Department of Health & Social Care

NHS Continuing Healthcare Decision Support Tool

User Notes

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What is the Decision Support Tool (DST)?

1. The DST is a national tool which has been developed to support practitioners in the application of the *National Framework* for *NHS Continuing Healthcare and NHS-Funded Nursing Care* 2018 (the National Framework). The tool is a way of bringing together information from the assessment of needs and applying evidence in a single practical format to facilitate consistent evidence-based recommendations and decision making regarding eligibility for NHS Continuing Healthcare. All staff who use the DST should be familiar with the principles of the National Framework and have received appropriate training.

When should the DST be used?

2. The DST should be completed by a multidisciplinary team, following a comprehensive assessment and evaluation of an individual's health and social care needs. Where an assessment of needs has been recently completed, this may be used, but care should be taken to ensure that this remains an accurate reflection of current need.
3. The comprehensive assessment of needs should be in a format such that it can also be used to assist Clinical Commissioning Groups (CCGs) and local authorities to meet care needs regardless of whether the individual is found eligible for NHS Continuing Healthcare.
4. The assessment of needs should be carried out in accordance with other relevant existing guidance, making use of specialist and any other existing assessments as appropriate. The DST is not an assessment of needs in itself.
5. The assessment of needs that informs completion of the DST should be carried out with the knowledge and consent of the individual, and the individual should be given a full opportunity to participate. The individual should be given the opportunity to be supported or represented by a carer, family member, friend or advocate if they so wish. The eligibility assessment process should draw on those who have direct knowledge of the individual and their needs.
6. An individual will be eligible for NHS Continuing Healthcare where it is identified that they have a 'primary health need'. The decision as to whether an individual has a primary health need takes into account the legal limits of local authority provision. Using the DST correctly should ensure that all needs and circumstances that might affect an individual's eligibility are taken into account in making this decision. Primary health need is explained in paragraphs 54-66 the National Framework.
7. Completion of the tool should be carried out in a manner that is compatible with wider legislation and national policies where appropriate.

Note:

Whilst this document is intended to be as clear and accessible as possible, the nature of the NHS Continuing Healthcare process is such that some words used may not be immediately understandable to someone who is not professionally trained. As far as is possible, professionals completing the DST should make sure that individuals, and carers or representatives (where consent is given), understand and agree to what has been written. In some situations advocacy support may be needed.

How should consent be approached with the DST?

8. Where the individual concerned has capacity, their informed consent should be obtained before completion of the Decision Support Tool (if consent has not already been obtained when the Checklist was completed). This consent needs to cover both the completion of the tool and the sharing of relevant information between the professionals involved. Please see paragraphs 72-73 of National Framework which gives detailed guidance on what is required for consent to be valid.

9. If there is a concern that the individual may not have capacity to give consent to the assessment process or to the sharing of information, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. It may be necessary for best interest's decisions to be made, bearing in mind the expectation that all who are potentially eligible for NHS Continuing Healthcare should have the opportunity to be considered for eligibility. Guidance on the application of the Mental Capacity Act in such situations is provided in paragraphs 74-81 of the National Framework.

10. The fact that an individual may have significant difficulties in expressing their views does not of itself mean that they lack capacity to make a decision. Appropriate support and adjustments should be made available in compliance with the Mental Capacity Act and with equalities legislation.

11. Robust data-sharing protocols, both within an organisation and between organisations, will help to ensure that confidentiality is respected but that all necessary information is available to complete the DST. The duty to share information (for the purposes of providing an individual with health or adult social care) as set out in Section 251B of the Health and Social Care Act 2012 applies equally to assessments for NHS Continuing Healthcare as it does to other health and/or care and support assessments.

Who can complete the DST? The Multidisciplinary Team (MDT)

12. In accordance with regulations an MDT in this context means a team consisting of at least:

    - two professionals who are from different healthcare professions, or
    - one professional who is from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014.

13. Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs and, where possible, have recently been involved in the assessment, treatment or care of the individual. CCGs may use a number of approaches (e.g. face-to-face, video/tele conferencing etc.) to arranging these MDT assessments in order to ensure active participation of all members as far as possible

What is the role of the individual/representative in the assessment of eligibility process?

14. The individual should be invited to be present or represented wherever practicable. The individual and their representative(s) should be given reasonable notice of completion of the DST to enable them to arrange for a family member or other person to be present, taking into account their personal circumstances. If it is not practicable for the individual (or their representative) to be present, their views should be obtained and actively considered in the completion of the DST. Those completing the DST should record how the individual (or their representative) contributed to the assessment of their needs, and if they were not involved why this was.
15. Even where an individual has not chosen someone else to support or represent them, where consent has been given the views and knowledge of family members should be taken into account.
16. Completion of the DST should be organised so that the individual understands the process, and receives advice and information to enable them to participate in informed decisions about their future care and support. The reasons for any decisions should be transparent and clearly documented.

How should the DST be used?

17. All sections of the DST must be completed.
18. The DST is intended to support the process of determining eligibility, and ensure consistent and comprehensive consideration of an individual's needs. The evidence set out in the tool should be used by the MDT to help make a recommendation based on the four key characteristics of nature, intensity, complexity and unpredictability of need, as explained in paragraphs 147-152 of the National Framework and Practice Guidance note 3.
19. The DST requires the MDT to set out the individual's needs in relation to 12 care domains. Each domain is broken down into a number of levels, each of which is carefully described. The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided. This involves matching, as far as possible, the extent and type of the individual's specific needs with the descriptor in the DST that most closely relate to them. This approach should build up a detailed picture of needs and provide the evidence to inform the decision regarding eligibility. However an exact match will not always be possible and, apart from more obvious cases, the domain descriptor levels will not determine eligibility but merely help inform consideration of the "primary health need" test using the four key characteristics of nature, intensity, complexity and unpredictability. These four key characteristics should be applied to the totality of needs.

How are the care domains divided into levels of need?

20. Each domain is subdivided into statements of need representing no needs ('N' in the table below) low (L), moderate (M), high (H), severe (S) or priority (P) levels of need, depending on the domain (see Figure 1). The table below sets out the full range of the domains. The

detailed descriptors of them are set out in the 12 domain tables for completion later in this document.

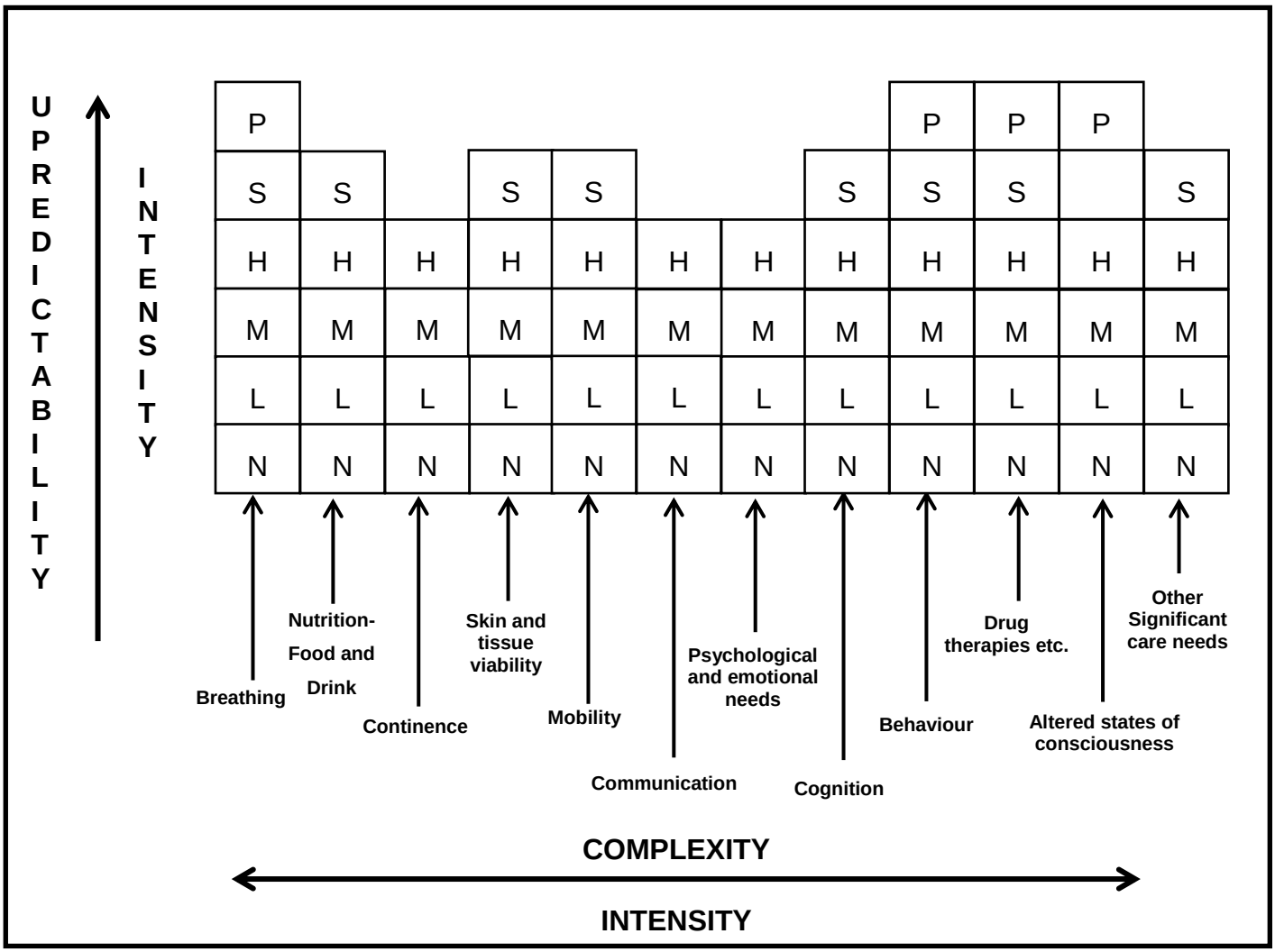

Figure 1: How the different care domains are divided into levels of need.

21. The descriptors in the DST are examples of the types of need that may be present. They should be carefully considered but may not always accurately describe every individual's circumstances. The MDT should first determine and record the extent and type of need in the space provided. If there is difficulty in placing the individual's needs in one or other of the levels, the MDT should use professional judgement based on consideration of all the evidence to decide the most appropriate level. If, after considering all the relevant evidence, it proves difficult to decide or agree on the level, the MDT should choose the higher of the levels under consideration and record the evidence in relation to both the decision and any significant differences of opinion. The MDT should not record an individual as having needs between levels. It is important that differences of opinion on the appropriate level are based on the evidence available and not on generalised assumptions about the effects of a particular condition or assumptions about the individual's needs.

22. Care should be taken regarding terminology. The fact that an individual has a condition that is described as ‘severe’ does not necessarily mean that they should be placed on the ‘severe’ level of a particular domain. It is the domain level descriptor that most closely fits their needs and the support they require that should be selected (for example, the fact that an individual is described as having ‘severe’ learning disabilities does not automatically mean that they should be placed on the ‘severe’ level of the Cognition domain, similarly an individual considered as having a high risk of falling might or might not fit the high level in the mobility domain).

23. The Fast Track Pathway Tool (rather than DST) should always be used for any individual with a rapidly deteriorating condition that may be entering a terminal phase. For other individuals who have a more slowly deteriorating condition and for whom it can reasonably be anticipated that their needs are therefore likely to increase in the near future, the domain levels selected should be based on current needs but the likely change in needs should be recorded in the evidence box for that domain and taken into account in the recommendation made. This could mean that a decision is made that they should be eligible for NHS Continuing Healthcare immediately (i.e. before the deterioration has actually taken place) or, if not, that a date is given for an early review.

24. It should be remembered that the DST is a record of needs and a single condition might give rise to separate needs in a number of domains. For example an individual with cognitive impairment will have a weighting in the cognition domain and as a result may have associated needs in other domains, all of which should be recorded and weighted in their own right (refer to Practice Guidance note 30).

25. Some domains include levels of need that are so great that they could reach the ‘priority’ level (which would indicate a primary health need), but others do not. This is because the needs in some care domains are considered never to reach a level at which they on their own should trigger eligibility; rather they would form part of a range of needs which together could constitute a primary health need.

26. Within each domain there is space to justify why a particular level is appropriate, based on the available evidence about the assessed needs. It is important that needs are described in measurable terms, using clinical expertise, and supported with the results from appropriate and validated assessment tools where relevant.

27. Needs should not be marginalised just because they are successfully managed. Well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an on-going need, such that the active management of this need is reduced or no longer required will this have a bearing on NHS Continuing Healthcare eligibility. This principle is incorporated into the domain descriptors of the DST. For example, in the behaviour domain the level of support and skill required to manage risks associated with challenging behaviour helps determine the domain weighting. In such cases the care plan (including psychological or similar interventions) should provide the evidence of the level of need, recognising that this care plan may be successfully avoiding or reducing incidents of challenging behaviour (refer to paragraphs 142-146 of the

National Framework and Practice Guidance note 23). For example, where psychological or similar interventions are successfully addressing behavioural issues, consideration should be given as to the present-day need if that support were withdrawn or no longer available and this should be reflected in the Behaviour domain.

28. It is not intended that this principle should be applied in such a way that well-controlled health conditions should be recorded as if medication or other routine care or support was not present. For example, where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain. Similarly, where an individual's skin condition is not aggravated by their incontinence because they are receiving good continence care, it would not be appropriate to weight the skin domain as if the continence care was not being provided (refer to paragraphs 142-146 of the National Framework).

29. There may be circumstances where an individual may have particular needs that are not covered by the first 11 defined care domains within the DST. In this situation, it is the responsibility of the assessors to determine and record the extent and type of the needs in the "additional" 12th domain provided entitled 'Other Significant Care Needs' and take this into account when determining whether an individual has a primary health need. The severity of the need should be weighted in a similar way (i.e. from 'Low' to 'Severe') to the other domains using professional judgement and then taken into account when determining whether an individual has a primary health need. It is important that the agreed level is consistent with the levels set out in the other domains. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility.

How should the DST be used to help to identify a Primary Health Need?

30. MDTs are required to make a recommendation as to whether the individual has a primary health need, and is therefore eligible for NHS Continuing Healthcare. This should take into account the range and levels of need recorded in the DST and include consideration of the nature, intensity, complexity and/or unpredictability of the individual's needs. Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs.

31. At the end of the DST, there is a summary sheet to provide an overview of the levels chosen and a summary of the individual's needs, along with the MDT's recommendation about eligibility or ineligibility. A clear recommendation (and decision) of eligibility for NHS Continuing Healthcare would be expected in each of the following cases:

    - A level of priority needs in any one of the four domains that carry this level.
    - A total of two or more incidences of identified severe needs across all care domains.

32. Where there is either

    - A severe level need combined with needs in a number of other domains or
    - A number of domains with high and/or moderate needs

This may also, depending on the combination of needs, indicate a primary health need and therefore careful consideration needs to be given to the eligibility decision and clear reasons recorded if the decision is that the person does not have a primary health need.

33. In all cases, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments should be taken into account in determining whether a recommendation of eligibility for NHS Continuing Healthcare should be made. It is not possible to equate a number of incidences of one level with a number of incidences of another level, as in, for example 'two moderates equals one high'. The judgement whether an individual has a primary health need must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of the individual's needs.

34. The recommendation should:

- provide a summary of the individual's needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs.
- provide statements about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these characteristics provided in paragraphs (refer to paragraphs 58-66 of the National Framework) of the National Framework.
- give an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability.
- in the light of the above, give a recommendation as to whether or not the individual has a primary health need (with reference to paragraphs (refer to paragraphs 58-66 of the National Framework) of the National Framework). It should be remembered that, whilst the recommendation should make reference to all four characteristics of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

What happens after the DST has been completed?

35. The coordinator should ensure that all parts of the DST have been completed, including the MDT's recommendation on eligibility (agreed/signed by MDT members), and forward it to the CCG for decision making. The coordinator should also advise the individual of the timescales for decision making (i.e. normally within 28 calendar days). In doing this, they should also check whether there is a need for urgent and/or interim support and liaise with the CCG and local authority to ensure that this is put in place where appropriate.

36. The equality monitoring data form should be completed by the individual who is the subject of the DST, but not if one has already been completed when screening with a Checklist and only if the individual agrees to this. Where the individual needs support to complete the form, this should be arranged by the CCG co-ordinator. The equality monitoring form should be forwarded to the appropriate location, in accordance with the relevant CCG's processes for processing equality data.

37. A copy of the completed DST (including the recommendation) should be forwarded to the individual (or, where appropriate, their representative) together with the final decision made by the CCG, along with the reasons for this decision. If someone is acting as the individual's

representative they are entitled to receive a copy of the DST provided that the correct basis for sharing such information has been established. This basis could be any one of the following:

a) consent from the individual concerned (where they have capacity to give this).

b) consent from a court appointed deputy (health and welfare) or someone who holds Lasting Power of Attorney (health and welfare) for that individual.

c) a "best interest" decision to share information made under the Mental Capacity Act (where the individual lacks capacity to consent to the sharing of information).

38. Where an individual lacks capacity but has an appointed Lasting Power of Attorney (property and finance), information (including a copy of the completed DST) should be shared in order for them to carry out their LPA duties, unless there are compelling and lawful reasons why this should not happen. If there is doubt in such cases advice should be sought.