APPENDIX III

Walsall Council

NHS
Walsall Clinical Commissioning Group

ASSESSMENT PROCESS
FOR
NHS CONTINUING HEALTH CARE
OPERATIONAL GUIDANCE FOR PRACTITIONERS

September 2014

Improving Health
and Wellbeing for Walsall

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1. Introduction

1.1 This document describes the process by which people in hospital or in the community are assessed using the criteria established by the National framework on NHS Continuing Health Care and NHS Funded Nursing Care. The revised framework came into operation on 28th November 2012.

1.2 This process has been agreed jointly between Walsall CCG, Walsall Healthcare Trust and Walsall Social Care and inclusion.

1.3 This guidance should be read along with other relevant policies.

1.4 The process is for any member of staff involved with or completing any of the National Framework tools.

1.5 The National Framework has been subject to an Equality Analysis by the Department of Health, and the findings from this will guide local processes. These will ensure that due regard is given to the need to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the act.

2. The National Framework

2.1 The Department of Health produced an updated National Framework for NHS Continuing Health Care and NHS Funded Nursing Care in November 2012. This laid down national eligibility criteria was intended to make decision-making on who is eligible for fully funded care by the NHS more **consistent, fairer** and **easier to understand.**

2.2 To support this, the new national system has dedicated assessment tools for professionals to utilise to aid them in their decision making:-

- A **Checklist Tool** (Appendix A)
- A **Decision Support Tool** (Appendix B)
- A **Fast-Track Tool** (Appendix C)

2.3 Details of all of these documents are available on the Department of Health website: www.dh.gov.uk or on the CCG Extranet site.

2.4 The framework states that four characteristics of need, namely nature, intensity, complexity and unpredictability may help determine if the quality or quantity of care required is beyond the limit of a Local Authorities' responsibilities. Any of these alone or in a combination may demonstrate a 'Primary Health Need'.

2.5 The health care needs (domains) are set out in the Checklist and described in more detail in the Decision Support Tool (DST) (appendix A and B)

2.6 The National framework places emphasis on Multi-Disciplinary Teams (MDT) being fully involved in the decision-making. The role of the trained assessment co-ordinator is to co-ordinate the input of the MDT and to complete the Decision Support Tool (DST). No DST assessments will be accepted within the Complex Care Commissioning department unless it is demonstrated that there have been at least 2 professionals involved in the assessment. An example of this may be a health professional and a social worker.

2.7 In Walsall, Social Workers are encouraged to be actively involved in the assessment process and contribute knowledge and information to it. However, the statutory responsibility for determining whether someone is eligible for full NHS funding rests with the NHS (via the CCG). Only individuals (or carers on their behalf) have the right to appeal against decisions made by Walsall CCG on eligibility (See Appeals policy).

2.8 If the local authority representative disagrees with the recommendation of Walsall CCG they can evoke the dispute policy (see dispute policy).

2.9 NHS continuing healthcare (CHC) is subject to a review as a person's condition may change and they may no longer be eligible for CHC. Therefore regular reviews are built into the process to ensure that the care package continues to meet the individual's needs.

2.10 The reasons given for a decision on eligibility should not be based on:

a. person's diagnosis
b. setting of care
c. ability of the care provider to manage care
d. use (or not) of NHS-employed staff to deliver care
e. need for /presence of 'specialist' staff in care delivery
f. the fact that a need is well managed
g. the existence of other NHS-funded care
h. any other input-related (rather than needs-related) rationale

Local Authorities should not be required to provide services beyond those they can legally provide under Section 21 of the National Assistance Act 1948. (available at www.legislation.gov.uk)

2.11 All assessments should have patient or family/carer involvement (if patient consents or it is in their best interests) and their views/comments should be incorporated within the assessments. Contact details for the person who is to receive the completed DST and confirmation of the decision following eligibility determination should be clearly stated on

the front page of the DST.

3. The Assessment Process for People in Hospital

3.1 The Assessment Process for people in hospital is set out in the Flow Chart 1.

3.2 This process has been developed jointly between Walsall CCG and Walsall local authority and follows the national guidance. (NHS CHC practice guidance 2012) It is designed to ensure that those people who are likely to be eligible for NHS continuing healthcare are assessed using the national tools.

3.3 Anyone who requires an extensive package of care (or the re-commencement of an existing package) to enable safe discharge from hospital is entitled to be considered for eligibility for NHS continuing healthcare by the NHS.

3.4 The checklist will be completed by the appropriately trained healthcare professional or Social worker and should involve the individual and the patient's representative. The patient's condition should be medically stable before assessment is commenced.

3.5 Before carrying out an assessment, the MDT should have first considered whether there is potential for further rehabilitation (e.g. intermediate care) which might make a difference to the level of independence achieved. If this is a realistic option, then it is not necessary at this stage to make a decision on eligibility for NHS continuing healthcare.

3.6 The assessors should ensure that they have an individual's informed consent before the process of determining eligibility for NHS continuing healthcare commences. If the capacity of an individual is questionable then the 2 stage capacity assessment should be completed prior to commencement of assessment.(appendix D)

3.7 At all stages in the process, every effort should be made to inform individuals and/or carers, and to involve them in the assessment process wherever possible. They should be made aware that the completion of a Checklist may not result in CHC eligibility.

3.8 For those who do not meet the requirements of the Checklist, there is no requirement for a full assessment using the Decision Support Tool. A copy of the Checklist should be sent to the Social Work Team (if completed by a health professional) and to the Continuing Healthcare Team. Negative checklists need to be sent to Integrated Discharge admin team to be processed and logged onto appropriate health & social care databases for future reference.

3.9 Patients/carers should be informed of the outcome of the CHC Checklist assessment with an explanation of why they do not meet the criteria for further assessment for NHS continuing healthcare (as summarised in the last page of the Checklist). A standard letter (attached to checklist) must be given to the patient/carer informing them of the outcome . This letter will be given by the professional who has completed the checklist.

3.10 If the outcome is negative an individual, or carer on their behalf, may request further consideration using the DST. In such a case, the request must be made to the Integrated Discharge Team Manager who will liaise with the appropriate Assessor. The Assessor will take into consideration all the information available, including information from the individual or carer.

3.11 If, after completing their assessments the Social Work Team believes that further consideration is necessary, then they can request this of the CCG with a fully completed rationale of why the request is being made. Requests should be made to the appropriate assessor (Integrated Discharge Team) with the rationale.

3.12 If the outcome of the checklist is that a full DST is required then the checklist should be sent to the Integrated Discharge Team for the team to co-ordinate the completion of a full DST.

NB: Only assessors who have received appropriate training can undertake the co-ordination/completion of the assessment although other professionals can contribute to the completion.

The patient's representative should be invited to participate and the co-ordinator will seek MDT involvement. DST's should have at least 2 signatures and should reflect MDT involvement and include comments/ views of patient/ representative.

3.13 On completion of a full assessment, the DST should be forwarded to the Continuing Healthcare commissioning department for a decision on eligibility. The final decision on whether an individual fulfils the criteria rests with the CCG and assessors should make patients/representatives aware that the recommendation is not authorised until it has been via the weekly eligibility/ratification panel. Decisions will be notified to the Assessment Co-ordinators' following the weekly eligibility panel within one working day. The Local Authority Brokerage Team is notified of decisions in order to cascade decisions to the nominated Social Worker.

NB: To facilitate hospital discharge and prevent 'bed blocking' if an Integrated Discharge Nurse completes a positive DST that has been completed following the process above and it demonstrates undoubtedly a 'Primary Health Care Need' then a senior nurse from the Continuing Healthcare Commissioning Team can agree CHC eligibility.

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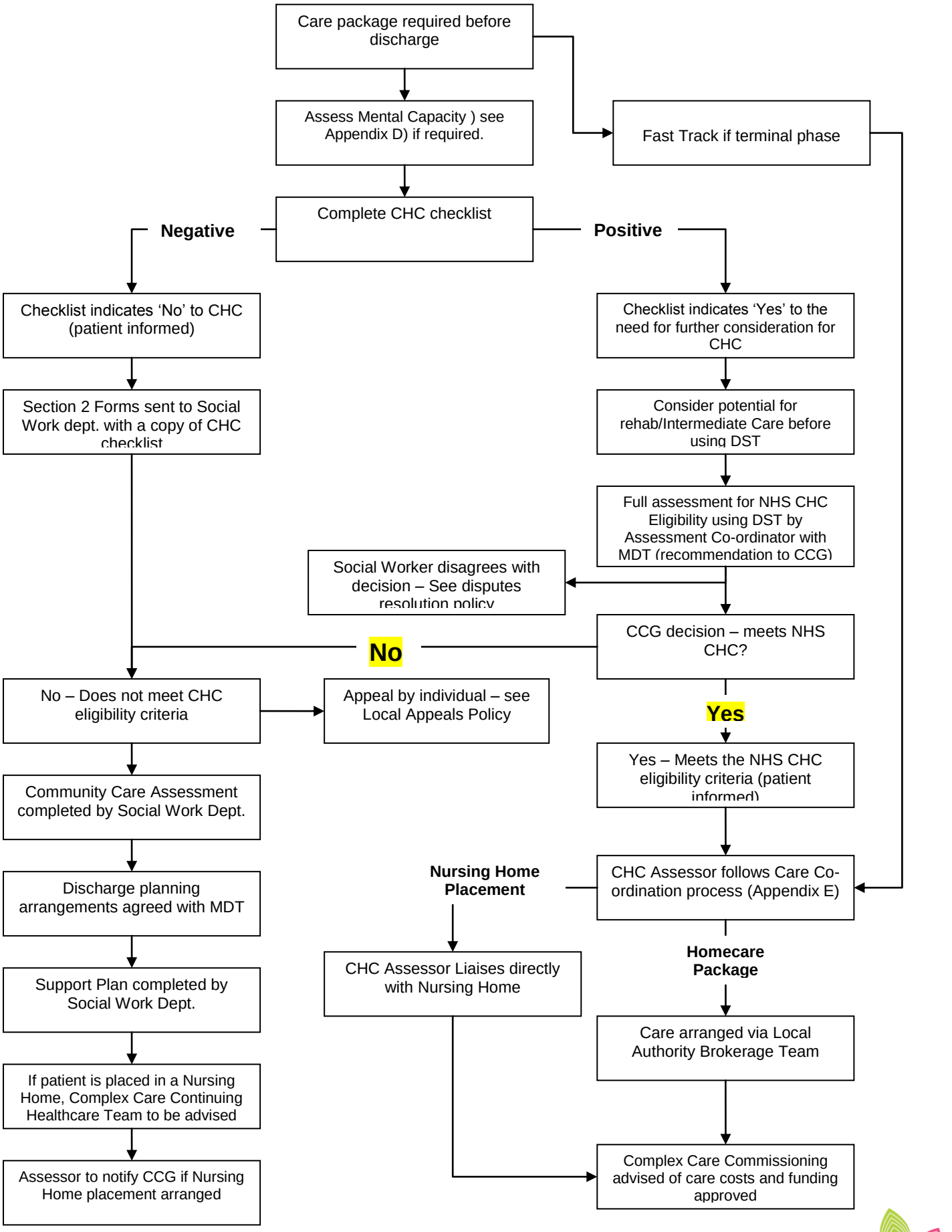
3.14 For patients agreed as eligible for CHC the relevant assessor (Integrated Discharge Team) will arrange the care co-ordination of that patient (refer to care co-ordination policy)

3.15 Copies of DST's will be sent to the identified individual following eligibility/ratification panel by the Continuing Healthcare administrator. If not specified on the DST it will be sent to the patient.

3.16 For those not eligible for Continuing Healthcare but who are entering a Nursing Home the assessor will be required to complete a record of nursing care need (Appendix E) and send to the Funded Nursing Care administrator (based in the Continuing Healthcare commissioning team) to enable payment of the Funded Nursing care contribution.

NHS Continuing Health Care Assessment Process **APPENDIX III**

People in Hospital (Flow Chart 1)



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4. The Assessment Process for Out of Borough Hospitals

4.1 The assessement process for patients in out of borough hospitals is set out in Flow chart 2.
Anyone who requires a package of care (or the re-commencement of an existing package) to enable safe discharge is entitled to be considered for eligibility for NHS continuing healthcare.

4.2 Any positive checklist completed for a patient with a Walsall CCG G.P should be faxed to the Continuing Healthcare commissioning team on 01922 602488 with a copy to the allocated Social Worker. The checklist should be completed by the appropriate Health or Social Care professional which may include the out of borough hospital professionals.

4.3 Upon receipt of a positive checklist into the commissioning department a request will be made for a CHC asessor (for Walsall CCG) to complete the DST tool utilising assessments from other relevant professionals, ensuring a MDT approach. Information will be taken at ward level from various disciplines (including information from medical notes). A minimum of two professionals should sign the document.

4.4 Wherever possible the designated Social Worker should be part of the process. Any differences in points of view within the domains should be documented on the DST.

4.5 The completed DST will be sent to the Continuing Healthcare Commissioning department for eligibility to be considered at the weekly approval panel. The final decision rests with Walsall CCG.

4.6 The individual will be informed formally with a letter sent from Walsall CCG. The assessor will contact the hospital and feedback the decision verbally to the nurse in charge of the applicable ward in order to inform the individual on a timely basis to allow discharge plans to be put in place. The assessor will also inform the designated Social Worker.

4.7 The co-ordination for those eligible will be completed by a dedicated CHC Assessor on behalf of Walsall CCG, in conjunction with professionals involved in their care.

4.8 If the patient is not eligible for CHC it will be the responsibility of the Social Worker to request necessary assessments from the ward. For nursing home placements a Funding Nursing Care record should be completed and forwarded to the Funded Nursing Care administrator.

Assessment Process for People in Out of Borough Hospital

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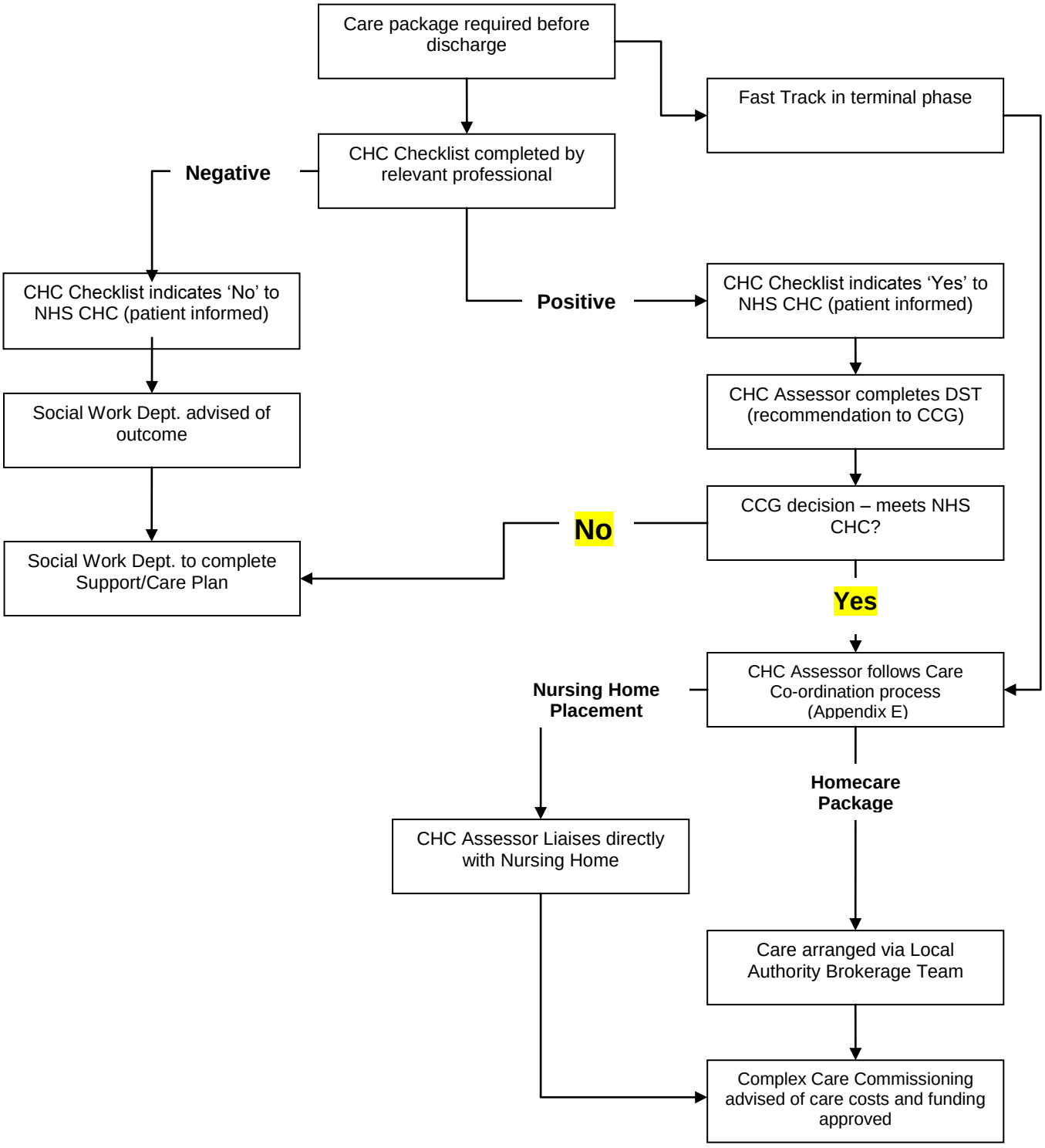

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5. Assessment Process for People in the Community

5.1 Anyone who requires a package of care is entitled to be considered for eligibility for NHS continuing healthcare.

5.2 The checklist will be completed by the appropriate healthcare professional or Social Worker and should involve the individual and the patient's representative.

5.3 Before carrying out an assessment, consideration should be given as to the potential for further rehabilitation (e.g. intermediate care) which might make a difference to the level of independence achieved. If this is a realistic option, then it is not necessary at this stage to make a decision on eligibility for NHS continuing healthcare.

5.4 The assessors should ensure that they have an individual's informed consent before the process of determining eligibility for NHS continuing healthcare commences. If the capacity of an individual is questionable then the 2 stage capacity assessment should be completed prior to commencement of assessment.(Appendix D)

5.5 The individual and their carers should be involved in the assessment process. They should be made aware that completion of checklist may not result in NHS continuing healthcare eligibility.

5.6 For those who do not meet the requirements of the Checklist, there is no requirement for a Full assessment using the Decision Support Tool.

5.7 Patients/Carers should be informed of the outcome of the Checklist assessment with an explanation of why they do not meet the criteria for NHS Continuing Health Care (as summarised in the last page of the Checklist). A standard letter (attached to checklist) must be given to the patient/carer informing them of the outcome. This letter will be given by the professional who has completed the checklist.

5.8 If the outcome is negative an individual, or carer on their behalf, may request further consideration using the DST. In such a case, the request must be made to the appropriate Assessor who will take into consideration all the information available, including information from the individual or carer.

5.9 If, after completing their assessments, the Social Work Team believes that further consideration is necessary, then they can request this of the CCG with a fully completed rationale of why the request is being made.

5.10 If the outcome of the checklist is that a full DST is required (and has been completed by the Social Worker) then the checklist should be sent to the Local Authority Brokerage Team who will request a full assessment from the appropriate assessor. If the checklist is completed by a health professional who is not trained in completion of DST's, the professional will request the full DST from the appropriate trained assessor within the CCG.

NB: Only assessors who have received appropriate training can undertake the co-ordination /completion of the assessment.

5.11 The full DST should be completed within 28 days of the checklist being completed as per National Guidance.

5.12 On completion of a full assessment the DST should be forwarded to the Continuing Healthcare Commissioning department for an eligibility decision on 01922 602488.

5.13 The final decision on whether an individual fulfils the criteria rests with Walsall CCG and assessors should make patients/representatives aware that the recommendation is not authorised until it has been via the weekly eligibility/ratification panel. Decisions will be notified to assessment co-ordinators' following the weekly eligibility panel. The local authority Brokerage Team is also notified of weekly outcomes.

5.14 If the patient is eligible the details will be forwarded to the CHC assessors for care co-ordination, who will arrange a care package to meet the needs of the individual following further discussion with the assessor.

Assessment Process for People in the Community

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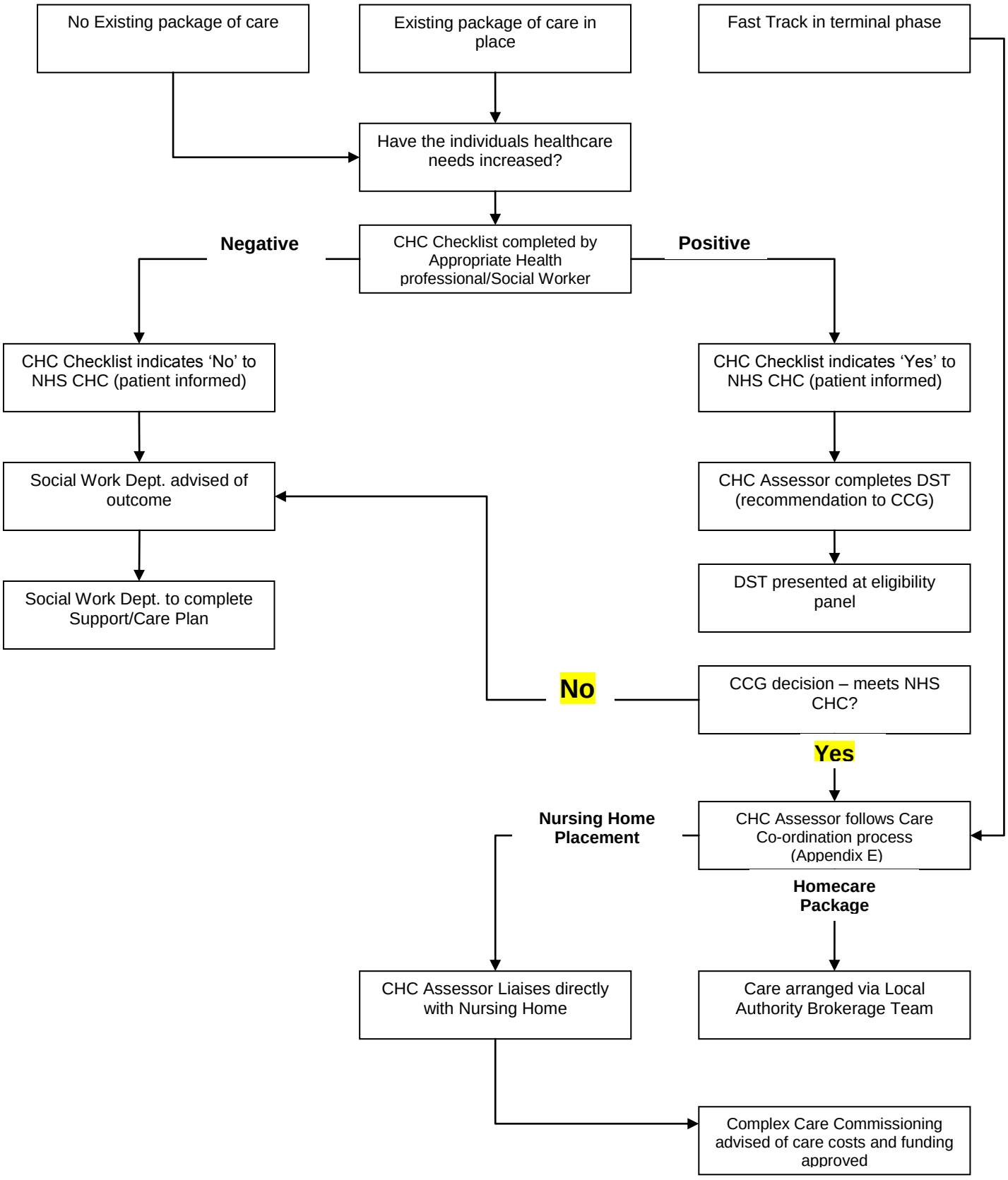

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6. Fast Track Process

6.1 The Fast-Track Tool (Appendix C) is for individuals with a rapidly deteriorating condition that may be entering a terminal phase and who require 'fast-tracking' for the immediate provision of NHS continuing healthcare because they need an urgent package of care. Fast-tracking must not be used as a short-cut to achieving discharge or to change funding stream, when the individual is palliative but has not yet reached the end-of-life stage.
NB If a care intervention is **not** urgently needed (within 24 hours) then a full DST must be completed.

6.2 Within the hospital setting the Fast-Track form can be completed by a consultant, specialist palliative care nurse, integrated discharge nurse or a CHC assessment co-ordinator (this is also relevant for out of borough hospitals) who should give the reasons why the person meets the criterion required for the fast-tracking decision. The Fast Tract Tool should be supported by a prognosis, if available. For patients in the community it can be completed by palliative care nurses, community matrons or district nurses. A full assessment using the Decision Support Tool should be completed within 28 days of completion of the fast track form (if appropriate). The continuing healthcare commissioning team will request the DST from the appropriate professional.

6.3 A fast track must be completed for those individuals transferring into an End of life diversion bed by the placing health care professional.
Prior to 28 days a full DST should be completed (if appropriate) and sent to continuing healthcare commissioning team by the appropriate professional which may include Macmillan nurses, matrons and CHC assessors.

6.4 Careful decision making is essential to avoid undue distress that might result from a person moving in and out of NHS continuing healthcare eligibility within a very short period of time.

6.5 The fast track should be completed within 24 hours of request (one working day) excluding weekends.

6.6 The completed fast track should be sent to continuing healthcare commissioning department who will authorise eligibility and notify the assessor.

6.7 Care co-ordination will be completed by an appropriately trained professional (refer to care co-ordination policy). This will be in conjunction with the assessor.

7. Reviews

7.1 All newly eligible CHC patients will receive an initial 3 month scheduled review which will be undertaken by a MDT team. Further reviews will be conducted at least annually.

7.2 The assessor/s will indicate on the DST the time frame for the next review which should be at least annually but can be more frequent if the condition is such that it is likely to change in a shorter period of time.

7.3 Relatives/carers should be involved in the review process and it will be the responsibility of the assessor to coordinate this

7.4 All scheduled reviews will be generated via the continuing healthcare commissioning team on a monthly basis and will be sent to the CHC Assessment Team and Initial Intake Team for allocation.

7.5 It is the responsibility of the lead assessor to arrange reviews to ensure they are multidisciplinary and have family/carer involvement.

7.6 Upon completion the assessor will forward the completed DST to the Continuing Healthcare Commissioning team. Any reviews indicating that the patient remains eligible for CHC will not be presented at eligibility panel but will continue to be funded by Walsall CCG.

7.7 Any reviews indicating that the patient is no longer eligible will be presented at the eligibility panel. Only DST's depicting MDT involvement and family/carer participation will be accepted.

7.8 Unscheduled reviews can be requested if a patient's condition changes unexpectedly. Requests should be directed to the continuing healthcare commissioning team who will request a new DST from the appropriate professional.

7.9 All unscheduled reviews will be presented at the weekly eligibility panel

8. CHC Eligibility for Clients in Receipt of Section 117 Aftercare

See appendix F.

9. References

DH,2012 (revised)	The national framework for NHS continuing Healthcare and NHS Funded care www.gov.uk/.../**national**-**framework**-for-nhs-**continuing**-**healthcare**-and-nhs-funded-nursing-care
HMSO,1948	National assistance Act www.legislation.gov.uk