain independent in his/her home environment. It should also be completed when a need for temporary or permanent change in living arrangements or accommodation is being considered due to complex health and social care needs of the individual. Individuals undergoing Complex Assessment should be considered for referral to a medical practitioner with relevant expertise, for example, in the assessment of older people, a geriatrician or GP with a specialist interest. The Complex Assessment may also identify the need for a uni-professional, specialist assessment.
16. Complex assessment involves collation of information gathered through screening, core assessment and, where appropriate, specialist assessment summaries, carer's assessment and input from the GP and medical practitioners. Summaries of any assessments carried out will need to be co-ordinated, drawn together and interpreted by a professional in this role. The complex component of NISAT, therefore, should only be used by professionals trained and supervised in complex assessment.
 17. Similarly, the distinction between health and social care needs is complex and requires a careful appraisal of each individual's needs. In this context, it is for clinicians, together with other health and social care professional colleagues and in consultation with the service user, his/her family and carers, to determine through a comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services. In the latter case, the service user may be required to pay a means tested contribution.
 18. A detailed guidance document, including a Practitioner Manual, on the operation of NISAT is provided separately and will accompany the training associated with the roll-out of NISAT across Northern Ireland in the coming year.
 19. Finally, in accordance with the Standards for Assessment and Care Management, assessments should be written in plain language and should be shared with service users and carers as soon as possible.

CARE PLANNING

20. Care Planning is a way of agreeing, arranging and managing the health and social care services which enable a person to live at home, to manage a long term condition or, where necessary, to move into a residential care or nursing home. Care planning provides an opportunity to consider all options for meeting assessed health and social care needs. Care plans must be person-centred and focused on preserving or restoring as far as possible the individual's capacity for independent living.
21. Service users or their authorised representatives and carers should be supported to make informed choices and should, with other relevant professionals and/or agencies, agree the expected outcomes. The result should be a personalised care plan which reflects the service user's assessed health and social care needs. The care plan should include:
 - details of the care and/or services to be provided, the time-frame for delivery and by whom;
 - identification of risk and how it will be managed;
 - the contribution to delivery of the care plan to be made by the assessed individual and their carer(s);
 - the objectives and expected outcomes;
 - identification of the environment which is most appropriate for the delivery of the care and/or services;
 - the name and contact details for the case manager;
 - a review date; and
 - consent from the assessed person to share relevant information provided in the assessment and the care plan with those involved in delivering the care and/or services, as required, and with the carer where applicable.
22. The care plan should be printed in a format suited to individuals or their authorised representatives and carers. Service users should be made aware of the importance, for them with regard to service delivery and review, of the care plan and **must** be offered a copy of their care plan. Where a service user refuses receipt of the care plan, this decision, together with the reasons, should be recorded on the case records. HSC staff should periodically remind the service user of his/her entitlement to receive a copy of the care plan and of the benefits of so doing. A record of reminders offered and their outcomes should also be maintained.
23. Assessment and care planning is likely to highlight areas of need which cannot be met or which may remain unmet once the care arrangements are put in place. Such unmet need must be recorded, aggregated and passed to the appropriate managers and service planners for action. In the interim, appropriate risk management strategies should be put in place and the circumstances of the case kept under regular review.

MANAGING AND IMPLEMENTING THE CARE PLAN

24. Managing the care plan will require the case manager to undertake a variety of tasks and make use of a range of skills as well as demonstrating a comprehensive knowledge of community care resources and how to access these. The case manager will need to:
- specify the services required and the expected outcomes for the service user and carer, as appropriate;
 - identify and secure the necessary resources or funding for services within the HSC Trust's accountability framework;
 - where necessary, and with appropriate support from relevant professionals, negotiate with service providers and agree the terms of service provision;
 - confirm that the terms of service provision are agreed and that appropriate arrangements are in place to ensure that any contractual requirements will be met;
 - ensure service users and, where appropriate, carers are given details of financial costs and information on the financial assessment arrangements;
 - ensure a care timetable for delivery of the specified care and/or services is in place and working;
 - co-ordinate the range of services to meet the care plan;
 - make sure that reviews take place (the frequency of which will be dictated by the circumstances and complexity of the individual's care or care package but no less than annually); and
 - ensure that reviews are person-centred and inclusive, take into account the experience/views of service users and carers, and service providers, and that they inform changes in care or service provision.

MONITORING IMPLEMENTATION OF THE CARE PLAN

25. The needs of people and their circumstances change. Monitoring of the care plan will therefore be an ongoing task and where service users' needs are changing rapidly or frequently, adjustments may have to be made to the care package. Arrangements for monitoring should be part of the service specifications and the case manager will be responsible for ensuring that the specified arrangements are followed. The main focus should be on whether the quality and appropriateness of the provision meets the agreed outcomes for individuals and, where appropriate, their carers. Persons receiving services, their authorised representatives, carers and service providers should contribute to both formal and informal monitoring arrangements.

REVIEW

26. A review of needs and the services provided should take place at the times or intervals specified in the care plan or at any other time deemed necessary. Whilst the review process is a formal arrangement, reviews should be conducted to suit the individual circumstances of service users and their carers. Suitable support

should be offered to facilitate this. Reviews need not involve large, formal meetings. The case manager should, however, always ensure that:

- changing needs or circumstances are recognised and re-assessment of need is undertaken, when necessary;
- the care plan is revised to take account of changing needs and circumstances;
- services are consistent in meeting needs in an appropriate manner and in accordance with the expected standard of quality;
- any unmet need is identified and responded to;
- consideration is given to whether case management is still required and, if not, alternative arrangements are made;
- the views of service users and carers inform the review process and its outcomes;
- service users are offered a copy of their updated care plan and, if they decline, the decision is recorded; and
- consent from the service user to share relevant information from the review and the updated care plan with those involved in delivering the care and/or services, as required, and with the carer, where applicable.

27. Review is an integral part of care delivery and is particularly important in case managed situations in view of the complexity of need and resources involved. The case manager is responsible for ensuring that the written record of the review sets out the decisions taken, the actions agreed, who will take these forward and the timescales to be achieved. Reviews must not become a “routine” or “administrative” task. As a minimum, a formal review should take place once a year. More frequent reviews may be required in response to changing circumstances or at the request of service users or other persons, including carers, or agencies involved in their care.

FILE RECORDS AND CONSENT TO SHARE RELEVANT INFORMATION

28. HSC Trusts should maintain up-to-date case records in accordance with the HSC Trust’s management and professional requirements. Records should be compiled, maintained and stored in a manner which respects the confidentiality of service users and their right of access to personal information held about them.
29. As outlined in the Department’s guidance ‘A Code of Practice on Protecting the Confidentiality of Service User Information’,⁷ the sharing of a service user’s

⁷ The Code of Practice on Protecting the Confidentiality of Service User Information can be accessed at <http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf>

Staff Information Leaflet can be accessed at:
<http://www.dhsspsni.gov.uk/staff-guidance-on-confidentiality0109.pdf>

Service User information leaflet can be accessed at:
<http://www.dhsspsni.gov.uk/codeofpracticeleafletmay2009.pdf>

personal information can benefit service users, enables the HSC organisations to function effectively and is often necessary in the public interest. Such benefits, however, need to be carefully balanced against a service user's expectation that such information be kept confidential. It is essential, therefore, that service users are kept actively involved in decisions about the uses and disclosures of their information. This includes seeking the service user's consent to sharing relevant information that would support the caring role with involved family members, informal carers and/or service providers.

30. At a minimum, HSC Trusts should ensure that the following information is recorded:
- the service user's consent that relevant information:
 - provided in the assessment process may be shared with Health and Social Care Professionals and Service Providers who can contribute to his/her care;
 - in relation to his/her health and social care needs may be shared with his/her carer(s); and
 - in relation to his/her health and social care needs may be obtained from others involved in his/her care; and
 - the service user's understanding that:
 - the information shared may be used for the purpose of providing a service, or care to him/her and further assessment may be required;
 - he/she may withdraw his/her consent to share information or to have further assessment at any time, but that this may affect ability to provide full services for him/her; and
 - he/she has the right to restrict what information may be shared and with whom, but that this may affect ability to provide full services for him/her.

PART 2: PROVISION OF SERVICES

31. The Department retains as core objectives of community care:
- the development of domiciliary, day and respite services to enable people to live in their own homes wherever possible; and
 - the promotion of a flourishing independent sector⁸ alongside good quality public services.
32. HSC Trusts should therefore provide, or arrange the provision of, a range of flexible and responsive services aimed at maintaining people in safety and dignity in their own homes or in as near a domestic environment as possible for as long as they wish and it is safe and appropriate to do so. Low level practical interventions have a vital role to play in maintaining independent living and maintaining quality of life for service users and carers alike. The Department will expect to see a continuing commitment to such practical intervention and other low level interventions, for example, emotional support through befriending and support groups, which could be provided through sustainable engagement with the independent sector, in recognition of the value of early intervention.
33. A key component of the vision of shifting resources and emphasis from institutional care to care in the individual's own home has been the intention to utilise the independent sector more effectively. In this context, HSC Trusts are reminded of the need to achieve optimum quality, flexibility of supply and value for money in procuring services, and of their responsibility to fully consider all available service provision rather than rely solely on the availability of in-house services.
34. In responding to assessed need, the HSC Board and HSC Trusts should explore and develop innovative services alongside the following key elements of community care provision and delivery:
- Self care;
 - Direct Payments;
 - Domiciliary care;
 - Day care;
 - Respite care;
 - Intermediate care; and
 - Residential care and nursing home care.

SUPPORTING SELF CARE

35. Supporting self care is about more than giving service users information about their condition or about facilitating access to support services. It is about acknowledging the central role they can play in managing their own care and support and

⁸ For the purpose of this circular, the independent sector is comprised of private, voluntary, community and social enterprise providers

empowering them and their family and carers to handle their condition and manage their circumstances as safely and effectively as possible.

36. The HSC Board and HSC Trusts will need to work with GPs, community pharmacies, health and social care organisations, independent sector organisations, District Councils and the Public Health Agency to facilitate the development of self care arrangements and lifestyle education programmes.

DIRECT PAYMENTS

37. Direct Payments are cash payments made in lieu of direct social care services provision in the community and aim to:
 - offer more flexibility in how services are provided;
 - provide people with greater choice and control over their lives; and
 - empower them to make their own decisions about how their care is delivered.
38. Case Managers should recognise the potential of Direct Payments to empower individuals and their carers, as appropriate, to arrange the provision of some or all of their own services. Service users must consent to receiving Direct Payments. Difficulties can arise where HSC Trusts and service users are not clear as to their respective obligations and responsibilities. HSC Trusts should ensure that they clearly explain to each potential Direct Payment recipient what responsibilities, including compliance with regulatory and accountability requirements, a Direct Payment involves.
39. The prospect of becoming an employer and accompanying responsibilities can, for many people, be a daunting prospect and there is evidence which suggests some people may be discouraged from entering into a Direct Payments agreement by this perceived burden. For this reason, it is important that the HSC Board and HSC Trusts ensure that appropriate, independent support services (such as, but not limited to, those provided by the Centre for Independent Living⁹) are available to support and advise both those considering a Direct Payment and those receiving Direct Payments. Such services should be designed to support recipients in the management of Direct Payments, including compliance with accountability and regulatory requirements, and to optimise the independence and flexibility that Direct Payments can enable.
40. The use of Direct Payments **does not** absolve HSC Trusts of their responsibility to ensure the provision of quality, safe and effective social care services. HSC Trusts have a duty to regularly monitor and review the quality of care provision and, through their assessment and review processes, are required to ensure that personal assistants/care workers employed under Direct Payments have access to

⁹ Information about the work of the Centre for Independent Living can be accessed through: <http://cilbelfast.org/>

relevant supports, including training, which will assist them to care for service users safely at home.¹⁰ HSC Trusts must also ensure that appropriate accountability arrangements are in place to allow effective financial monitoring.

DOMICILIARY CARE

41. Domiciliary care is the provision of personal care and associated domestic services that are necessary to maintain an individual person in a mutually agreed measure of health, hygiene, dignity, safety and ease in their home. While the primary responsibility is to those at greatest risk, it is recognised that early intervention through preventative low level support can play a valuable role in promoting independence, dignity, well-being and quality of life.
42. Domiciliary care services should, wherever possible, be rehabilitative in nature and promote and encourage independence. The Department has issued Regional Access Criteria for Domiciliary Care¹¹ to provide a framework for a more consistent approach to eligibility and fairer access to domiciliary care. The criteria for domiciliary care cover the following services:
 - personal care;
 - practical care;
 - non-residential respite care;
 - day care/resource centre; and
 - transport as required (where this falls within the domiciliary care budget).
43. Identified risks to independence, or personal safety are compared to the eligibility criteria against four bands (critical, substantial, moderate or low), thus enabling the HSC Board and HSC Trusts to identify those most at risk and therefore give priority to service provision. HSC Trusts are also required:
 - to use these criteria when considering allocation of domiciliary care packages; and
 - to develop methods of risk assessment to help them identify those individuals where risks to independence appear relatively low but are likely to become more serious over time and so facilitate early preventative intervention, where possible.

¹⁰ Guidance in relation to Direct Payments, including training of personal assistants, can be accessed through:
<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/directpayments-about/directpayments-guidance.htm>

¹¹ Circular HSS (ECCU) 2/2008: Regional Access Criteria for Domiciliary Care can be accessed at:
http://www.dhsspsni.gov.uk/eccu_2_2008.pdf

DAY CARE

44. Day care settings are centre or community-based programmes and offer a range of activities on an individual or group basis to support the care, safety and well-being of persons aged 18 or over. They are also a resource to families, carers and communities. Day care settings seek to meet the assessed needs of individuals for care, support, supervision, skills development, rehabilitation or re-enablement. Individuals may benefit from day care by reason of functional impairment, physical or sensory disability, mental illness, cognitive impairment, learning disability, ill-health, age and family or life circumstances.
45. These comprehensive programmes provide a variety of social care, healthcare or other related services in a protective setting during any part of the day, but are less than 24-hour care. Among their objectives are:
 - to maintain, or support a return, to independent living in the community;
 - to promote social inclusion;
 - to provide assistance with personal care or other daily living activities;
 - to maintain, develop or re-learn physical or mental skills;
 - to provide treatment or some healthcare;
 - to provide emotional support;
 - to promote education, training or employment opportunities; and
 - to provide respite for carers.
46. Day care settings play an important role in many people's lives in relation to promotion of skills development and social inclusion and helping to delay or offset the need for more institutionalised care. However, in line with the culture of greater choice, equity and person-centred services, HSC Trusts should seek to expand and build on statutory and independent sector provision that enable access to education, training, employment support and other meaningful daytime activity that empower service users and provide support to carers. This will include appropriate co-location of services; flexible use of buildings and flexible opening hours (including weekend opening and holiday period options); the development of "drop-in" services; and review of opportunities for earlier intervention or activities with a preventative focus such as community development initiatives, leisure schemes and use of volunteers, befriending schemes and adult learning opportunities.

RESPITE CARE

47. Respite care, sometimes known as "short breaks", is when a cared for person and carer get a chance to spend some time apart. This gives the cared for person a chance to experience new opportunities. It also gives the carer a break from the caring role.
48. Respite care is an important component of a continuum of comprehensive support services available to cared for persons and carers not only on a planned basis, but also in emergency situations. It is provided for a specified period of time and may

take place in a variety of settings. It might be for a few hours a day at a centre; or for a few days, or a couple of weeks in a residential care home or nursing home or living with an approved support family in some areas. A domiciliary care service or sitting service at home can also sometimes be arranged. Alternatively, it may take the form of a worker taking the cared for person out to give the carer some time on their own at home. HSC Trusts should ensure, wherever possible, that respite in an institutional setting is only offered where it is the preferred option of all parties.

49. Respite services, at a minimum, should:

- properly reflect the needs of modern living;
- offer a range of options so that cared for persons and carers can choose that which best meets their unique needs;
- be age appropriate, of high quality and ensure the safety of the individual being cared for;
- be easily accessible by cared for persons and carers when, how, and where it is needed; and
- be available both in and out-of-hours, at weekends and accommodate crisis/emergency situations.

INTERMEDIATE CARE

50. In recent years increasing demands on the acute sector, particularly in Accident and Emergency Departments, have been evidenced in some of the difficulties seen around inappropriate admissions to hospital, waiting lists and delayed discharges. A key element of reform and modernisation is the need to develop fully integrated primary and community care services that focus on people at greatest risk by supporting them to live independent lives and reducing unnecessary and inappropriate reliance on hospital services.

51. Intermediate care is a range of integrated services designed to prevent unnecessary hospital admission, promote faster recovery from illness, support timely discharge and maximise independent living. Intermediate care services should be time-limited, usually no longer than six weeks and frequently as little as two weeks or less. Commissioners and providers should work together to ensure that local health and social care economies develop a range of solutions to address locally identified needs.

RESIDENTIAL CARE AND NURSING HOME CARE

52. It is recognised that there may be a point where the intensity of needs, the safety of the service user and care worker, pressure on the family and the cost effectiveness of the care package will mean that residential care or nursing home care becomes the most appropriate care option and that such a choice is often a positive one in providing a level of reassurance and security to service users, carers and their families.

53. In relation to placement in a residential care home or nursing home, case managers will need to ensure, among other things, that:
- the home has the necessary skills to support and to care for the service user particularly where challenging behaviours are known to be present and risk management processes, where needed, are in place;
 - appropriate follow-up, and access, by the home, to advice and support from HSC Trust staff experienced in managing challenging behaviours is available in relation to the placement and afterwards for as long as is considered necessary;
 - care plans developed within the home, including management and back-up strategies, are fit for purpose and reviewed on a regular basis dictated by the need of the service user and any presenting risks; and
 - the home is operating in compliance with relevant regulations and associated standards which will be informed by Regulation and Quality Improvement Authority (RQIA)¹² inspection reports.
54. Services users who require personal social services delivered in a residential care home or nursing home are entitled to a choice of appropriate accommodation. Where a service user's first choice of residential care or nursing home is not available at the time it is required, HSC Trusts should facilitate an interim move to an alternative home from where the service user can transfer to the home of first choice when a place becomes available. HSC Trusts should ensure that this position is communicated clearly to the service user, the service user's authorised representative, where appropriate, and the service user's family/carer(s) as soon as it becomes apparent that the service user requires to be admitted to a residential care home or nursing home. It should be noted that if being discharged from hospital, the service user **does not** have the right to remain in hospital until a place becomes available in the home of first choice. Discharge arrangements put in place must be appropriate to the needs of the service user and have due regard to the needs of carers.

COMPLAINTS

55. All service users who are unhappy at any stage of the care management process have the right to make a complaint under the HSC Complaints Procedure.¹³ In addition, Agencies and Establishments regulated by the RQIA ("regulated services") must operate a complaints procedure that meets the requirements of the HSC Complaints Procedure.

¹² Information about the work of the RQIA can be accessed through:
<http://www.rqia.org.uk/home/index.cfm>

¹³ Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning can be accessed through: <http://www.dhsspsni.gov.uk/hsccomplaints>

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56. HSC Trusts should ensure that service users and any person acting on their behalf are provided with a copy of the regulated services' complaints procedure and that this is available in a range of formats if required. This should include a step-by-step guide to making a complaint, the HSC Trust's role in local resolution, if required, the timescales involved and an outline of the role of the RQIA (including contact details for the RQIA).
57. If a service user or the service user's representative is unhappy with the service being received or with the home in which the service user is living, they should be advised of their right to make a complaint as set out in Paragraphs 59 and 60, as appropriate. All regulated services are required to provide advice to service users and their relatives/representatives, as necessary, on how to make a complaint, and who to contact outside the service or home if they remain dissatisfied with the provider's handling of the complaint or if they require support.
58. Regulated services are also required to keep a record of complaints received and of their outcomes. In addition, they are required to provide the RQIA, on request, with a statement containing a summary of complaints made during the preceding 12 months and the action that was taken in response. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider trends and issues for the purposes of raising standards. It should be noted that Section 145 of the Health and Social Care Act 2008 extended the coverage of the Human Rights Act 1998 to residents in residential care and nursing homes where their care has been contracted for by HSC Trusts.
59. Service users who have had their care arranged by a HSC Trust should be encouraged to raise their concerns, at the outset, with the registered manager¹⁴ or registered provider.¹⁵ Alternatively the service user may, if they prefer, raise their concerns with their case manager or other representative of the HSC Trust which facilitated their placement. Where a complaint cannot be resolved at a local level (that is through the registered provider and/or the HSC Trust), service users or their representatives may approach the Northern Ireland Commissioner for Complaints (the Ombudsman).¹⁶
60. Private funders (those who have chosen to arrange and pay for their own care without HSC Trust involvement, for example, in a residential care or nursing home) cannot avail of HSC Complaints Procedure save where their complaint relates to

¹⁴ The registered manager is the person registered under Part III of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 as the manager of the establishment or agency

¹⁵ The registered provider is the person registered under Part III of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 as the person carrying on the establishment or agency

¹⁶ Information about the work of the Ombudsman can be accessed at: <http://www.ni-ombudsman.org.uk/>

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the HSC Trust's decision making in relation to the HSC Contribution toward the cost of nursing provided in nursing homes or the nursing care funded by that contribution - see Paragraph 76. For all other matters, they are entitled to use the service providers' complaints procedure and may contact the RQIA if they feel their complaint has not been handled appropriately and the matter concerned is a breach of standards or regulations.

61. HSC Trusts should ensure that all registered providers, from whom they commission services, publicise the arrangements for dealing with complaints. Complaints procedures must meet the requirements of HSC Complaints Procedure, relevant legislation and the relevant Minimum Standards.¹⁷ HSC Trusts should also advise those considering making a complaint, of the free advocacy support services offered by Patient and Client Council¹⁸ and the voluntary sector.

¹⁷ The relevant standards can be accessed through:
<http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards.htm>

¹⁸ Information about the work of the Patient and Client Council can be accessed at:
<http://www.patientclientcouncil.hscni.net/>

PART 3: CHARGING FOR PERSONAL SOCIAL SERVICES

62. The following paragraphs provide guidance on the key issues of:

- charging for personal social services where a service user requires residential care or nursing home care;
- self funders;
- HSC contribution toward the cost of nursing provided in nursing homes;
- choice of accommodation;
- third party contributions;
- placements and contracts; and
- complaints.

CHARGING FOR PERSONAL SOCIAL SERVICES WHERE A SERVICE USER REQUIRES RESIDENTIAL CARE OR NURSING HOME CARE

63. The Health and Personal Social Services (Northern Ireland) Order 1972 requires that a person is charged for personal social services provided in residential care or nursing home accommodation arranged by a HSC Trust. **There is no such requirement, or authority, to charge for healthcare provided in the community, either in the service user's own home or in a residential care or nursing home.** Consequently, all references to financial assessment and charging hereafter apply to the provision of personal social services in residential care or nursing home accommodation.

64. A financial assessment should only commence **after** an assessment of the service user's health and social care needs has been completed. The financial circumstances of individuals **should never** be used as the reason for failing to offer assessment of need or, as appropriate, access to the care management process.

65. The Health and Personal Social Services (Assessment of Resources) Regulations (Northern Ireland) 1993 (the 1993 Regulations)¹⁹ set out the form of the financial assessment used to determine how much an individual is required to contribute toward the cost of personal social services provided in a residential care or nursing home. While the Department's Charging for Residential Accommodation Guide 2009 (CRAG)²⁰ explains the application of the regulations, it is emphasised that the 1993 Regulations are the only authoritative statement of the law. CRAG serves as an aid to assist in interpretation of the regulations and should be read only in conjunction with the legislation.

¹⁹ The 1993 Regulations can be accessed at: http://www.opsi.gov.uk/sr/sr1993/pdf/nisr_19930127_en.pdf

²⁰ The most recent Charging for Residential Accommodation Guide can be accessed through: <http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-residential-accommodation/ec-residential-accommodation-guidance.htm>

66. The financial assessment includes an assessment of capital and of income. Capital includes savings and assets such as, in most cases, the value of a resident's former home. An upper capital limit establishes the threshold where any service user who has capital of greater value is considered able to meet the full cost of his/her care, while a lower capital limit sets out the level of capital which is excluded from the financial assessment. Where a service user has capital that falls between the two limits, he/she will be expected to make a means tested contribution toward the cost of his/her care from that capital.
67. In addition, income is also assessed in the financial assessment. All residents who contribute from their income must retain a weekly Personal Expenses Allowance (PEA) designed for them to spend on personal items. Where a service user's assessed contribution is less than the cost of an appropriate place in a residential care or nursing home, HSC Trusts will make up the difference.
68. HSC Trusts must ensure that residents are given a clear explanation of how the assessment of resources will be carried out, and how their contribution will be calculated. Residents must, however, be informed that their assessed contribution may change in line with any changes to their capital or income. The level of upper and lower capital limits and the PEA are set out in the annual HSS (ECCU) Circular which outlines amendments to the 1993 Regulations.²¹
69. If a resident is unable to provide the HSC Trust with the information needed to carry out the assessment, the HSC Trust should establish if a third party has been granted Power of Attorney, been appointed Controller by the Office of Care and Protection, or is otherwise dealing with the resident's affairs.
70. Where a HSC Trust has reason to believe that a service user has deliberately deprived himself/herself of capital in order to reduce the assessed contribution to care costs, it has the discretion to recover this money or financially assess the service user as if he/she is still in possession of the capital he/she deprived himself/herself of.

SELF FUNDERS

71. A self funder is an individual who is assessed as able, or declares themselves able to meet the full cost of his/her care, but whose care is arranged and managed by a HSC Trust (as opposed to a private funder who arranges and pays for their own care). HSC Trusts should be clear, however, that a person's ability to fund their own care has no impact on their right to access and, where appropriate, progress through, the care management process. Where assessment confirms the need for a residential care or nursing home placement, some people may choose to opt-out

²¹ The annual HSS (ECCU) Circular which outlines amendments to the 1993 Regulations can be accessed through:
<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-residential-accommodation/ec-residential-accommodation-guidance.htm>

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of the care management process and thereby assume full responsibility for both the arrangement and, where appropriate, cost of their care. In the case of nursing home placement, service users should be advised of the availability of the weekly HSC contribution toward the cost of nursing care.

72. Self funders should be advised by HSC Trusts that, in accordance with the provisions in the CRAG, they may be held liable for the disposal of any assets which could be viewed by HSC Trusts as deliberate deprivation of capital to reduce accommodation charges and that they must retain financial records pertinent to funds which they expend whilst in care. In the event of a self funder residing in more expensive accommodation, this may necessitate a move to other, less expensive, accommodation, provided the individual's needs can be met there. Such a move should not be considered, however, if it is likely to have a lasting detrimental impact on the service user's physical or emotional well-being.
73. Where an individual chooses to opt out of the care management process, HSC Trusts must do everything they can to make available the same advice and guidance, in the appropriate formats and at appropriate times, as they would for a service user whose case is case managed. The reason for opt-out should be recorded in the service user's case record. The service user should also be advised that he/she can choose to avail of the care management process at a future date. Similarly, residents of residential care homes or nursing homes who did not have initial contact with the HSC can avail of the care management process at any time if they so choose. Homeowners and Trust staff should be alert to this possibility.

HSC CONTRIBUTION TOWARD THE COST OF NURSING PROVIDED IN NURSING HOMES

74. In October 2002, the Northern Ireland Assembly introduced a weekly HSC contribution towards the cost of nursing care provided in nursing homes. This flat weekly payment is intended to pay for the professional care given by a registered nurse employed in a nursing home. For individuals with assessed nursing needs who pay privately, the flat weekly rate is payable by HSC Trusts to homeowners. Alternatively, it is discounted from the charges raised by HSC Trusts for people who are required to refund HSC Trusts at the full rate.
75. This payment is, however, subject to the outcome of a Nursing Needs Assessment where the individual's nursing needs are identified. HSC Trusts should ensure that homes discount the full value of any nursing payment, and that residents should not be charged more than the agreed rate less the contribution. The Department has issued revised guidance (ECCU 1/2006) on the 'HPSS Payments for Nursing Care Scheme'.²²

²² Circular ECCU 1/2006: HPSS Payments for Nursing Care in Nursing Homes can be accessed at: http://www.dhsspsni.gov.uk/hpss_payments_for_nursing_care_circular.pdf

76. Individuals who have arranged their own placement in a nursing home who are unhappy either with the Trust's decision-making regarding their eligibility for the HSC Contribution, or with the quality of the nursing element of their care that the HSC contribution is paying for, can access the HSC complaints process in line with Paragraph 59 and of this Circular. However, complaints about any other aspect of their care or services that they receive in the nursing home fall outside the HSC complaints process and should be pursued in line with Paragraph 60 of this Circular.

CHOICE OF ACCOMMODATION

77. All service users assessed as requiring personal social services in a residential care or nursing home have the right to a choice of suitable accommodation and, subsequently, the right to select **preferred accommodation** provided the choice is suitable for the service user's care needs and the HSC Trust can agree a contract with the home to make sure the service user receives the care and support needed.
78. HSC Trusts should provide a directory of residential care and nursing homes and information about other useful sources of information such as the latest inspection report from the RQIA. The directory of residential care and nursing homes should contain all homes in the area that are registered with the RQIA. Some individuals may choose to live outside the HSC Trust's area for a variety of reasons, for example, to be close to family or friends. HSC Trusts should seek to facilitate such placements subject to confirmation of the home's registration with the RQIA, and its agreement to the HSC Trust's terms and conditions of contract.
79. Where a placement is being considered in another part of the United Kingdom under extra-statutory authority, the HSC Trust must request approval from the Department before making a placement. In requesting approval, the HSC Trust must provide the Department with the total weekly cost of the placement and confirm that:
- it is satisfied that the home:
 - can meet the service user's assessed needs;
 - is registered with the appropriate regulatory body for the area in which the home is located; and
 - has arrangements in place for protecting vulnerable adults and for managing concerns which in turn link with policy and procedures set out by the Local Authority in whose area it is located;

An information booklet providing advice on who is eligible for HPSS Payments for Nursing Care and how to apply can be accessed at:
http://www.dhsspsni.gov.uk/payments_for_nursing_care_information_leaflet.pdf

- it has in place appropriate arrangements to receive:
 - reports from the home about the support provided to the service user ensuring that the home has up to date contact details for the provision of such reports; and
 - reports of inspection of the home undertaken by the relevant regulatory body;
- the service user and their family have been advised in writing that care homes outside Northern Ireland are regulated in line with the regime operating in the area of placement, and that, while the statutory duty of quality remains with the HSC Trust, the full weight of the Northern Ireland regulatory framework cannot be brought to bear on a care home outside Northern Ireland; and
- the arrangements for the transport of the individual to the home are safe and appropriate.

80. Where an individual selects accommodation at the most competitive rate available, the HSC Trust may only recoup that client's assessed contribution in line with the 1993 Regulations.

81. Not all service users however, will select accommodation at the lowest rate available and may instead select **more expensive accommodation**. HSC Trusts must ensure that all additional payments are as a result of an informed choice, and that the rationale for the additional payment is fully transparent, for example, the rationale could be an optional additional service or an experience-based preference on the part of the service user. The service user's rationale for selecting the more expensive accommodation must be noted and agreed.

THIRD PARTY CONTRIBUTIONS

82. Case managed service users are not permitted to make additional payments from their own resources, including the PEA. The additional cost of more expensive accommodation **must** be met by a third party such as a family member, friend or voluntary body, who is both willing and able to meet the cost. HSC Trusts should be clear that the level of that payment is the difference in cost of the selected accommodation and the cost of other appropriate but less expensive accommodation which was available at the time of selection.

83. HSC Trusts should enter into legally binding agreements with third parties outlining their assent to meet the extra cost. It must be made clear to the third party that the level of their contribution may change and that any increase in the total tariff may not be divided equally between the HSC Trust and the third party. The third party will remain liable for the additional cost of the placement over and above the going rate for placements in the HSC Trust area (or the rate agreed by the HSC Trust for

an out-of-area placement), where the going rate is the tariff necessary to secure other appropriate accommodation.

84. In subsequent years the third party will remain liable to fund the difference in cost between the selected accommodation and the rate at which the HSC Trust can secure appropriate care in those years. The HSC Trust remains responsible for funding up to the level agreed at the time of placement, even where it is able to secure placements at lower rates in later years. If a third party subsequently reneges on the agreement, HSC Trusts should consider moving the service user to less expensive accommodation. Such a move should not be considered, however, if it is likely to have a lasting detrimental impact on the service user's physical or emotional well-being.
85. There are obvious risks for HSC Trusts in entering into third party agreements. Those risks are exacerbated when a placement is made in another part of the United Kingdom under extra-statutory authority. Whilst the aim must always be to facilitate choice for service users, HSC Trusts have a parallel responsibility to secure best value for money and protect the public funds for which they are accountable. A HSC Trust's decision to enter into a third party agreement about more expensive accommodation must be informed by a risk assessment of the third party's commitment and capacity to sustain an agreement.

PLACEMENT AND CONTRACTS

86. Once the service user has made a decision, HSC Trusts should arrange for care in the service user's preferred home. If this is not available, the HSC Trust should seek placement in other homes according to the preference of the client. HSC Trusts are reminded, however, that while service users do have the right to refuse to go into a home, they **do not** have the right to occupy a hospital bed once assessed as fit for discharge. In these circumstances, HSC Trusts must work with the service user, their family, friends or carers, in order to explore alternative options. In December 2004, the Department issued a Regional Protocol on delayed discharge related to patient choice to introduce consistency in the way delayed discharge from hospital is managed.²³ The HSC Board, working with HSC Trusts, is required to develop its own procedures, in line with the guidance, to eliminate non-availability of a patient's choice of home as a reason for their discharge from acute hospital being delayed.
87. HSC Trusts are required to contract for placements at the most competitive rate available for accommodation which it considers suitable for meeting the service user's need. While the regional rate for residential care and nursing home placements, set annually by the HSC Board on the basis of what is fair and affordable, provides the benchmark for residential care and nursing home

²³ The Regional Protocol on delayed discharge related to patient choice can be accessed at: <http://www.dhsspsni.gov.uk/index/hss/ec-community-care>

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placement, HSC Trusts are required to contract for the full cost of the assessed care needs, even where that is not obtainable at the regional rate.

88. When contracting with homes, HSC Trusts should contract for the full cost of the placement, and, where there has not been a determination of continuing healthcare need, seek reimbursement under the 1993 Regulations. Residents can, however, seek the agreement of both the HSC Trust and the home to pay their assessed contribution directly to the home. Where this is the case, HSC Trusts should document the request and inform the service user that they should not be charged any more than their assessed contribution.
89. In the case of more expensive accommodation, the HSC Trust should pay the home the agreed tariff and recover the third party payment by treating the third party contribution as if it were part of the resident's income. **If a home requests an increase to a third party payment, it must do so through the HSC Trust as the contracting party.** Third parties can seek the agreement of both the HSC Trust and the home to pay their contribution directly to the home. Where this is the case, HSC Trusts should ensure that this agreement is documented. Should the third party wish to change the method of payment in the future, this should be facilitated.
90. HSC Trusts remain financially liable for the full cost of accommodation should third parties default on their obligations, and should advise service users and third parties that any default may result in the service user being moved to less expensive accommodation. HSC Trusts should, therefore, ensure mechanisms are in place to remain informed of the level of weekly tariff and any third party payment.
91. The Department is, however, aware of the difficulty HSC Trusts face in ensuring that all costs are contracted for. The HSC Trust contract should reflect the full cost of meeting assessed care needs. Payments in respect of occasional services, such as hairdressing, are a matter between the resident and the home and may be paid for from the resident's PEA.
92. In line with the Care Standards for Residential Care Homes and Nursing Homes, HSC Trusts should work with residential care home and nursing home providers to ensure that all case managed residents, or their representatives, receive a copy of their individual written agreement that sets out their terms of residency. The agreement should be easy to read and understand.
93. HSC Trusts are reminded that their contracting duties do not end following placement and, where appropriate, assessment of the service user's financial resources. HSC Trusts should be actively engaged in ensuring that the service user's needs continue to be met and ensuring that terms and conditions are being fulfilled, that they are consulted about any necessary changes to these terms and conditions before they happen.

LEGISLATIVE CONTEXT

These key pieces of legislation provide the framework for the provision of community care services in Northern Ireland –

- (i) **Health and Personal Social Services (Northern Ireland) Order 1972**
 - places a duty on the HSC Board and HSC Trusts to provide or secure the provision of integrated health and personal social services to promote the physical and mental health, and social welfare of the people of Northern Ireland.

- (ii) **Chronically Sick and Disabled Persons (Northern Ireland) Act 1978**
 - identifies the need for and publication of information about services to promote the social welfare of chronically sick and disabled people; and relates to the provision of services to chronically sick and disabled people.

- (iii) **Mental Health (Northern Ireland) Order 1986**
 - outlines the general duty of the HSC Board and HSC Trusts to make arrangements designed to promote mental health, to secure the prevention of mental disorder and to promote the treatment, welfare and care of persons suffering from mental disorder.

- (iv) **Disabled Persons (Northern Ireland) Act 1989**
 - relates to appointment of authorised representatives of disabled persons, the assessment of needs of disabled persons and the duty to take into account the abilities of carers of disabled people.

- (v) **The Health and Personal Social Services (Assessment of Resources) Regulations (Northern Ireland) 1993**
 - set out the legislative context for the financial assessment of an individual's resources, in order to determine how much they can contribute towards the cost of personal social services provided in residential care and nursing homes.

- (vi) **The Carers and Direct Payments Act (Northern Ireland) 2002**
 - gives carers the right to an assessment of their own needs and allows HSC Trusts to provide personal social services to carers directly.

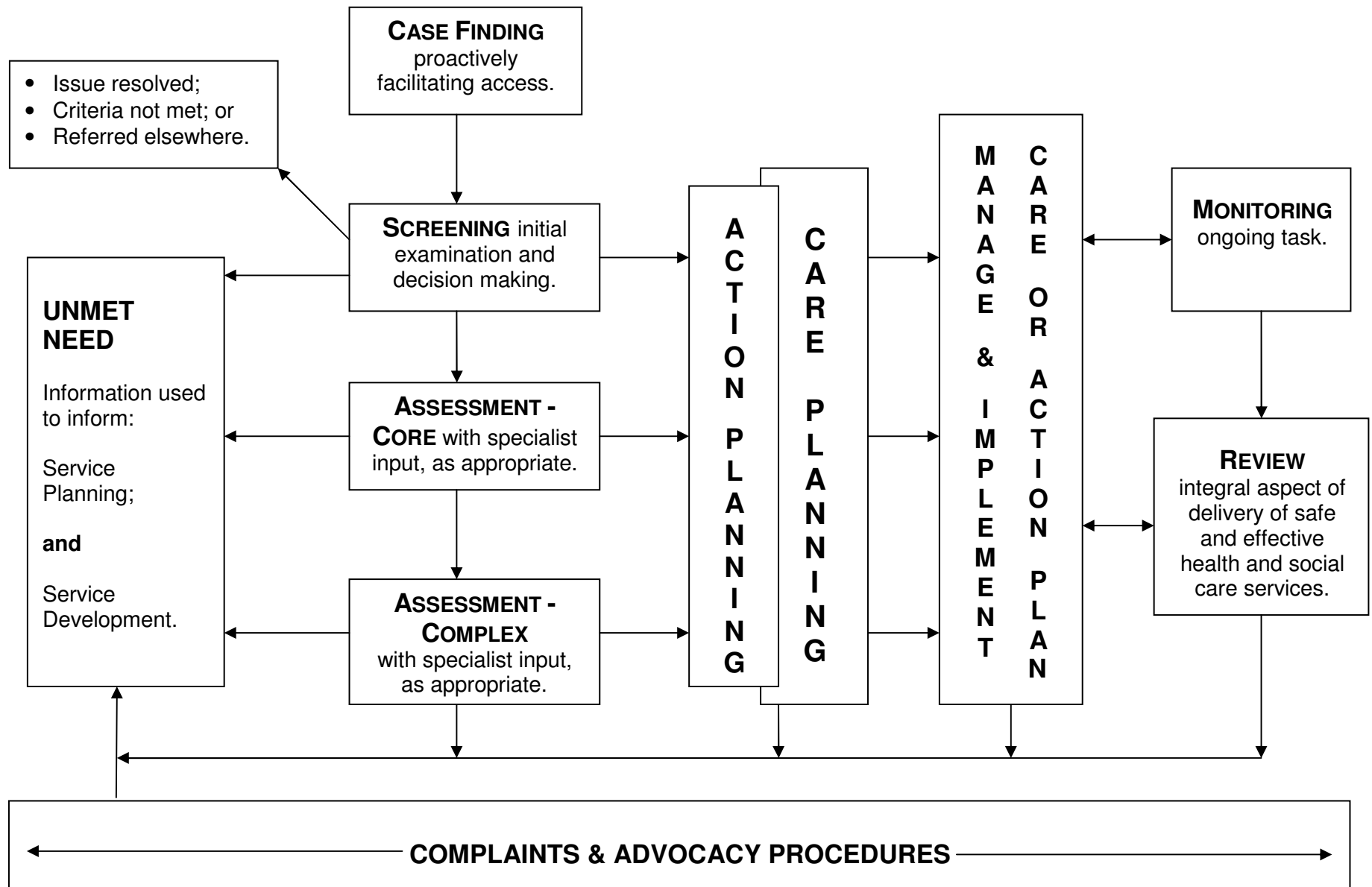
Key guidance documents include –

1. “People First: Community Care in Northern Ireland for the 1990s”, DHSS.
2. “Care Management: Guidance on Assessment and Provision of Community Care”, DHSS 1991.
3. “Establishing Area of Residence: Guidance for Purchasing”, issued by the DHSS 1996.
4. “From Hospital to Home” Social Services Inspectorate, DHSS, November 1997.
5. “Quality Standards Assessment and Care Management” Social Services Inspectorate, DHSS, October 1999.
6. The Health and Personal Social Services (Assessment of Resources) Regulations (Northern Ireland) 1993, and the accompanying manual “Charging for Residential Accommodation Guide” (CRAG), which provides information on how service users’ income and capital resources are to be calculated for the purpose of assessing their ability to pay for personal social services provided in a residential care or nursing home.
7. The Regional Protocol on delayed discharge related to patient choice, DHSSPS, December 2004.
8. Good Management, Good Records - Guidelines for Managing Records in Health and Personal Social Services Organisations in Northern Ireland, DHSSPS, December 2004,
9. Circular: ECCU 1/98 Discharge of Hospital Patients.
10. Circular: ECCU 1/2006 on the HPSS Payments for Nursing Care scheme.
11. Circular: HSS (ECCU) 1/2007, Direct Payments - Training of Personal Assistants.
12. Circular: HPSS (EPCC) 1/2007, Enhancing Primary and Community Care - Services Closer to Home.
13. Circular HSC (SQSD) 31/2007 Guidance on Complaints in Residential and Nursing Homes.
14. Circular HSS (ECCU) 2/2008, Regional Access Criteria for Domiciliary Care.
15. Residential Care Homes Minimum Standards, DHSSPS, January 2008.

Circular HSC (ECCU) 1/2010

16. Nursing Homes Minimum Standards, DHSSPS, January 2008.
17. Domiciliary Care Agencies Minimum Standards, DHSSPS, July 2008.
18. Complaints in HSC: Standards and Guidelines for Resolution and Learning, April 2009.
19. 'A Code of Practice on Protecting the Confidentiality of Service User Information', DHSSPS, January 2009.
20. Circular HSS (ECCU) 2/2009: Regional Carer's Support and Needs Assessment Tool, December 2009.

CARE MANAGEMENT – A DYNAMIC PROCESS



Glossary of Terms

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| Assessment | a person-centred process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated, undertaken with the individual, his/her carer and relevant professionals. |
| Care management | is a whole concept which embraces the key functions of: case finding; case screening; undertaking proportionate, person-centred assessment of an individual's needs; determining eligibility for service(s); developing a care plan and implementing a care package; monitoring and reassessing need and adjusting the care package as required. |
| Care package | a combination of services designed to meet a person's assessed needs. |
| Care plan | the outcome of an assessment. A description of what an individual needs and how these needs will be met. |
| Care planning | a process based on an assessment of an individual's need that involves ascertaining the level and type of support required to meet those needs, and the objectives and potential outcomes that can be achieved. |
| Care worker | a person who is paid to deliver care to an individual. |
| Carers | people who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability. |
| Main carer | the individual who, without payment, takes primary responsibility for providing help and support to a person who may not be able to manage at home without this help because of frailty, illness or disability. |
| Case finding | includes proactively publicising information about health and social care services and how to access them in an accessible, informative and 'user friendly' manner which will assist both those who are likely to require support and/or services, and referring agencies (including General Practitioners) in making appropriate referrals. |
| Case Management | describes the activity, included within the concept of care management, of advocating and co-ordinating services for a service user who needs this high level of support. |

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| Case manager | a practitioner who, as part of their role, undertakes case management, i.e. the individual who maintains a single, overview of the needs and progress of a service user who may have complex needs or be in contact with several practitioners or agencies; embedding a common language of assessment; care planning; response; and improving trust, communications and information sharing between the service user, carers (as appropriate), practitioners and service providers. The terms care manager , care co-ordinator or lead professional and, in the context of NISAT, Key Worker have also been used to describe this role. |
| Direct Payments | money paid by HSC Trusts that allows individuals to arrange for themselves the social care services required to meet their needs as assessed. |
| Disablement | in relation to persons, means that they are substantially and permanently handicapped by illness, congenital deformity, sensory impairment or any other prescribed disability. |
| Domiciliary/home care | the range of services put in place to support a person in their own home. |
| Financial assessment | The process by which HSC Trusts assess a service user's capital and income to determine the balance of how much he/she will be expected to pay towards the cost of their care in a residential care or nursing home, and how much will be funded by HSC Trusts. This is sometimes also known as a ' means test '. |
| Hospital discharge | the process of leaving hospital after admission as an in-patient. |
| Independent sector providers | includes private, voluntary and community organisations and social economy enterprises. |
| Intermediate care | a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable people to return home following hospitalisation; or to prevent admission to a long term residential care or nursing home; or intensive care at home to prevent unnecessary hospital admission. |
| Long term condition | Illnesses which lasts longer than a year, usually degenerative, causing limitations to one's physical, mental and/or social well-being. Long Term Conditions include Diabetes, COPD, Asthma, Arthritis, Epilepsy and Mental Health problems. Multiple long term conditions make care particularly complex. |
| Monitoring | ongoing oversight of people's needs and circumstances to ensure the quality and continued appropriateness of support and services |

to meet the agreed outcomes for the individual and, where appropriate, his/her carer(s). The person receiving the services, his/her authorised representative and carer(s), where appropriate, and service providers all have a part to play in formal and informal monitoring.

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| Normal hours | services provided during office hours or the normal working day, usually 9:00am to 5:00pm; Monday to Friday. |
| Nursing home | means, with specified exceptions, for example, a hospital, any premises used, or intended to be used, for the reception of, and the provision of nursing for, persons suffering from any illness or infirmity. |
| Out-of-hours | services provided outside of the normal working day, but not including “night-sitting” services, live-in or 24-hour services. |
| Personal care | <p>includes the provision of appropriate assistance in counteracting or alleviating the effects of old age and infirmity; disablement; past or present dependence on alcohol or drugs; or past or present mental disorder; and, in particular, includes:</p> <ul style="list-style-type: none">(a) action taken to promote rehabilitation;(b) assistance with physical or social needs; and(c) counselling, <p>but does not include any prescribed activity.</p> |
| Person-centred assessment | an assessment, which places the individual at the centre of the process and which responds flexibly and sensitively to his/her needs. |
| Private Funder | resident of a residential care or nursing home who arranges and pays for their own care under a private contract. |
| Representative | an individual who is authorised to act or advocate on behalf of another. |
| Residential care home | <p>an establishment is a residential care home, with specified exceptions, for example, a hospital, if it provides or is intended to provide, whether for reward or not, residential accommodation with both board and personal care for persons in need of personal care by reason of -</p> <ul style="list-style-type: none">(a) old age and infirmity;(b) disablement;(c) past or present dependence on alcohol or drugs; or |

(d) past or present mental disorder.

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| Respite care | temporary residential care, nursing home or social accommodation provided to an ill or disabled person to allow a carer a break from caring. Respite care may also be delivered in the service user's own home. The term short breaks has also been used. |
| Review | a planned procedure to determine whether or not the services supplied continue to meet the needs of the individual. |
| Screening | examining a referral to determine the most appropriate response and the further level of assessment that is required. |
| Self care/Self management | with appropriate support, many people can learn to be active participants in their own health and social care, living with and managing their conditions and meeting their own needs. This can help to prevent complications, slow down deterioration and even avoid getting further conditions and increased needs. The majority of people with long term conditions fall into this category - so even small improvements can have a huge impact. The development of direct payments for social care is an important development in the area of self care/self management. |
| Self funder | an individual who is assessed as able, or declares themselves able to meet the full cost of his/her care. |
| Service user | a person who is receiving or is eligible to receive health and social care services. They may be individuals staying in their own homes, living in residential care or nursing homes, or being cared for in hospital. |
| Sitting service | a service, which provides someone to sit with a person to allow the carer to take a break. |
| Specialist assessment | an assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care, for example, stroke, cardiac care, bereavement counselling. |