MUCKARMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Dr Petra Corr

Date: 13 June 2023

I, Dr Petra Corr, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of the Northern Health and Social Care Trust (NHSCT) in response to a request for further evidence by the Inquiry Panel.

This is my second statement to the Inquiry.

In exhibiting any documents I will use my initials "PC" so my first document will be "PC1"

Section 1: Qualifications and position

1.1 Qualifications

Dr Petra Corr CPsychol; BSSc. Hons.; DClinPsych
HCPC registered Practitioner Psychologist.

Certificate in Health Services Management (UUJ)

Doctorate in Clinical Psychology (QUB)

MSc in Clinical Psychology (QUB)

BSSc. Single Hons. Psychology (QUB)

1.2 Position: Director of Mental Health, Learning Disability and Community Wellbeing within the Northern Health and Social Care Trust

Further Requested Information for Inquiry following the Hearing on 5 April 2023 at which Dr Petra Corr gave evidence on behalf of NHSCT.

Section 2: Modules to be addressed

Module 2: Health Care Structures and Governance, points (g) and (i).

Section 3: Module 2g (Interrelationship between Trusts re patients admitted to Muckamore)

3.1 Q1 Page 10 of Transcript - Please confirm the size of the population covered by NHSCT at present.

The Northern Health Social Care Trust Population is approximately 485,681 (NISRA, mid-year 2023-24).

3.2 Q2 Page 11 of Transcript - Please provide and exhibit to your statement the Care Management Procedure.

Please find attached at exhibit PC1, Circular HSC (ECCU) 1/2010 issued by the Department of Health, Social Services and Public Safety on Care Management, Provision of Services and Charging Guidance (2010) and the NHSCT Care Management Guidelines to support the implementation of Circular HSC (ECCU) 1/2010 guidance at exhibit PC2.

3.3 Q3. Page 26 of Transcript - Please confirm the number of patients who used MAH over the various years that come from the NHSCT prior to 2016.

Date	Total number of NHSCT Admissions		Patients with multiple admissions						
			2	**3**	**4**	**5**	**6**	**7**	**11**
2008	15								
2009	25		1						
2010	35		1						
2011	40		1		1				
2012	33		5						
2013	63		3	4	1			1	1
2014	48		3	1		1	1		
2015	51		6	2				1	
2016	42		9	1	2				
2017	45		2	1	2				
2018	22		2						
2019	4								
2020	1								
2021	1								

3.4 Q4. Page 28 & 29 of Transcript - Project Lead Post – how long did this post exist prior to 2007?

As my previous statement declared, I can only provide information in relation to the Northern Trust which was established in 2008.

3.5 Q5. Page 32 & 33 of Transcript - '*In 2015 the Northern Health and Social Care Trust initiated Muckamore Admission and Discharge Meetings, which were a formal interface meeting to discuss the progress of patients who had been admitted to hospital.*'

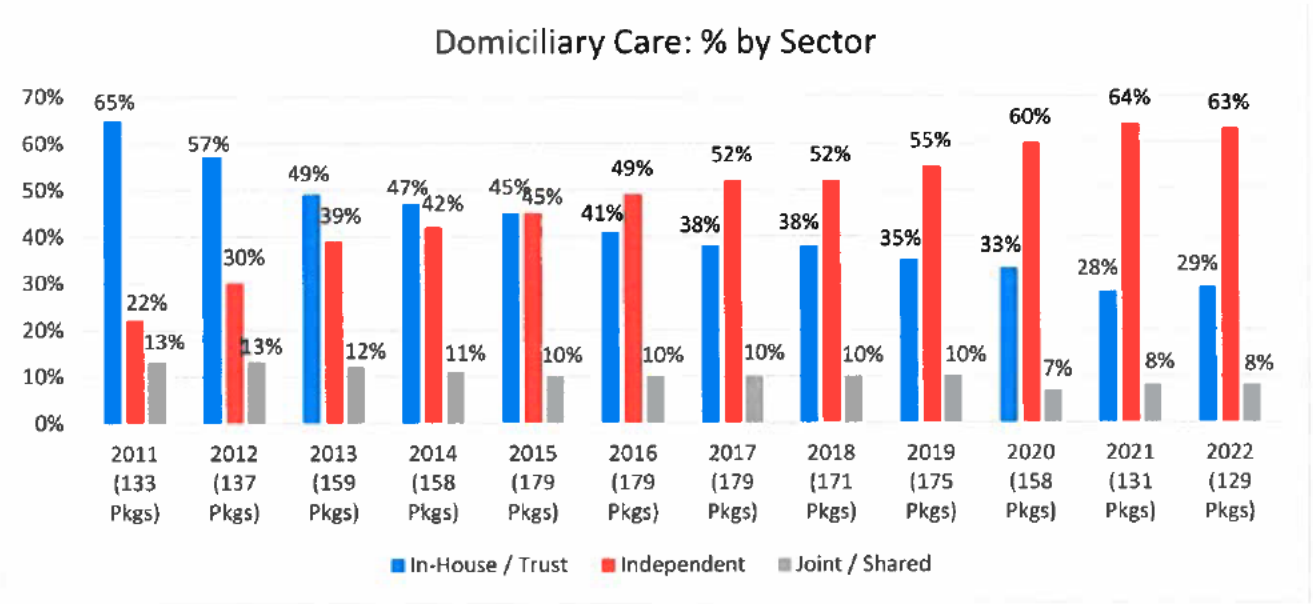
Is there a written down guidance or policy document as to the establishment of those meetings, when meetings started, what the purpose of them is, and how frequently they're to be conducted.

Please see attached policy at Exhibit PC3.

3.6 Q6. Page 60 of Transcript - Audit of Admissions carried out in 2018 – to look at impact on service on admissions to hospital. Revolving door admissions. Inquiry requested copy of audit.

Audit of Admissions carried out in 2018 is attached at Exhibit PC4.

3.7 Q7. Page 66 of Transcript - Provide information in relation to the split between statutory and private providers across all packages of care and specifically learning disability.



3.8 Q8. Page 67 of Transcript - Graph at paragraph 4.5.2 of Dr Corr's statement shows number of direct payments but not financial costs. Inquiry asked if that data re financial cost is available.

YEAR	DPs	Value (£)
2012	56	£380,512.75
2013	64	£441,968.84
2014	74	£590,056.13
2015	98	£745,767.51
2016	110	£956,515.32
2017	135	£1,276,034.12
2018	158	£1,543,131.31
2019	190	£1,903,769.65
2020	214	£2,300,938.75
2021	240	£2,619.923.28

Section 5: Declaration of Truth

The content of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed:
Dr Petra Corr, Director of Mental Health, Learning Disability and Community Wellbeing

Date: 15 June 2023

Table of Contents

Circular HSC (ECCU) 1/2010

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk
AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

To: Chief Executives HSC Board, PHA, HSC Trusts
Chief Executive, RQIA
Chief Executive, Patient and Client Council

Copy: Directors of Finance HSC Board and HSC Trusts
Director of Social Care and Children's Services, HSC Board
Executive Directors Social Work, HSC Trusts

Date: 11 March 2010

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 manager[4] 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

ENQUIRIES

Enquiries about this circular should be addressed to:

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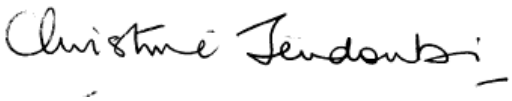


CHRISTINE JENDOUBI
Director of Primary and Community Care

CONTENTS

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;

- 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 sector[8] 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 Living[9]) 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 Care[11] 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 serous 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

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 manager[14] 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/

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 Council[18] 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 servicer 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

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

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.

ANNEX A

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.

ANNEX B

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.

16. Nursing Homes Minimum Standards, DHSSPS, January 2008.

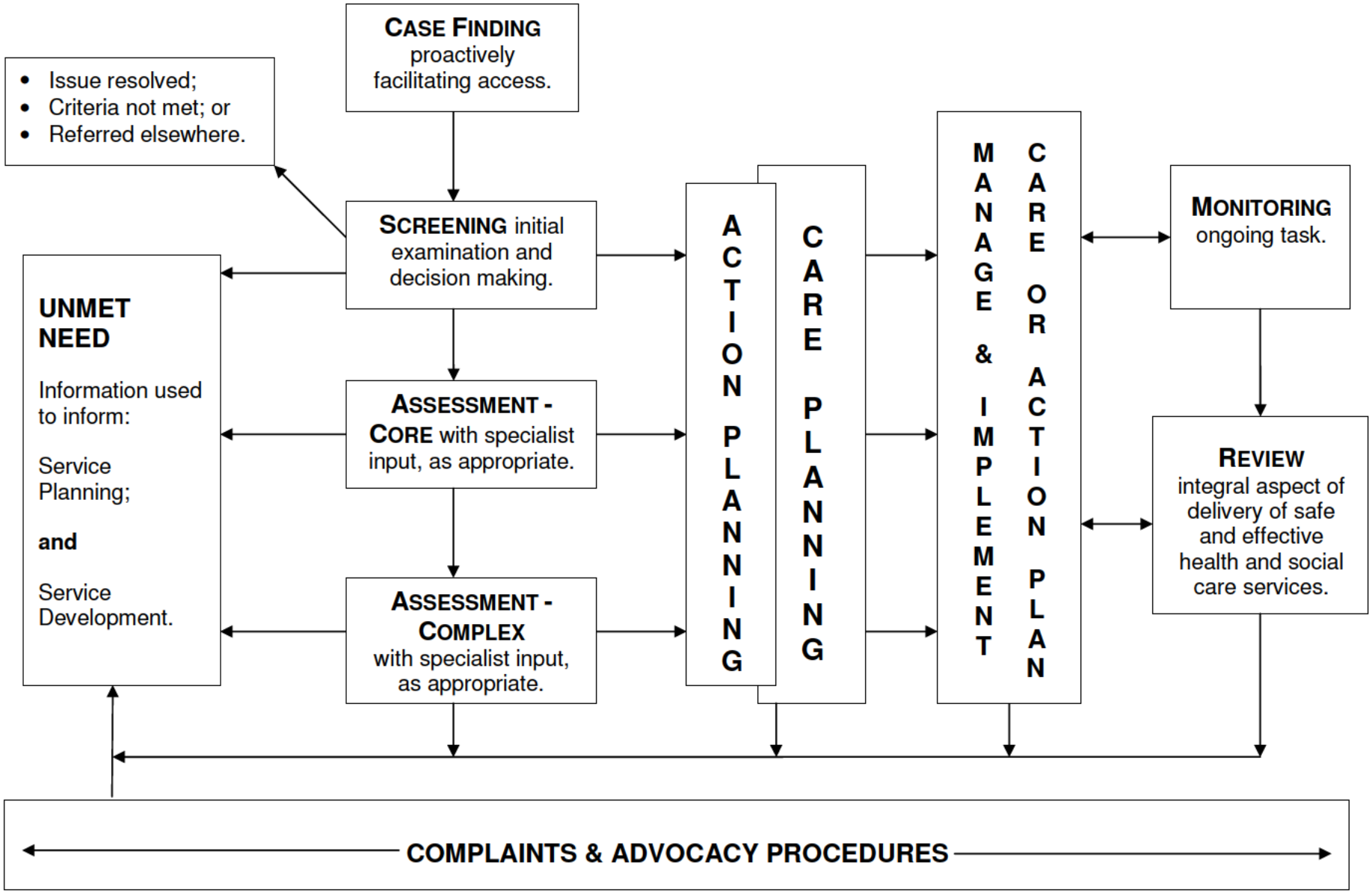
17. Domiciliary Care Agencies Minimum Standards, DHSSPS, July 2008.

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



ANNEX D

Glossary of Terms

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.

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.
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	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: (a) action taken to promote rehabilitation; (b) assistance with physical or social needs; and (c) counselling, but does not include any prescribed activity.
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	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 - (a) old age and infirmity; (b) disablement; (c) past or present dependence on alcohol or drugs; or

(d) past or present mental disorder.

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.

This is an official Northern Trust policy and should not be edited in any way			
Please note that the policy library on Staffnet will contain the most up to date version of Trust policies			
Reference No:	**NHSCT/20/1508**		
Title:	**Care Management Guidelines – To support the implementation of Circular HSC (ECCU) 1/2010 guidance**		
Key words within policy (max 10 words)	Care Management Criteria Assessment Case Management		
Policy Author(s):	Wendy Longshawe, Community Lead for Physical Disability Alyson Dunne, Assistant Director Learning Disability Melanie Phillips, Assistant Director, Community Care Diane Spence, Assistant Director, Mental Health Catherine Cassidy, Assistant Director, Social Work & Social Care Governance Pauline Cummings, Head of Service, Adult Learning Disability Margaret Diamond, Professional Lead for Community Nursing Anita White, Lead For Acute Care of Elderly Services & Hospital Social Work Maureen Serplus, Head of Mental Health Services for Older People Caroline McGonigle, Social Work & Social Care Governance Manager Jacqueline Tomlinson, Team Manager, Permanent Placement Team David McIlwaine, Finance Manager		
Responsible Director:	Petra Corr, Director of Mental Health, Learning Disability and Community Wellbeing		
Policy Type:	Trust Wide ☒	Division Specific ☐	
	Profession led ☐	Clinical and/or social care ☒	Specialist Committee ☐
Policy Replacement:	Yes ☒ No ☐	Care Management Guidelines **NHSCT/16/1031**	
Directors/Divisions policy to be issued to:	Nursing and User Experience☐ Medicine and Pharmacy ☐ Finance and Estates Services ☒ Medicine and Emergency Medicine ☐ Human Resources, Organisational Development and Corporate Communications ☐ Community Care ☒ Surgical and Clinical Services ☐ Mental Health, Learning Disability and Community Wellbeing ☒ Women, Children and Families ☐ Strategic Development and Business Services ☐		
Target Audience, ie, specific staff groups	This policy is directed to Social Work, Nursing, Allied Health Professionals, Finance staff and staff working with adult patients in both the hospital and community setting		
Approved by:	*Dr Kate Scott & Mrs Suzanne Pullins* Co-chairs, Clinical and Social Care Policy and Guidelines Committee	10 January 2020	
Operational Date:	11 January 2021	**Review Date**	30 June 2023
Policy Library Categories: (Please tick as appropriate)	Clinical and Social Care - Hospital (incl Comm Hosp) ☐ Clinical and Social Care - Children's Hospital & Community ☐ Clinical and Social Care - Community ☐ Clinical and Social Care - Mental Health and/or Learning Disability ☒ Children's Nursing ☐ Maternity & Gynae ☐ Estates ☐		

	Health & Safety	☐	Human Resources	☐
	Palliative Care	☐	Major Incident Plan	☐
	Infection Control	☐	Information Management	☐
	Family Planning	☐	Allied Health Professions	☐
	Finance	☐	Trust Wide	☒
	Safeguarding Children	☐		
NHSCT Vision **To deliver excellent integrated services in partnership with our community**				

Care Management Guidelines - To support the Implementation of Circular HSC (ECCU) 1/2010 Guidance

Contents **Page No**

Care Management Guidelines

1.0 Introduction

This policy provides guidance for staff to ensure consistency on the application of Care Management principles and procedures within the Mental Health, Learning Disability and Community Wellbeing Division, Community Care Division, Medicine and Emergency Medicine Division and the Surgical Division.

2.0 Underpinning Principles

A number of principles underpin the Care Management Process.

Staff should:

- intervene no more than is necessary;
- treat people as individuals and prevent oppressive practices and discrimination
- 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;
- advocate for service users where appropriate
- 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.

Staff engaged in the care management process must also be alert to their responsibilities as detailed in the NHSCT Standards of Business Conduct, Impartial, honest and open in their work. (Appendix 1)

3.0 Responsibilities

Directors are responsible for the dissemination and implementation of this guidance within the divisions.

Line managers are responsible for ensuring that staff have a working knowledge of and adhere to the guidance and that any amendments are disseminated.

All staff are responsible for familiarising themselves with and adhering to this guidance'.

4.0 Definition of Care Management

Care management is defined as being "focused on people with complex, or frequently or rapidly changing needs, or on people with more straight forward and stable needs but where services or service providers need to be coordinated and undertaken by a range of professionally qualified staff in social work and health, with appropriate training skills and experience". People who should be considered for care management in all 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;
- 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; please note the need for respite does not mean an automatic need to be care managed
- 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).

Please note the decision to implement care management processes remains a professional decision between the professional involved and their line manager. Once discussed a record must be made in the service user's file to reflect that consideration of the care management process has been made and the decision to proceed either as care managed or non-care managed/ level 1 must be clearly stated. When a service user's situation reflects any of the examples described above, this does not mean an automatic management under care management processes. These processes should only be used where it is deemed appropriate and to the service user's benefit.

Professionals are required to use the care management process for the purpose it is intended and not subject service users to this process unnecessarily.

Service users in receipt of independent service providers, or respite, or deemed incapable of managing their own finances should no longer automatically be care managed. Equally, the level of care provided in terms of domiciliary hours should not on its own determine whether the service user should automatically be care managed.

4.1 Care Management Criteria to be applied

Cases which should be considered as possibly benefitting from the care management process should be those that indicate;

- A high level of dependency; and
- A high level of risk; and
- A high level of service input

OR

- It is likely that there may be a need for institutional care.

4.2 Care Management Process

Management or senior management approval and oversight are required in the care management process.

Named Workers in consultation with their Team Leader/Senior Practitioner will identify when service users meet the criteria to be care managed. All

assessments, care plans and reviews must be signed off by the Team Leader/Senior Practitioner to ensure compliance with the care management standard.

An effective care management process requires certain key functions to be carried out. These may be separated into the following distinct stages:

1. Case Finding;
2. Screening;
3. Assessment of Need;
4. Care Planning;
5. Managing and Implementing the Care Plan;
6. Monitoring implementation of the Care Plan; and
7. 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).

4.3 Case Finding

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.

4.4 Screening

At the point of referral the screening of the information contained within the referral may determine if care management process is appropriate. However it will not always be clear at this stage as further information obtained through the assessment process may determine more appropriately if the service user meets the criteria to be supported through the care management process. Following an initial assessment the service users' needs may be determined to be best met outside care management processes.

Where the service user does not meet the criteria for care management, the referral will remain with the professional for access to a particular service. This will be deemed a level 1 case.

Clear evidence must be included in the service users file as to whether they are care managed or non-care managed. This decision should be made in consultation with the line manager and the joint decision reflected in the records.

Where the service user meets the criteria for care management the referral will be allocated by the Team Manager to the most appropriate professional for co-ordination of the multi-disciplinary assessment. At this point this professional becomes the named worker for the service user. This will be deemed a level 2 case.

Team leaders will be responsible for maintaining an accurate list of care managed cases for their team. This will be used to inform service planning and future audit of practice.

4.5 Assessment of Need

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.

Decisions about longer-term care should in MOST instances not be made in hospital settings, it is recognised that in certain exceptional circumstances that the multi-disciplinary team assessment is that long term care is in the patient's best interest when discharging from hospital. Such decision will have been made in consultation and with the agreement of the community named worker.

(Note: While NISAT is the regional tool of choice it is acknowledged that other assessments continue to be used).

Where alternative assessments are used they should clearly reflect compliance with numbers 1 – 7 on pages 5 & 6.

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:

4.6 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".

4.7 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.

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.

4.8 Care Planning

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 plans must be person-centred and focused on preserving or restoring as far as possible the individual's capacity for independent living.

The care plan should include:

- The service users strengths and identified needs reflecting the holistic assessment and including physical, emotional, social, mental health, emotional, spiritual, financial, and personal relationships (where appropriate)
- Clearly identified Deprivation of Liberty issues and Human Right considerations
- 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 family/carer(s);
- Unmet needs, areas of disagreements and contingency arrangements
- 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 named worker, and the person to be contacted in emergency situations if this is different from the named worker
- Monitoring arrangements and review date
- 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.
- A record of who has received copies of the care plan or requested not to receive a copy
- Signatures of service user where appropriate and a note recorded as to why the Service User did / could not sign

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. 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.

Unmet needs must be recorded on the individuals care plan 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.

4.9 Managing and Implementing the Care Plan

Managing the care plan will require the named worker 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 named worker 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 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, taking into account the experience/views of service users and carers, and service providers, and that they inform changes in care or service provision.

- Ensure that any charges that could be made by the Service Provider are stated clearly to the Service User and documented regarding agreement by the Service User / family as appropriate.

4.10 Monitoring Implementation of Care Plan and Review

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.. Arrangements for monitoring should be part of the service specifications and the named worker 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.

Consideration should be given at the review process as to whether or not the service user requires to remain care managed/level 2 or should now be non care managed / level 1.

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.

Line managers must ensure that all care managed cases are reviewed as per the agreed time scales. Where the named worker is absent the line manager must put appropriate arrangements in place. Any issues in this regard should be escalated to senior management

The named worker 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 care 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;
- consent from the service user to share relevant information from the review and the updated care plan, where appropriate, with those involved in delivering the care and / or services, as required, and with the carer, where applicable.

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Review is an integral part of care delivery and is particularly important in care managed situations in view of the complexity of need and resources involved. The named worker 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. All dates of review should be recorded on the Care Plan.

4.11 Role of the Named Worker

The role of **named worker** will be undertaken by suitably trained professional staff.

The named worker may change as the service user's needs change to ensure they receive the most appropriate services to meet their individual needs.

The main responsibilities of the **named worker** will include:

- Co-ordinating and collating the health and care assessment information where this is undertaken by a number of professions
- Co-ordinating the completion of a Carer's assessment, where appropriate
- Exploring care options arising from the comprehensive assessment
- Initiating the financial assessment process associated with elements of the package
- Ensuring that a personalised care plan in place / developed which reflects the Service User's health and social care needs
- Implementation and monitoring of the care plan
- Responding to emergencies or breakdown in care arrangements
- Monitoring overall quality and effectiveness of the care package
- Reviewing the domiciliary care package, as required and no less frequently than six monthly
- Review of people in permanent care should be annually
- Multi-disciplinary liaison, as required
- Visiting the service user. The level of contact between service user and named worker/carer will be determined by the level of complexity and identified risks and should be agreed with the named worker's Team Leader/Senior Practitioner.

4.12 Role of Staff Contributing to the Care Management Process

Care management is a holistic approach to meet the assessed needs of service users and carers. It requires that all staff involved have ownership and assume their responsibility in contributing to assessment, care planning, monitoring and review.

The main responsibilities of all staff will be:

- Be available in a timely fashion to provide professional assessments
- Full completion of all assessment paperwork within agreed timeframes
- Provide professional summary and recommendations post assessment to inform care plan
- Input to the care plan
- Attendance at reviews as requested by named worker or submission of written report where appropriate if unable to attend
- Communicate with the named worker regarding any significant changes which requires the care to be adjusted/modified
- Undertake tasks agreed at assessment or reviews in a timely fashion and communicate outcomes to named worker
- Communicate with the named worker when their involvement is deemed no longer to be required
- Maintain records of communication and contact in a legible manner and in a manner which reflects the standards required

Named Workers and their Team Leaders/Senior Practitioners must ensure that appropriate file records are maintained at each stage of the care management process in line with best practice and Standards for Assessment and Care Management (DHSS 1999) and Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance.

4.13 Supervision Process

During operational supervision all care managed cases will be reviewed and any areas of concern should be discussed with the Team Leader/Senior Practitioner. This will be documented and actions required will be undertaken within agreed timescales. Named workers and their supervisor who is responsible for the quality of the supervisee's performance against the care management standards, must ensure all care management cases are discussed in supervision and evidence of the discussion and actions agreed must be recorded on the supervision record. The frequency of how often each individual case will be discussed will depend on the complexities of the case in addition to the stage the case is within the care management process. This means that not *all* care managed cases will be discussed in each supervision. All new assessments, care plans and reviews must be presented in supervision (either formal or informal) and be approved and signed by the supervisor. Equally, where there are increased levels of concerns or risks the case should be *brought* back to supervision by the named worker/key worker.

Supervision is a two-way process and there are responsibilities placed on named workers to highlight issues of concern regarding the cases they are currently responsible for. Likewise Team Managers have a responsibility to ensure that a systematic process is in place to monitor the management of all cases and in particular care managed cases.

There is an expectation that Team Leaders/Senior Practitioners can demonstrate that they are regularly reviewing case records to ensure that all appropriate documentation is being completed in full and all agreed actions are being carried out within agreed timescales.

Senior managers who directly supervise and are accountable for Team Leader's practice have a responsibility to ensure supervision arrangements are robust and care managed cases are considered.

4.14 Transfer of Cases

All transfer of cases must be planned. Where it is indicated that a case is being transferred from another team, a review should be convened by the named worker who is currently responsible for the case. It is essential that the receiving Team Leader/Senior Practitioner is notified, invited to the review and the case record shared with the Team Leader/Senior Practitioner prior to the review so he/she can make an informed decision on who is best placed to take on the named worker role. The named worker designate should also be

in attendance at the review and have had an opportunity to apprise themselves of relevant issues of the case through a file review.

A summary of the key issues must be compiled by the named worker in preparation for the transfer and be shared with all relevant staff.

4.15 Unmet Need

Where the assessment and care planning process identifies unmet need which represents an unacceptable level of risk to the service user or carer, this must be documented in the care plan and a risk management strategy adopted, based in the Risk Management in Direct Care Situations (NHSCT, 2010). It must be recognised that risk management is a process that will involve the engagement of all relevant professionals, service users and family members. It is most likely that case discussions will facilitate this process and any documentation arising from such case discussions must clearly demonstrate the risks identified, the options discussed and the actions required to manage these risks. There will be shared accountability for the decisions made.

4.16 Situations where service user or carer are not complying with the recommended care plan

Where any staff member becomes aware of service user or carer not complying with the recommended or agreed care plan, it is their responsibility to report this to the named worker. The named worker will then be responsible for addressing this issue with the service user/carer and informing their Team Manager. Guidance on consent and capacity will inform staff as to how to address such situations. Where non-compliance constitutes a risk to the service user/carer/staff, a risk management strategy must be adopted based on Risk Management in Direct Care Situations (NHSCT, 2010). Case discussions will facilitate this process and the documentation arising from such case discussions must clearly demonstrate the risks identified, the options discussed and the actions required to manage these risks. There will be shared accountability for the decisions made.

4.17 Communication between Staff and Agencies

Communication between staff will be facilitated with the introduction of multi-disciplinary case records, where multi-disciplinary teams exist.

In situations where other professional staff are involved in providing care, written communication prior to or attendance at reviews should be requested by the named worker. The identification of staff involved with a service user will be facilitated by the named worker completing a check list of staff and service involvement which will be updated prior to each review.

Where there are difficulties being experienced by a named worker in obtaining a response from any service/staff, the Team Manager should be alerted and

they in turn should alert the relevant service manager. These actions should be documented in the case record.

4.18 Decisions in relation to capacity

Adults are always presumed to be capable of making their own decisions, unless it is demonstrated that they are unable to do so. Where a Professional is concerned that a service user does not have the mental capacity to make a specific decision, they should undertake or arrange as appropriate an assessment of the person's capacity in relation to the decision to be made. Capacity assessments are decision specific, at a point in time.

The ability of an individual to make financial decisions should be discussed at the assessment, care planning and review stages and recorded in the personal plan of care.

Individuals must be assumed to have capacity to take their own financial decisions unless it has been established they lack capacity. There must be clear assessments detailing exactly what capacity the service user has, what limits they are able to manage independently and also with assistance.

Where an individual's mental capacity is in doubt, the principles outlined in the Mental Capacity Act (NI) 2016 (not yet fully enacted) will provide clear direction to staff. Staff in the interim are required to follow the "Best Interest" decision making practice principles. Where there are adequate formal or informal arrangements for support in place, this should be noted in the assessment. If there are no arrangements, or those in place are unsatisfactory, the Named Worker and Team Leader/Senior Practitioner need to identify what could ensure proper safeguards.

The ability of an individual to make financial decisions should be discussed at the assessment, care planning and review stages and recorded in the personal plan of care.

Individuals must be assumed to have capacity to take their own financial decisions unless it has been established they lack capacity. There must be clear assessments detailing exactly what capacity the service user has, what limits they are able to manage independently and also with assistance.

Where an individual's mental capacity is in doubt, the Capacity Act will provide clear direction to staff however as it is not yet in place staff are required to follow the Best Practice principles. Where there are adequate formal or informal arrangements for support in place, this should be noted in the assessment. If there are no arrangements, or those in place are unsatisfactory, the Named Worker and Team Leader/Senior Practitioner need to identify what could ensure proper safeguards.

This could range from having an agreed agent collect their pension, seeking an Appointee to handle welfare benefit entitlement through the Department of Work and Pensions, or seeking the protective oversight of the Office of Care

and Protection. The Named Worker and Team Leader/Senior Practitioner may wish to seek advice from a range of sources about the most appropriate and least restrictive options available for the service user.

The level and type of support required (including its limits) should be clearly stated in the personal plan of care drawn up to meet the identified needs. The service user should be encouraged to contribute to their plan as fully as they are able. The plan should clarify an individual's vulnerability whether through physical or sensory disability, fluctuating conditions affecting mental health or mental capacity, or longer term conditions which limit decision making. It should include contingency arrangements where changes to an individual's circumstances, such as fluctuating mental capacity, can be anticipated.

Named Worker and Team Leader must ensure there are secure written records of all financial transactions where staff spend any money on behalf of the service user.

5.0 FINANCES

Please refer to NHSCT Service Users' Finances (Management of) as referenced in Evidence Section.

The Named Worker must discuss all cases where staff are involved in managing finances in operational supervision with their Line Manager or with the professional supervisor who also provides operational supervision, and verification must be recorded to demonstrate proper management. A clear line of accountability must be set out and clearly evidenced through Named Worker – Operational Manager – Locality Manager/AGM/GM – Heads of Service – Assistant Directors and Directors.

Health and Social Care staff should not become involved in handling a service user's money or affairs except in exceptional circumstances, see below.

A case note should be made at the assessment and review stage detailing the circumstances in which it became necessary to handle the service user money/affairs. This record should include when and by whom a capacity assessment was completed.

A plan should be made regarding how to manage a similar situation in the future e.g. consider whether longer term support is required to manage finances/affairs. (Enduring Power of Attorney/Guardianship)

Each assessment, care plan and review should include details of how the service user's finances are being managed. In situations where staff are involved in supporting the management of finances, a clear record of these decisions and processes must be maintained and discussed in full by the named worker/support worker with the supervisor. Receipts must be countersigned and verified as being accurate as well as being maintained for audit purposes.

5.1 Guidance to all staff

- This process should only occur in exceptional circumstances (for example when a service user, who is incapacitated, requires urgent essential shopping undertaken and has no other form of assistance).

- Agreement from a Line Manager/Professional Supervisor must be sought prior to the Health & Social Care staff member undertaking any management of finances. This must be recorded in supervision and the client file.

- Receipts should be obtained which detail individual items purchased; these must be returned to the service user.

- Receipt books must **always** be used for **any** financial transaction made on behalf of an individual, no matter how small. Keeping a receipt book will protect you from any misunderstandings.

- Heads of Service/Locality Managers/AGMs must satisfy themselves that the teams/services they are responsible for are maintaining care management processes and the required practice as detailed in this guidance through regular audit and sampling of files in supervision with their operational supervisors.

- Any financial transaction on behalf of a service user should be undertaken on the same day and on no account should money or effects be taken home overnight. Appropriate arrangements must be agreed with the Line Manager.

- If you lose any money or property belonging to a service user you must report it immediately to your Line Manager and complete an Incident Report, otherwise you could be accused of theft.

- You must not accept any gifts, services, cash or vouchers from service users.

- You must not become involved in Wills or Bequests.

- Never use your own loyalty cards when shopping for service users.

- Never borrow from, nor lend money to service users.

- Do not sell or dispose of property belonging to a service user.

- Do not sell or give anything to a service user eg catalogue shopping.

- Do not offer to provide a service to an individual eg gardening.

- Do not look after any property belonging to a service user, no matter how short a time.

- If it is agreed necessary to remove amounts of cash/effects from a service users home for safekeeping, two members of staff are required to be present.

- In no circumstances should staff obtain or use a service users credit/debit cards or PIN number to withdraw cash or make purchases.

- In an urgent situation where access is required to cash and Social Security fund is not appropriate/available, a request should be made to access Article 15 funds.

A training programme will be developed and provided by the Social Services Training Department in partnership with CCE to support the implementation of this guidance.

6.0 OTHER GUIDANCE/ADVICE:

General Social Care Council Codes of Practice
Specifically but not exclusively Standard 2 “strive to establish and maintain the trust and confidence of service users and carers”, Standard 5 “uphold public trust and confidence in social care services”.

6.1 Evidence Base/References

Standards for Assessment and Care Management (DHSS 1999)

Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance

Risk Management in Direct Care Situations (NHSCT, 2010)
http://policies.northerntrust.hscni.net/download/58/clinical-social-care-mental-health-learning-and-physical-disability/1359/risk-management-in-direct-care-situation-nhsct14813-tw-mh.doc

Mental Capacity Act (NI) 2016

NHSCT Service User Finances (Management of)
Available via the following link http://policies.northerntrust.hscni.net

6.2 Equality, Human Rights and DDA

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories.

The policy has been **'screened out'** without mitigation or an alternative policy proposed to be adopted.

6.3 Alternative formats

This document can be made available on request on disc, larger font, Braille, audio-cassette, easy read and in other minority languages to meet the needs of those who are not fluent in English.

6.4 Sources of Advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

6.5 Personal & Public Involvement (PPI)/Consultation Process

Consultation on this guidance took place with the following:

- Anita White, Head of Hospital Social Work
- Roy Hamill, Assistant Director Primary Care, Care of Older People Services
- Wendy Magowan, Assistant Director Primary Care, Care of Older People Services
- Marlyn Grant, Service User Consultant
- Ann Cardwell, Volunteer, Mental Health Older People Services

Review of the Guidelines took place with the following

- Wendy Longshawe, Community Lead for Physical Disability
- Alyson Dunne, Assistant Director Learning Disability
- Melanie Phillips, Assistant Director, Community Care
- Diane Spence, Assistant Director, Mental Health
- Catherine Cassidy, Assistant Director, Social Work & Social Care Governance
- Pauline Cummings, Head of Service, Adult Learning Disability
- Margaret Diamond, Professional Lead for Community Nursing
- Anita White, Lead For Acute Care of Elderly Services & Hospital Social Work
- Maureen Serplus, Head of Mental Health Services for Older People
- Caroline McGonigle, Social Work & Social Care Governance Manager
- Jacqueline Tomlinson, Team Manager, Permanent Placement Team

7.0 Policy Sign Off:

Diane Spence

_____

Policy Author Date: 30 September 2020

Roy Hamill Date: 11 January 2021

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Director of Community Care

Petra Corr Date: 11 January 2021

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Director of Mental Health, Learning Disability and Community Wellbeing

APPENDICES

Appendix 1

Standards of Business Conduct

Information for Staff

General Principles

All staff must be impartial, honest and open in our work for the Trust.

Staff are all expected to:

- make sure that the interests of service users and clients remain paramount at all times;
- be impartial and honest in the conduct of official business;
- declare any involvement with private companies or contractors as these may present a compromise or conflict of interest with the position they hold.
- Declare employment in any private enterprise
- use the public funds entrusted to the best advantage of the service by always making sure there is value for money
- always make choices and decisions on the basis of merit when carrying out public business.

Staff must also make sure that they do not:

- abuse their official position for personal gain or to benefit family, friends,
- undertake outside employment that could compromise Trust duties; nor
- seek to advantage or further private business or other interests in the course of official duties.

Staff must make sure that they are not placed in a position which risks, or appears to risk, a conflict between private interests and health and social care duties.

This primary responsibility applies to all staff especially those who commit resources directly by requisitioning and ordering goods or those who do so indirectly by, for example, prescribing medicines.

You could also have a personal or financial interest in a private nursing or residential home or other private care provision or services and be involved in the assessment, care planning or discharge of patients and clients to residential facilities or domiciliary care.

Do:

- make sure you understand the guidelines on Standards of Business Conduct and consult your manager if you are not sure;
- make sure you are not in a position where your private activities/ responsibilities and Trust duties may conflict;

- declare any relevant interests in writing and seek permission prior to taking on outside work to confirm there is no potential conflict of interest ;
- obtain written permission from your manager before seeking or accepting commercial sponsorship;
- Comply fully with the contents of the Trust's Anti-Bribery Policy.

Do not:

- accept any gifts, inducements or hospitality which might compromise your position as a public servant or conflict with your Trust duties;
- abuse your past or present official position to obtain preferential rates for private deals;
- unfairly advantage one competitor over another or show favouritism in awarding contracts;
- be involved in any Trust process where you have external connection to parties involved in that process;
- Misuse official information.

It is a requirement of the Trust that all staff declare relevant interests and abide by the established guidelines on Standards of Business Conduct. These are available on the Trust website or from your manager.

This information will be held on a register and made available for inspection by the public.

If in doubt, ask yourself these questions:

- Am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment with the Trust?
- Do I have access to information which could influence purchasing decisions?
- Could my outside interests be in any way detrimental to the Trust's provision of health and social care services or to the interests of patients and clients?
- Do I have any other reason to think that I may be risking a conflict of interest?

If you are still not sure – **declare it!**

<u>The Law</u>

The Bribery Act 2010 came into effect on 1 July 2011. This abolished all existing UK bribery laws and replaced them with a suite of new very different offences.

All staff must be aware that it is an offence corruptly to accept any inducement or reward for doing, or not doing, anything in your official capacity. You should not corruptly show favour or disfavour if you are handling contracts.

You should be aware that you will be prosecuted if you breach the provisions of the Act. You may lose your job and your superannuation rights.

Our Policy

We aim to adhere to the guidance set out in Circular HSS (GEN1) 1/95 issued by the HSS Executive in October 1995.

You could be disciplined if you do not declare a relevant interest or if you abuse your official position.

We have also developed a Whistleblowing Policy so that you can voice complaints or concerns about breaches of this guidance or other concerns of an ethical nature. This is available from your manager.

If you have any queries or want to clarify any of these matters, please write to:

Chief Executive Office
Bretten Hall
Antrim Area Hospital
Bush Road
Antrim
BT41 2RL

Appendix 2 Care Management Guidance for Staff/Named Workers

1. Case Finding
- Provide service users/carers with user friendly information regarding care management processes and services.
- Respond to referrals in a timely manner.
- Retain referral in service user file.

2. Screening
- Following Assessment, Named Worker (Supported by Manager/Senior Practitioner) decides if service user meets Criteria for Care Management or is a Non Care Managed Case. Cases requiring care management and multidisciplinary assessment of need include those that indicate:-
  - A high level of dependency; and
  - A high level of risk; and
  - A high level of service input
    OR
  - It is likely that there may be a need for institutional care.
- Record outcome of professional decision to care manage case or not in service user file.

3. Assessment
- For Service Users with functional mental health care needs or learning disability complete QPC documentation .
- PQC documentation not required if NISAT/e-NISAT completed for service users with dementia.
- Complete NISAT for individuals with physical disability and older people.
- Staff in HSW, Learning Disability and Adult Mental Health Teams to use existing assessment tools.
- Ensure signed consent for assessment is obtained.
- Evidence service users/carers strengths, preferences, needs and risks in assessment.
- Promote rehabilitative, strengths based approach.
- Maximize opportunities for service user independence and ability to live at home.
- Presume capacity to make decisions and manage finances.
- Seek decision specific capacity assessment as appropriate where there is cognitive impairment.
- Offer Carer Assessment as appropriate.
- Retain signed copy of assessment in service user file.
- Ensure information regarding Self Directed Support Provided.
- Provide sufficient information to service users/carers throughout assessment process to support informed decision making

4. Care/Support Planning

Care plans should:
- Prescribe service users strengths, needs, preferences, risk, DOL and detail service provision, monitoring and review.
- Identify contingency arrangements and unmet needs and how these will be managed.
- Decisions regarding long term care should not normally be made in hospital setting, unless MDT recommend there is no other appropriate discharge option.
- Complete NHSCT revised Care Plan/Bridging Care Plan/Personal Care/Support Plan as appropriate including monitoring arrangements, consent to share information.
- Provide signed copies of Care Plan as appropriate.
- Record completion date and schedule timely review.
- Retain signed copy of Care Plan in service user file.

5. Implementation
- Named worker responsible for:-
- Specifying services required.
- Completing paperwork to access services
- Securing funding.
- Negotiating with service providers and ensuring adherence to care plans to promote positive outcomes for service users /carers.
- Maintaining service user file/records.

6. Monitoring & Review
- Carry out timely reviews including carer reviews as appropriate.
- Co-ordinate a holistic review, linking with other professionals as required.
- Consider service user capacity in respect of decisions and finances as appropriate.
- Consider consent to share information/minutes.
- Ensure Care Plan revised and copies provided as appropriate.
- Provide signed copies of review minutes.
- Retain signed copy of review in service user file.
- Consider should service user continue to be Care Managed and record outcome of professional decision in service user file.

Ensure practice meets Standards of Business as identified in Appendix 1 of Care Management Guidelines

Appendix 3 Audit Reference

D	T	L	SU
Case Type			
CM		NCM	

CASE FILE/ CARE MANAGEMENT FILE AUDIT FORM

	Evident in case file			In correct file section		
Front Cover and Inside Front Pages of File	Yes	No	N/A	Yes	No	N/A
1. Personal Details are up to date in file						
2. EPEX/ SOS-CARE / Health number on front of file						
3. Up-to-date page 7 / service details stapled to inside front of file (if appropriate)						
Referral/Screening/Assessment/Risk Assessment	Yes	No	N/A	Yes	No	N/A
4. Referral form completed						
5. Evidence of Screening/professional decision making to determine proportionate assessment of need based on individual's presenting circumstances (i.e. Level 1 (Non-Care Managed Case or Level 2 Care Managed case) *Should be evident in referral/assessment documentation or contact records*						
6. Completed assessment of physical, emotional, psychological, spiritual, financial, social, personal relationship, strengths, needs and risks *(e.g. Initial assessment, core, complex, specialist, CMA, NISAT on file)*						
7. Relevant assessment/NISAT Consent Form signed by service user / carer						
8. Copy of signed assessment shared with service user / carer/ relevant others, if consent obtained, as appropriate						
9. Managing Risk in Direct Care situations Proforma completed, as appropriate						
10. Evidence of capacity assessment – regarding management of finances, as appropriate						

11. Evidence of capacity assessment – regarding ability to make informed decisions, as appropriate						
12. Evidence of best interest planning, as appropriate						
13. Referral to Office of Care & Protection, as appropriate						
14. Guardianship documentation evident *(Legal Section), as appropriate*						
15. Mental Capacity Act (NI) 2016 documentation evident						

	Evident in case file			In correct file section		
Care Plan File Section	Yes	No	N/A	Yes	No	N/A
16. Named Worker to ensure copy of Care Plan held and maintained on file						
17. Care Plan signed by service user / carer, where appropriate or recorded refused to sign or lacks capacity						
18. Copy of Care Plan provided or offered (may have refused same) to service user/carer/consultant/others						
19. Care Plan content must evidence : Person centred referencing holistic strengths, needs and choices/preferences, aimed at preserving independence						
20. Deprivation of Liberty issues/least restrictive options referenced as appropriate (applicable cases 7/8/12 onwards)						
21. Objectives and outcomes						
22. Monitoring arrangements						
23. Review date						
24. Consent obtained from service user / carer to share Care Plan with salient parties						
Review Section	Yes	No	N/A	Yes	No	N/A
25. Evidence of review occurring in accordance with timescale referenced in Care Plan if appropriate or sooner if required						
26. Copy of most recent review in file						
27. Review signed by service user / carer						
28. Consent obtained from service user/						

carer to share review minutes/ revised care plan/ service plan as appropriate with salient parties						
29. Copy of review minutes/report provided or offered to service user/carer/home/service provider, where appropriate						
30. Changing needs or circumstances recognised / re-assessed by named worker during review						
31. Care Plan/Service Plan revised by named worker as required to reflect change in needs / circumstances / identify management of unmet needs						
32. Copy of Revised Care Plan shared with salient parties as appropriate						
33. Review to facilitate Transfer of case in community settings/teams, as applicable						
On Hospital Admission Case files must evidence collaborative working	Yes	No	N/A	Yes	No	N/A
34. Recent assessments, care plans, reviews forwarded to HSW in line with Protocol for sharing Info in respect of known service users						
	Evident in case file			In correct file section		
Hospital Discharge/Transfer Arrangements Case files must evidence collaborative working:	Yes	No	N/A	Yes	No	N/A
35. Agreed Care Plans/ Service Plans informed by the assessment process are completed and shared with salient parties (e.g. service user, carer, service provider, primary care professionals) in advance of discharge to clarify actions/equipment required to facilitate a safe discharge.						
Running Records File Section	Yes	No	N/A	Yes	No	N/A
36. Running Records are up to date						
37. Contacts (dated and signed, no gaps)						
38. Records completed in a legible manner						
39. Records filed in order						
40. Evidence of decision making (i.e. action plans discussed at MDT meeting/supervision evident in running records / client case supervision records) Reference to service user views and agreed service provision						

Domiciliary Care Forms/ Direct Payments	Yes	No	N/A	Yes	No	N/A
41. All relevant forms on file						
42. Original Self Directed Support / Direct Payments forms in file						
43. Copy of Employer's Liability Policy Schedule on file						
44. Are original DP forms on file						
45. Has DP5 been completed in last 12 months						
46. Have Access NI checks been completed within 3 years (if applicable)						
CBPU Forms Section	Yes	No	N/A	Yes	No	N/A
47. All relevant forms on file						
Financial Approval	Yes	No	N/A	Yes	No	N/A
48. Authorisation of services evident e.g. DCAF Forms/ RPP1 indicate budget holder, contact records should evidence approval from budget holder						
49. If yes, financial implications discussed with service user/ carer e.g. Short Breaks Contribution, undertaking to pay, contacts etc. *(see contact records)*						
Correspondence File Section (correspondence / reports / email)	Yes	No	N/A	Yes	No	N/A
50. Evidence of engagement with relevant professionals / agencies						
Carer's Assessment *(not a specific section in file)*	Yes	No	N/A	Yes	No	N/A
51. Evidence that a Carer's Assessment offered						
52. Carer's Assessment/Review/Re-assessment on file						

Total Hours Domiciliary Package		None	1-10	10+
Other service	Supported Living	Day or Adult Centre	Placement – temporary	Placement – permanent
	Short Break	Intermediate Care Bed		Day Opportunities
	Direct Payments			

Issues/Concerns identified from Care Management audit of file

Positive practice/adherence to Trust policies / procedure

Auditor Name (Capitals)	
Audit Date	

Significant issues raised with Team Leader?

Yes ☐ No ☐ N/A ☐

Case file/Care Management Audit Feedback Template

Division:	Service User Name:
Team:	Soscare Number:
Locality:	

Significant issues/concerns identified from review of file

Auditor Signature:	**Date of Audit:**
Team Leader signature:	**Date shared with Team Leader:**

NHSCT Meeting to Review Muckamore Admissions and Discharges

Terms of Reference

Role

The remit of the Muckamore Admissions and Discharges Meeting is to review patterns in admissions and discharges to Muckamore Abbey Hospital (MAH) in order to allow for consideration of the best possible spectrum of delivery of assessment and treatment services for people with a learning disability who live in the NHSCT area. This is undertaken within the framework of the Directorate Governance Framework which is reviewed on an annual basis by the DGT:

Functions

- To review patterns of recent admissions to MAH and consider the themes of gaps in service provision within the community. To consider the other supports and assessments that were carried out in the community and what community based interventions and supports could be developed or delivered that would have made a difference for that person's pathway.

- To consider the other supports and assessments that were carried out in the community and what community based interventions and supports could be developed or delivered that would have made a difference for that person's pathway.

- To review patterns of recent discharges from MAH and consider the themes of gaps in service provision within the community that would facilitate smoother and more timely discharge. To consider the other supports, assessments and interventions that were carried out in hospital and how these can be delivered or developed in the community.

- To consider those currently receiving treatment in MAH and consider if any of these interventions could be developed or delivered in the community.

- To provide assurance that assessment and treatment services for people within NHSCT operate smoothly across the steps of care – considering in particular any impact of cross Trust working within these steps of care.

- To assure that staff across both NHSCT and Muckamore Abbey Hospital involved in the assessment, treatment and support of people with a LD are fully engaged or represented in review of these services in order to enhance the quality of the services delivered

- To consider Health and Safety issues.

- To consider any other C&SCG issues or concerns as raised by or brought to the meeting by members.

Agreed 19.9.16

Frequency

These meetings will occur on a quarterly basis.

Core Membership

The Core Membership from NHSCT will comprise the Head of Psychological Services; the Assistant Director of Learning Disability Services; Team Leaders for Community Treatment Services (Positive Behaviour Support Service and PROMOTE); Consultant Psychiatrist for community treatment services; Head of Services for Community LD Teams; Team Managers from Community LD Teams. In addition the Consultant Psychiatrists for community teams in the NHSCT will be present (these are employed by BHSCT).

The Core Membership from MAH will include the Consultant Psychiatrists for Cranfield; Lead Nurse for MAH; Ward Managers for Cranfield.

The meeting will be co-chaired by the Head of Psychological Services from NHSCT who has lead responsibility for provision of community based treatment services and [redacted], Assistant Director for Learning Disability Services NHSCT

Lists of individuals who will be discussed at the meeting will be collated by MAH admin services and will be circulated by NHSCT admin staff in advance of the meeting.

NHSCT Audit of Admissions to Muckamore Abbey Hospital (2013-2018)

Introduction

This audit has been prepared at the request of Mr [redacted] (Director, Mental Health, Learning Disability and Community Well-being Division)

Outlined below is a *preliminary* summary of admissions to Muckamore Abbey Hospital (MAH) for NHSCT service users over a five year period (between 2013/14 and 2017/18. This is based upon data provided by Medical Records at Muckamore Abbey Hospital, minutes of the NHSCT 'Admissions and Discharges Meeting' and information provided by the NHSCT's Rapid Assessment Interface Discharge (RAID) Service, based in Causeway and Antrim Emergency Departments. Information has also be requested in relation to admissions to MAH from other HSC Trusts and also LD contacts with the Regional Emergency Social Work Service (RESW); however to date this has not been received.

1) NHSCT Admissions to Muckamore Abbey Hospital

Table 1. NHSCT admissions to MAH per month and year (13/14 to current year)

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Total
13/14	6	3	3	3	5	6	9	9	6	5	2	2	59
14/15	7	2	4	2	3	6	6	4	4	5	6	6	55
15/16	4	7	2	4	3	3	4	4	1	5	6	4	47
16/17	2	3	7	3	0	5	4	2	2	3	1	6	38
17/18	8	3	1	3	4	5	4	2	5	1	1	3	40
18/19	3	5	4	2	-	-	-	-	-	-	-	-	14

Table 1 highlights a reduction in admission to Muckamore over the five-year period in question. Indeed, when comparing 2013/14 to 2017/18, the number of admissions has reduced by approximately one third.

Table 2. Breakdown of* NHSCT *admissions to MAH per year by admission ward

	General admissions	Sixmile	Iveagh (children's)	Total
13/14	57	2	0	59
14/15	53	1	1	55
15/16	46	0	1	47
16/17	37	1	0	38
17/18	34	3	3	40
18/19 (Apr-July)	13	0	1	14

Table 2 provides a breakdown of admissions and separates general adult admissions from adults admitted to Sixmile Ward and children admitted to Iveagh.

2) Repeat Admissions

From reviewing the data provided, it was apparent that some service users had multiple admissions during each year. The tables below provide a breakdown of the number of admissions per service user for that year.

Table 3. Admissions to MAH per year by no. of admissions per service user (13/14)

No. of admissions	No. of service users	Total Admissions
1	26	26
2	4	8
3	3	9
4	0	0
5	0	0
6	0	0
7	1	7
8	0	0
9	1	9
Total	35	59

Table 4. Admissions to MAH per year by no. of admissions per service user (14/15)

No. of admissions	No. of service users	Total Admissions
1	30	30
2	3	6
3	1	3
4	0	0
5	0	0
6	0	0
7	1	7
8	0	0
9	1	9
Total	36	55

Tables 3 and 4 highlight that during both 2013/14 and 2014/15, one service user had 7 separate admissions and one service user had 9 admissions.

Table 5. Admissions to MAH per year by no. of admissions per service user (15/16)

No. of admissions	No. of service users	Total Admissions
1	23	23
2	1	2
3	6	18
4	1	4
Total	31	47

Table 6. Admissions to MAH per year by no. of admissions per service user (15/16)

No. of admissions	No. of service users	Total Admissions
1	18	18
2	3	6
3	3	9
4	0	0
5	1	5
Total	25	38

Table 7. Admissions to MAH per year by no. of admissions per service user (17/18)

No. of admissions	No. of service users	Total Admissions
1	26	26
2	2	4
3	2	6
4	1	4
Total	31	40

The tables above highlight that there are fewer service users experiencing very high number of multiple admissions in more recent years, when compared to 2013/14 and 2014/15. Multiple admissions are still occurring, however, and a further analysis of these individuals is necessary.

3) Length of admission

The data provided has allowed for analysis of length of admission. The table below highlights the length of admission, grouped into categories, by number of admissions.

Table 8. Length of stay per admission by year

	0-3m	**3-6m**	**6-12m**	**12m+**	**Remains in-patient**
13/14	52 (88.1%)	2 (3.4%)	0 (0%)	5 (8.5%)	2
14/15	44 (80%)	2 (3.6%)	2 (3.6%)	7 (12.8%)	2
15/16	37 (78.7%)	4 (8.5%)	1 (2.1%)	5 (10.7%)	2
16/17	26 (68.4%)	5 (13.2%)	3 (7.9%)	4 (10.5%)	3
17/18	22 (55%)	6 (15%)	9 (22.5%)	3 (7.5%)	8
18/19	8	6	0	0	3

The table above highlights that the length of the majority of admissions are between 0-3 months in duration. Admissions during 2016/17 and 2017/18 appear to have been longer, however, with a greater number of service users remaining in the hospital for between 3m to 12m. This potentially highlights an issue with the discharge process, which was been acknowledged at a recent meeting held at Muckamore, chaired by Dr C Milliken. This may be due to difficulties maintaining placements during an admission and identifying appropriate placements for people upon discharge.

4) NHSCT Service Developments

During the past five years, NHSCT LD Services have implemented a number of initiatives in attempt to reduce admissions to Muckamore, where possible. Brief details of these are provided below:

i. Admissions and Discharges meetings commenced in 2013. Senior Managers within NHSCT Learning Disability Services, Community Team Managers, Consultant Psychiatrists and Muckamore Abbey representatives attend these meetings. All admissions and discharges over the previous three-month period are reviewed. Community supports that may help address difficulties for particular service users are identified. In addition, it allows service users who have had multiple admissions to be identified and alternative or additional supports are discussed. As an example, the service user in 2013/14 who had 9 admissions was identified and alternative community supports and interventions (including DBT) were introduced. Following this, the number of admission for this service user has significantly reduced.

ii. In 2012, an analysis of MAH admissions highlighted that the vast majority were not known to NHSCT's Challenging Behaviour Service. Admissions were largely in relation to service user's mental health or forensic needs. In 2014, NHSCT's Promote Service became operational which was able to offer more intensive support to service users experiencing mental health difficulties or who had forensic needs. This has led to an increase in community-based interventions (e.g. DBT) for this client group. In 2016 further service development saw the introduction of the 'Intensive Support Service' (ISS) which provides an 'in reach' service to clients experiencing a crisis or facilitate an admission to a community respite or assessment/intervention bed.

iii. As mentioned above, Community Treatment Services (PBSS, Promote and ISS) have access to an emergency respite bed in Woodford Park, Coleraine (10 days per month). In addition, there is a bed based in Hollybank Respite Unit, which provides access to a community based assessment and intervention as an alternative to admission to hospital, if appropriate. The addition of the ISS has helped increase the use of this bed as they can provide additional support to facilitate an admission.

iv. In addition to the above, staff working within the Community Team's for People with a Learning Disability (CTPLD) also provide interventions and implement strategies aimed at reducing admissions, on both a proactive basis and in response to a crisis. Crisis interventions include arranging emergency respite, arranging emergency psychiatric review, increased contact with family and service user and providing information to RESW in advance. Teams have recently started recording all potential admissions that have been prevented, and this will be useful to analyse at a future date to identify those strategies that are most effective.

v. In 2017, RAID began to provide assessments to people with a learning disability who presented at an Emergency Department. These assessments have proved very effective and RAID have developed excellent links with Learning Disability Services. Care pathways have been produced and a reporting proforma is completed by the RAID Practitioner following any contact with someone with a learning disability, which allows timely follow up by services involved in their care. Quarterly RAID/LD Interface Meetings have been established to review service users seen for assessment to allow patterns and service users frequently attending RAID to be identified.

Information provided by RAID in relation to contacts and admissions for people with a learning disability is provided below. This highlights that 12% of services users seen for assessment were admitted in year one and 7.5% were admitted in year 2. This reduction is likely due to improved interface working between RAID and LD Services.

Table 7. LD referrals to RAID and admissions to MAH by month per year

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July	Total
Aug16-Jul 17	Referrals	3	4	3	3	7	6	8	7	12	4	4	12	73
	Admissions	0	1	3	0	1	0	1	1	2	0	0	0	9
Aug17-Jul 18	Referrals	5	9	2	5	6	6	7	10	15	5	7	3	80
	Admissions	1	3	0	0	0	0	0	0	2	0	0	0	6

5) Summary and recommendations

The preliminary analysis in this report highlights that, overall, the total number of admissions to MAH have generally been reducing since 2013/14. This is within the context of the wider resettlement process of long stay patients and therefore more complex people living in the community

Some service users continue to be admitted on multiple occasions and further analysis to identify potential reasons for this is required.

Whilst the number of admissions seem to be reducing, the proportionate length of admissions appears to have increased. It is possible that this is due to people with more complex needs being admitted, necessitating a longer treatment period. In addition, it is possible that some placements may have been terminated by providers during an admission, which results in LD Services having to identify new placements, inevitably delaying the discharge process. Issues with the discharge process has been identified during recent meetings with MAH personnel and other HSC Trusts. NHSCT has agreed to engage with MAH and independent providers at a much earlier stage to address this issue.

A further analysis of bed days across this five year period would be helpful to gain more information about length of admissions and the use of the hospital more generally.

As mentioned at the beginning of this report, this is a *preliminary* analysis of information received to date. Further information will be requested in relation to out of hours referrals to RESW which have led to admissions. Information regarding admissions from other HSC Trusts will also allow comparison with NHSCT admissions, accounting for population sizes.

A period of further analysis as detailed above will also allow NHSCT LD Services to identify further areas of service development in the future. This will include further support for people outside of normal working hours and access to dedicated community assessment and intervention beds.

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21 September 2018