

Dear Colleague

Hospital Based Complex Clinical Care

Summary

1. This letter provides guidance on Hospital Based Complex Clinical Care and replaces guidance on NHS Continuing Healthcare contained in CEL 6 (2008).
2. This guidance is effective from Monday 1 June 2015. The Scottish Government will monitor the application of the guidance.

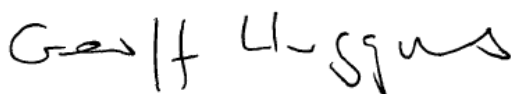
Background

3. On the 2 May 2014, the then Cabinet Secretary for Health and Wellbeing, published the Independent Review of NHS Continuing Healthcare and announced he was accepting the recommendations of the report. He committed to revising guidance by Spring 2015. This guidance fulfils that commitment.

Action

4. Chief Executives and Chief Officers of Integration Authorities must ensure that this guidance is circulated widely and brought to the attention of all relevant staff.

Yours sincerely



GEOFF HUGGINS

DL (2015) 11

28 May 2015

Addresses

For action

Chief Executives, NHS Boards
Chief Officers of Integration
Authorities
Medical Directors, NHS Boards
Nurse Directors, NHS Boards
Directors of Social Work, local
authorities

For information

NHS Board Chairs
Chief Executives, Special Boards
Chief Executives, local
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INTRODUCTION

1. On 2 May 2014 the [Independent Review of NHS Continuing Healthcare](#)¹ was published. The then Cabinet Secretary for Health and Wellbeing accepted all nine recommendations with the key recommendation to replace [NHS Continuing Healthcare CEL 6 \(2008\)](#)² which the review established was no longer fit for purpose.

“This report makes a number of recommendations for reforming NHS Continuing Healthcare and putting in place a system which will be applied consistently and transparently by all NHS Boards.

Where patients are assessed as needing this form of acute long-term care the expert group make clear that the most effective and safe way to deliver this is in a hospital setting.”

**Alex Neil, MSP, the then Cabinet Secretary for Health and Wellbeing
Scottish Government News Release – 2 May 2014**

2. The aim of this new guidance is to make the clinical decision more transparent with the primary eligibility question simply being “**can this individual’s care needs be properly met in any setting other than a hospital**”³ The outcome of this question needs to be discussed, documented and explained fully with individuals, families and carers.

3. For some individuals across Scotland, Hospital Based Complex Clinical Care will be required and this may mean a longer stay in hospital. The key aim for anyone that does need to be in hospital for a longer period of time is to get them well enough to return to whatever setting is most suitable for them in the community while ensuring that all health or social care needs are supported.

4. With integration of health and social care starting from April 2015, we will see the most substantial reform to the NHS in Scotland in a generation, transforming the way social care services are provided too. In broad terms, the aims of the Public Bodies (Joint Working) (Scotland) Act 2014 are:

- to improve the quality and consistency of care for patients, carers, service users and their families;
- to provide seamless, joined up care that enables people to stay in their homes, or another homely setting, where it is safe for them to do so; and
- to ensure that resources are used effectively and efficiently to deliver services that meet the needs of the growing population of people with longer term and often complex needs, many of whom are older.

¹ Independent Review in NHS Continuing Healthcare – 2 May 2014

² NHS Continuing Healthcare CEL 6 2008 – 7 February 2008

³ For the purpose of this guidance “a hospital” is any inpatient facility fully funded and managed by the NHS in Scotland.

5. Health Boards and Local Authorities along with the third and independent sectors will work together differently in order to ensure people in communities are supported to improve their lives and outcomes. The delivery of NHS and social care services will be responsive to population need. **It will require the workforce in all settings to work very differently with more healthcare provided in a community setting.** As far as possible it will see care being taken to the individual rather than the individual being taken to the care.

6. The reform of the NHS Continuing Healthcare policy provides an early example of how health and social care services can be delivered differently, not only for the future ageing population with increasing complex needs, but for all adult health and social care services across Scotland.

7. Strategic Commissioning plays a vital role in the integration of health and social care. Effective commissioning is at the heart of ensuring that the care people receive is seamless, with all organisations working together to improve outcomes of individuals receiving care.

Revised Guidance

8. This guidance is not merely a clarification of the NHS Continuing Healthcare policy that has been in place – rather, it is a fundamental reform of how we support people who have on-going clinical needs. This guidance seeks to abide by a number of core principles:

- As far as possible, hospitals should not be places where people live – even for people with on-going clinical needs. They are places to go for people who need specialist short-term or episodic care. Hospitals are highly complex institutions which should focus on improving the health of people with acute conditions before discharging them back into the community.
- The NHS in Scotland has a duty to provide healthcare. In a hospital setting, in order to fulfil that duty, the NHS will provide food and accommodation. However, when someone is living in the community, it is not the role of the NHS to pay for accommodation and living costs⁴ – other arrangements and support mechanisms are in place for that. Financial support for living costs should be considered on the basis of ability to pay, rather than through a clinical needs assessment.
- The reform of continuing care should contribute to the realisation of the Scottish Government's 20:20 vision for health and social care, recognising the shift from the NHS as a passive recipient of illness towards an organisation that will build healthcare support around the individual, in the community, through the work of health and social care partnerships.
- Given that we are seeking to care for more people with on-going clinical needs in the community, we need to ensure that services are commissioned to provide appropriate clinical and social care in community settings. Without this, social work and primary care will feel the burden of

⁴ Except specific short term, time limited episodes of care such as NHS respite or intermediate care (see Annex B, paragraphs 10 & 11)

greater demand and we are therefore likely to see a missed opportunity for reform. We should look to disinvest in long-stay beds – in a proportionate, measured and safe way - and spend that resource, both money and staff, supporting people in the community, where personal outcomes are almost always better.

9. Research has consistently shown that people want to live as independently as possible and to remain in their own homes for as long as they feel safe. If that is not possible then they want to be supported in a homely setting where they are able to stay connected with their local community and social network. No one generally plans for a future where they will live out the rest of their life in a hospital.

10. Hospitals provide vital healthcare services that are highly valued by the public. But we know that a prolonged stay in hospital can result in:

- a sense of disconnection from family, friends and usual social network leading to boredom, loneliness, loss of confidence, hopelessness, and depression;
- increased susceptibility to healthcare associated infection and delirium; and
- distress for family carers who have to spend time and money on regular, frequent visits to a hospital that may be some distance from home.

11. This is not a criticism of our hospitals nor of the dedicated staff who work there. Indeed, in the foreword to the continuing care report, the review panel stated “Scotland is blessed with an impressive number of dedicated and highly skilled professionals in health and social care.”

12. But hospitals should be places that we turn to when we need specialised investigations and treatment that are best provided there rather than in the community. Our community health and care services, working in partnership with third sector, housing and independent providers and with support from a range of specialists, are experts in supporting people to recover after an illness. They provide holistic and personalised care and support at home or in a homely setting for people who need chronic care and support or palliative and end of life care.

13. Information from stakeholders suggests that what people want is clarity and transparency about decision making, and fairness and equity in the funding arrangements.

14. The review panel recommend that the decision on eligibility should remain a specialist clinical judgement and subject to regular review. It proposes decision making that is transparent and framed around the question “**can this individual’s care needs be properly met in any setting other than a hospital?**” In other words, *does this person require on-going care and support that can only be provided safely and effectively in a hospital?*

15. NHS Continuing Healthcare, as described in CEL 6 (2008) will be replaced by this simpler, more transparent eligibility question. Currently the NHS fully funds the

costs for 385 people in care homes⁵. These individuals, and others eligible before 1 June 2015, will continue to be fully funded by the NHS as long as they remain eligible under the CEL 6 (2008) criteria (Annex C).

16. The expectation is that the number of people in receipt of Hospital Based Complex Clinical Care will decline as more and more people with increasing specialist needs are appropriately cared for in a community setting.

Objectives of the new guidance

17. This guidance is based on the recommendations from the independent review and covers the responsibilities of the NHS in Scotland for providing Hospital Based Complex Clinical Care to the population. It replaces previous guidance contained in CEL 6 (2008).

18. The overall objectives of the new guidance are to:

- Promote a consistent basis for the provision of Hospital Based Complex Clinical Care.
- Provide simplification and transparency to the current system;
- Maintain clinical decision making as part of a multi-disciplinary process;
- Ensure entitlement is based on the main eligibility question **“can this individual’s care needs be properly met in any setting other than a hospital?”**
- Ensure a formal record is kept of each step of the decision process.
- Ensure that patients, their families and their carers have access to relevant and understandable information (particularly if the individual does not need to be in hospital but rather an alternative setting in the community).

19. This guidance is issued with effect from 1 June 2015. The Scottish Government will monitor the use of this guidance.

20. This guidance is applicable equally to individuals of all ages with any illness or disability.

Entitlement/Eligibility

21. The eligibility/entitlement has now been simplified and will be down to one primary question, **“can this individual's care needs be properly met in any setting other than a hospital?”**

22. The response to the eligibility question will be decided by the responsible consultant or equivalent specialist informed by the Multi-Disciplinary Team. This will be crucial in establishing the best place for an individual patient to have their clinical healthcare needs met. All options should be considered and the outcome of the process explained to the individual, their family and carer.

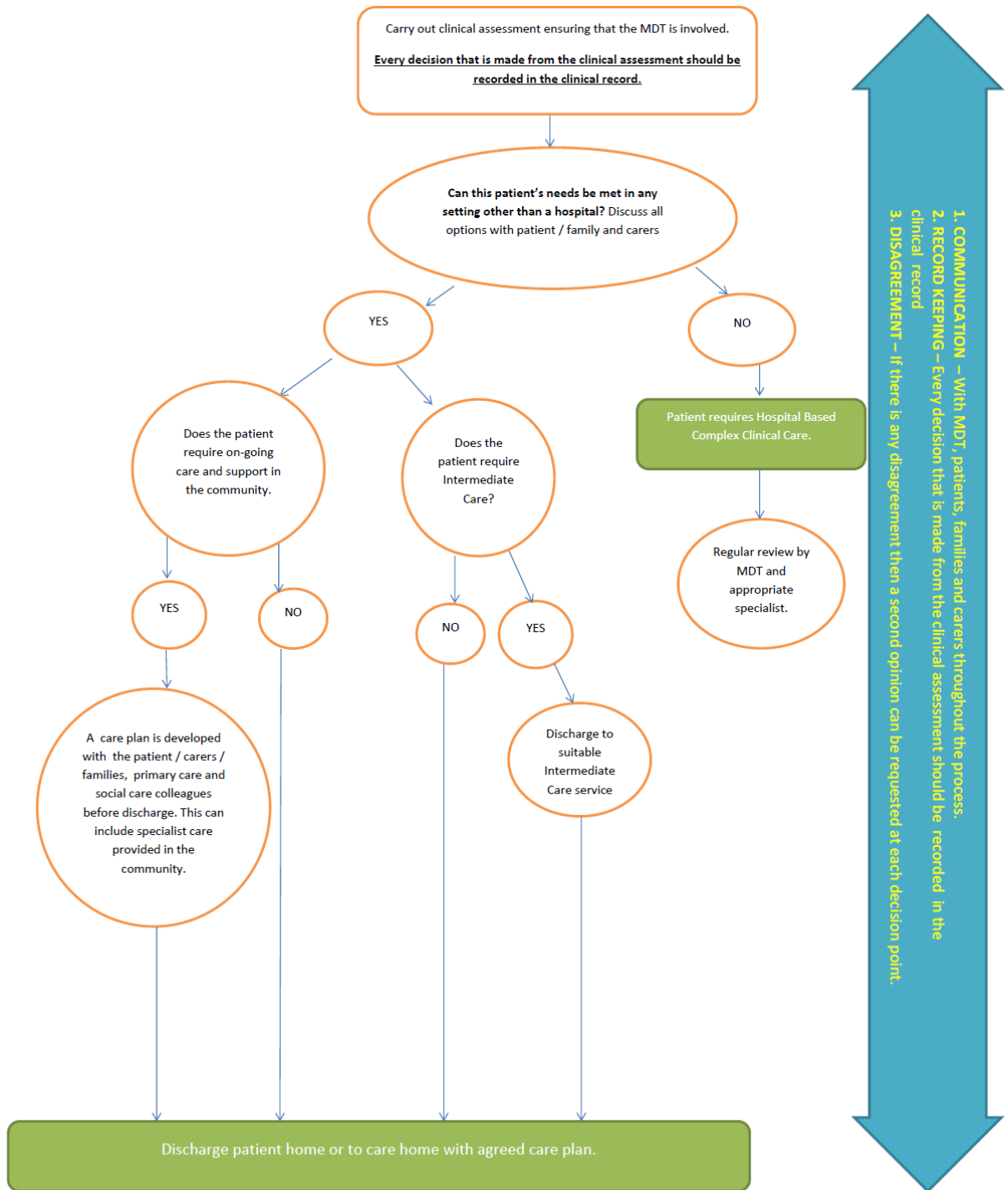
⁵ [Findings from the Balance of Care / Continuing Care Census - Census Held 31 March 2014](#)

23. Patients need to be made fully aware that, regardless of what setting they may be in, the NHS in Scotland has a legal responsibility to provide healthcare. With more people with higher needs being cared for in the community, integration authorities will need to plan how to shift resources – money, people and skills – into the community in order to provide more specialist care and support at home or closer to home. This will include health specialists working more closely with their community colleagues.

24. If, following comprehensive multidisciplinary assessment, the person does not require to remain in hospital, they will be discharged and their post hospital care and support needs will be met at home by the community health and care team, with appropriate specialist support. If a return home is not possible in the short term they will transfer to a step down bed in the community for a period of intermediate care and rehabilitation. If, following a period of intermediate care, the specialist multidisciplinary team, in consultation with patient, family or carer, considers that the individual requires long term care and support that cannot be provided at home or in alternative housing, they will move on to a care home as described in the Guidance on Choosing a Care Home on Discharge from Hospital⁶ (the 'Choice guidance'). In that situation, accommodation and non-healthcare costs will be liable to charging dependent on their personal financial circumstances.

25. This new way of working is described diagrammatically in an easy to follow flowchart overleaf. This represents the patient flow and options that should be considered during the patient's journey. Good communication, effective record keeping and patient involvement should run throughout the process.

⁶ http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf



26. A flowchart will be published on the internet, providing an interactive resource for people to use to find out more about the different stages of care, and how decisions are made.

27. The flowchart should be used in strategic commissioning to ask “do we have the right level of provision, in the right place, to meet people’s needs?” Service users will be able to use the flowchart to examine the options available at each stage.

Record keeping

28. The 2008 guidance specifically addressed the need for improved record keeping. However, the independent review was critical of current practice, particularly how NHS Boards communicate the details of the decision making process to patients and their families.

29. In line with the findings of the independent review and previous reports from the Scottish Public Service Ombudsman, it is vital that a comprehensive record of all aspects of the process and the outcomes of any decision are recorded appropriately.

Patient information

30. It is important that patients, families and their carers are involved throughout the discharge process and all options and decisions fully explained. They should be provided with clear written information about how hospital discharge procedures operate and what will happen if on-going care of any sort might be required. This should include information on how to appeal the decision to discharge and the NHS Complaints Procedure.

31. As with current medical practice, the patient is entitled to a second opinion. However, when a final decision has been reached that someone is clinically ready for discharge then there should be no delay. No individual has the right to choose to remain in hospital when there is no longer a need for in-patient care.

Dispute Resolution

32. If there remains disagreement between professionals, or between professionals and the patient, family or carer, then the dispute should go to the Medical Director (or deputy) of the NHS Board for final resolution. Where the dispute is between health and social care professionals as to on-going care needs then the decision to discharge from NHS care should reside with the Medical Director. Any remaining concerns should be resolved within the patient’s integrated care arrangements.

Independent Review of NHS Continuing Healthcare
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1. In 2013, evidence emerged that the NHS Continuing Healthcare (NHS CHC) policy was not being implemented consistently. As such, the then Cabinet Secretary for Health and Wellbeing commissioned an independent review which would look at:

- whether Scottish Government guidance was being followed, and a consistent approach was being taken across Scotland;
- whether record keeping was adequate, and decisions made were being clearly and appropriately articulated to all concerned;
- assess whether improvements were needed to raise awareness of NHS Continuing Healthcare amongst professionals and general public;
- assess whether the decision making process was based on clinical need rather than financial circumstances; and
- consider whether an independent appeals process was required.

2. The Commission found that the guidance was generally being followed but was no longer fit for purpose. Decisions on eligibility were being made on a clinical basis but were subjective and the variation across Scotland could not be readily explained. While detailed and comprehensive guidance on data collection was in place, this had not resulted in the provision of reliable, accurate or meaningful information. However, the main finding of the panel was that the guidance and operation of NHS Continuing Healthcare was no longer fit for purpose.

Independent Review Recommendations

i. The Panel recommended that CEL 6 (2008) should be completely revised and the term NHS CHC should be replaced with the term "Hospital Based Complex Clinical Care" (HBCCC). The choice of this term emphasises the recommendation that HBCCC should be a form of care that is only provided in facilities wholly funded and managed by the NHS.

ii. Eligibility for HBCCC should continue to be decided by specialist clinicians in partnership with a professional multidisciplinary team. No specific list of eligibility criteria, or scoring system, based on a description of an individual's current or predicted future condition, prognosis or care needs, should form part of the guidance. For the future the primary eligibility question should simply be **"Can this individual's care needs be properly met in any setting other than a hospital?"**

iii. The current annual census should be replaced. Consequently, all individuals in NHS hospital care at a point three months after admission should be considered for HBCCC unless they are a delayed discharge. At this point and every three months thereafter as necessary, a clinician and another member of the multidisciplinary team responsible for the care of the individual should assess and affirm this need on specifically designed documentation.

- iv. Health Boards and Local Authorities should determine the number of HBCCC beds that will require to be provided in their area. The Scottish Government should monitor progress towards more equitable provision than currently exists.
- v. The Scottish Government should, via the new census recommended in this report, monitor the shift of long term care venues from NHS to more homely care settings in all Health Boards.
- vi. An easy to read document containing information on HBCCC should be made widely available to patients, carers and all healthcare professionals. The document should be reviewed at a minimum every three years and revised at that time if thought necessary. The document should be available in printed form, in appropriate languages and formats.
- vii. When there is a dispute between an individual, their family and a multidisciplinary team about the most appropriate venue of care the decision should continue to be reviewed on an internal basis by a clinician from the same Health Board.
- viii. The principles and recommendations outlined in this report should apply equally to individuals of all ages.
- ix. It would be unfair and unjust if those who are currently in receipt of NHS CHC are disadvantaged by the proposals and the current financial arrangements should remain for these individuals without detriment.

POLICY CONTEXT

1. One of the key aims of this guidance is to ensure that people are in the right environment for the type of health or social care that they require.
2. Most individual patients who are admitted to hospital are discharged fairly quickly and will not require to stay in hospital for long periods of time. A small amount of patients across Scotland may need to stay in hospital longer due to their clinical healthcare needs.
3. Scottish Government policies aim to ensure people are able to either stay in their own homes, or another homely setting, where it is safe for them to do so in a community setting. This is a strong focus of both the *2020 Vision for Health and Social Care* and the integration of health and social care.

<p><i>'2020 Vision' for Health and Social Care</i>⁷ – Everyone is able to live longer healthier lives at home or in a homely setting.</p>
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<p>We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.</p>

4. The key aim of the Public Bodies (Joint Working) Scotland Act 2014 which provides the framework for integrating health and social care, is to provide seamless, joined up care that enables people to stay in their homes, or another homely setting, where it is safe for them to do so. The whole point of integrating health and social care is to improve people's lives and the outcomes for people who use health and social care services.
5. Everyone at some point in their lives is likely to experience some sort of hospital care. The main outcome for all patients is to improve their health so that they can be discharged back to a community setting as quickly and safely as possible.
6. There is clear evidence that an unnecessary prolonged stay in hospital can be detrimental to a person's physical and mental wellbeing and can result in:
 - a sense of disconnection from family, friends and usual social network leading to boredom, loneliness, hopelessness, confusion and depression;
 - increased susceptibility to healthcare associated infection and a higher risk of delirium, malnutrition, pressure sores, muscle wastage and falls.

⁷ 2020 Vision for Health and Social Care

- loss of confidence and ability to cope at home, resulting in a premature shift to permanent care, particularly for people with dementia; and
- distress to patient, family, carer or proxy as they are unable to plan ahead, and have to spend more time and money on regular, frequent visits to the hospital.

7. Acute hospitals are not the ideal environment in which to assess someone's long term needs. Every effort should be made to enable people to move to a less intensive setting in order to aid recovery and holistic assessment.

Intermediate Care

8. Intermediate care services are provided to individuals, usually older people, when they are leaving hospital or when they are at risk of being sent to hospital. The services offer a link between care provided in places such as hospitals and people's homes, and between different areas of the health and social care system – community services, hospitals, GPs and social care.

9. Intermediate care plays an important part in delivering integrated health and social care. It should be considered as a stepping stone for individuals getting back into a community homely setting.

10. The Scottish Government published a national framework on intermediate care, [Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland](#) in 2012. It describes a continuum of integrated services to prevent unnecessary admission to acute hospital or long-term residential care, promote faster recovery from illness, support timely discharge from hospital and optimise return to independent living.

11. Intermediate care services are now well developed across Scotland but need to go further. This forms part of wider work to develop a strategy for the long-term transformation of residential care and supported housing.

12. The Intermediate Care Framework recommends that intermediate care should be provided free of charge. This may be time limited (usually 4-6 weeks) but during the required period of Intermediate Care there should be no charge to the individual whatever the setting. Intermediate Care has the potential to pay its own way, when commissioned as part of a wider suite of integrated resources.

Self Directed Support

13. Self-directed support (SDS) is a term that describes the ways in which individuals and families can have informed choice about how their support is provided to them. It is most commonly used in the delivery of social care and support but it can cover a much wider range of services provided to meet a social care need.

14. SDS gives people control over an individual budget and allows them to choose how it is spent on support which meets their agreed social care personal

outcomes. SDS includes a number of options for getting support. The person's individual budget can be:

- taken as a Direct Payment (a cash payment);
- allocated to a provider the individual chooses. The council or funder holds the budget but the person is in charge of how it is spent (this is sometimes called an individual service fund);
- or the individual can choose a council arranged service;
- or the individual can choose a mix of these options for different types of support.

Further information for individuals, professionals and carers is available via the Self Directed Support Scotland website at <http://www.selfdirectedsupportscotland.org.uk/>

Free Personal and Nursing Care

15. Personal and nursing care is available without charge for everyone in Scotland aged 65 and over who needs it, whether at home, in hospital or in a care home. Free nursing care is available for people of any age who need it.

16. In order to receive personal care services commissioned or delivered by a local authority, or payments which allow people to choose who will provide the services to them, an individual needs to have an assessment by their local social work services. Full details on Free Personal and Nursing Care is available at <http://www.gov.scot/Topics/Health/Support-Social-Care/Support/Older-People/Free-Personal-Nursing-Care>.

<p>Current Eligibility</p>

1. Anyone who is currently in receipt of NHS Continuing Healthcare prior to 1 June 2015 will continue to be eligible to receive it. The independent review was clear that it would be unfair and unjust if those who are currently in receipt of NHS Continuing Healthcare are disadvantaged by the proposals and the current financial arrangements should remain for these individuals without detriment, as long as there remains a need for the specialist level of care described in CEL 6 (2008) and noted below.
2. The consultant (or GP in some community hospitals) will decide, in consultation with the multi-disciplinary team, whether the patient:
 - a) needs in-patient care arranged and funded by the NHS;
 - b) needs a period of rehabilitation or recovery, arranged and funded by the NHS; or
 - c) should be discharged from in-patient care.
3. Continuing in-patient care should be provided where there is a need for and regular specialist clinical supervision of the patient as a result of:
 - a) the complexity, nature or intensity of the patient's health needs, being the patient's medical, nursing and other clinical needs overall;
 - b) the need for frequent, not easily predictable, clinical interventions;
 - c) the need for routine use of specialist health care equipment or treatments which require the supervision of specialist NHS staff; or
 - d) a rapidly degenerating or unstable condition requiring specialist medical or nursing supervision.
4. For those patients eligible before 1 June 2015 under CEL 06 (2008) it should be noted that this is subject to review and not necessarily for life.