Guide to the Continuing NHS Healthcare Assessment Process

Continuing NHS Healthcare (CHC) is a package of care arranged and funded solely by the NHS, where it has been assessed that the person’s primary need is a health need. The issue is one of need. The person’s specific diagnosis, condition, financial position, the cost of providing the required care, or its setting do not determine eligibility. CHC is reviewed and people may move in and out of eligibility as their needs change.

Where a person is eligible for CHC, local authorities may still have some responsibilities including, for example, a role in assessment and review, supporting carers and meeting housing and educational needs.

This is a communication tool designed to help guide staff and the person being assessed through an initial discussion to explain the Continuing NHS Healthcare process.
What is this Guide for?

This guide is designed as a communication tool to help health and social care practitioners and the person undergoing assessment, their family, friends, carers or appointed advocates to understand the process for Continuing NHS Healthcare (CHC).

The word ‘person’ is used throughout this document to refer to a patient or service user, over the age of 18 years, for whom Continuing NHS Healthcare is being considered.

It is important that one staff member coordinates the whole process from beginning to end and remains the main point of contact for the person and their family. At the point where it is clear that Continuing NHS Healthcare should be considered this guide should be read by the person being assessed together with the health or social care practitioner responsible for coordinating the person’s care.

This guide should be used to complement the CHC Public Information Leaflet that provides an overview of the process for assessing individuals for Continuing NHS Healthcare, produced by the Welsh Assembly Government and available from the Local Health Board. A copy of the Public Information Leaflet should be given to the person following the discussion.

What is ‘Continuing NHS Healthcare’?

Continuing NHS Healthcare (also known as CHC) is the name given to a package of services which is arranged and funded solely by the NHS where it has been assessed that the person’s primary need is a health need, which is explained below.

CHC can be provided in any setting including the person’s home or a nursing home. In a person’s own home the NHS will pay for health care (for example services from a community nurse or specialist therapist) and personal care, but not the costs of food, accommodation or general household support. Where CHC is provided in a nursing home the NHS pays the care home fees including health, personal care, board and accommodation.

While overall responsibility for the care of those who are eligible for CHC will lie with the NHS there will be ways in which other agencies including social services may become involved including for example, support for carers, housing, education and leisure services or the provision of equipment.

Services provided by the NHS are free but services provided by a local authority may be charged for.

What is a Primary Health Need?

The primary health need is assessed by looking at all of the care needs and considering four key areas:

1. **Nature**: this describes the characteristics of a person’s needs for example; physical needs, mental health or psychological needs and the type of those needs. This also describes the overall effect of those needs on the person, including the type (quality), of help required to manage them.
2. **Intensity**: this relates to both the extent (quantity) and severity (degree) of the needs and to the support required to meet them, including the need for sustained or ongoing care (continuity).

3. **Complexity**: this describes how needs present and interact to increase the skill required to monitor the symptoms, treat the conditions or manage the care.

4. **Unpredictability**: this describes the degree to which someone’s needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to a person’s health if adequate and timely care is not provided.

A person’s healthcare needs may change over time and reassessment will take place at specified intervals, or when there is any significant change to their health. As a result of reassessment the person may move in and out of eligibility for Continuing NHS Healthcare.

**What is the difference between ‘Continuing NHS Healthcare’ and ‘NHS Funded Nursing Care’ (NHSFNC)?**

NHSFNC is not the same as Continuing NHS Healthcare. By law local authorities cannot pay for the services of a registered nurse. NHSFNC is a financial contribution from the NHS for the cost of the registered nursing care provided in a nursing home, for someone who is not eligible for Continuing NHS Healthcare and is not receiving nursing care in another way, for example, from district nurses.

NHSFNC is only for the registered nursing part of the care. Accommodation, food and all other care will be paid for by the person or by the local authority or partly by both depending upon a person’s financial means.

**When is an assessment needed?**

When it has been recognised that a person’s healthcare needs have changed, are complex and will require careful consideration of which care options will be most appropriate, a full assessment will be undertaken using the Unified Assessment Process and other appropriate assessments.

This process may involve assessments by several health and social care professionals such as an occupational therapist, physiotherapist, social worker, doctor, nurse and psychologist amongst others and are known as the Multidisciplinary Team (MDT). A multidisciplinary team is made up of two or more professionals who are involved in the person’s care and may be from health or social services.

Each individual assessment will make an important contribution to the comprehensive assessment showing the complete picture of a person’s health and social care needs.

As part of the assessment process, the key professional responsible for coordinating the person’s care will arrange for one or more of the professionals to meet with the person and their family, carer or chosen representative to discuss the assessments.
How to prepare for the first meeting?

Talk to each other!

Spending time with the person to discuss how the Continuing NHS Healthcare process works is an important activity for the professionals, the person, their family and carers. The aim of the discussion is to make sure the person and staff have a clear understanding of the Continuing NHS Healthcare process, complete the Unified Assessment, and plan what needs to happen next.

This is an opportunity for the person, their relatives and staff to raise issues and concerns, make sure that all the relevant assessments by members of the Multidisciplinary Team are completed, and to check that all the right people have been involved in the assessments.

In preparing for the discussion and to support the person through the process the following things should be considered:

- The professional needs to make sure that any help the person needs to understand the process, and to be involved in the assessments, is provided. For example, does the individual need an interpreter?
- The person, and where appropriate their family or representative, must have an explanation of what Continuing NHS Healthcare is, why it is being considered and what the process will entail.
- The person has to consent to the assessment and must be advised that they can withdraw that consent at any time during the process. However if the person has difficulty with memory, making decisions or expressing their views, further assessment or support might be needed, for example, from an independent advocate.
- Each person involved should be given time to ask questions and support should be offered by the professional to ensure that they are able to ask questions and express views at the multidisciplinary meeting.
- It is important to talk and share information in a clear, honest and open way as Continuing NHS Healthcare can be a source of a great deal of anxiety and confusion.
- The care co-ordinator and members of the multidisciplinary team must be prepared to ask and answer questions and be honest if uncertain of the answers. If they are uncertain they should find out and quickly respond with the right answer.


What if the individual does not consent?

If an individual refuses to consent to being assessed for Continuing NHS Healthcare or refuses the offer of a care package once they have been found eligible, it means that the NHS cannot then become responsible for paying for all of their care. The NHS will still provide health services, but the individual may be charged for services provided by the local authority.

All decisions to give or to refuse consent must be recorded.
Who should support the person?

The person can choose to have support from other people such as family, carers, friends or other representatives:

- If the person wants other people included, make sure that a convenient time for them to attend is planned as soon as possible, taking into account people’s time commitments and those living at a distance.
- For people unable to attend the meeting in person, arrangements should be made for them to pass on and receive relevant information. This will be included in the assessment documentation for use at the decision making meeting.
- If the person does not have support or does not wish to include family members, carers or friends, they must be informed of the availability of independent advocacy services, such as those provided by Age Concern.
- The most appropriate healthcare professionals to be involved are those who have been providing the direct care and have up to date knowledge of the person.

What is the right environment?

The discussion should take place where it is easy to talk and listen without distractions or disturbances and in a place that affords privacy.

Although the environment needs to be informal and comfortable, it may also be useful to have a table so that it is easier to take any written notes and open out the guide to help the discussion, particularly when explaining the process using the flowchart on pages 8&9.

What is a comprehensive assessment?

The comprehensive assessment is an assessment of all aspects of a person’s health and social care needs and is recorded using documentation called a Unified Assessment. If some parts of the document are not relevant they will be recorded as such.

All documentation must be clearly dated and signed.

The person, together with anyone they have chosen to support them, will be fully involved in the assessment. Any information that can help to give a full picture of the person’s needs should be included as part of the assessment, such as a diary or existing 24 hour care plan. The aim is to gather as full a picture as possible, to which all relevant people have contributed.

The assessment should not only identify all health and social care needs, but also explain how they affect the person and what the implications would be if their needs were not met. Before the discussion ends it is important to make sure everyone exchanges full names and contact details so that further thoughts or concerns can be shared and any outstanding queries can be acted upon.

How will the decision be made?

The outcome of the assessment will be discussed at a meeting of the Multidisciplinary Team. This will include the person together with their advocate if they wish, and the
professionals involved in the person’s care. As a minimum this will be the doctor, nurse
and social worker who have been most closely involved with the person. Other
professionals such as therapists may often be present.

When the person and their family do not wish to or are not able to be present they must be
confident that they have been fully involved in the assessment process up to this point so
that their views of their needs are presented effectively. In this case, following the meeting
one of the professionals present will discuss the outcome with the person and their family
at the earliest opportunity. In the best interests of effective decision making the meeting
should be postponed if the right people are not able to be present.

A document call a Decision Support Tool will be used to help the decision making and
ensure that the all the factors that might have a bearing on the person’s eligibility for
Continuing NHS Healthcare are taken into account and recorded. The completed decision
support tool will be included in the person’s medical notes and made available to the
person.

The assessments and the recommendation of the Multidisciplinary Team will be submitted
to the Local Health Board for final decision on eligibility. All Local Health Boards will have
processes in place to ensure decisions on eligibility are fair, rational, consistent and
comply with the Welsh Assembly Government policy.

There may be occasions when Local Health Boards may ask the multidisciplinary team to
undertake further work or to provide further information before they proceed to a decision.

What happens next?

When it has been determined that a person is eligible for Continuing NHS Healthcare a
care plan will be developed to show what is required and who will be involved. The plan
will be reviewed after six weeks initially, with a further review six weeks later to make sure
that the care provided is actually meeting the person’s needs.

Reviews will then take place every year or sooner if there are significant changes in the
person’s health needs. These reviews may result in changes to the way that the person’s
care is provided and funded.

How long will this process take?

The time taken for these assessments may vary but should be completed within six to
eight weeks from deciding to consider eligibility for Continuing NHS Healthcare through to
agreeing a care package.

In some exceptional circumstances the process may be completed much more quickly if it
is in the person’s best interests, or may be extended in very complicated cases. The care
coordinator will make sure the person and their family are kept up to date.

What happens if the person disagrees with the decision?

If the person disagrees with the decision they should discuss their concerns with the care
coordinator in the first instance. Every effort will be made to come to agreement by means
of informal discussion. If agreement cannot be reached, however, a formal review will be
needed. The review process will be fully explained to the person and their family and/or
carers and details of this discussion and planned actions will be recorded in the person’s medical notes.

Stage one of the review process is undertaken by a Continuing Care Manager. If the situation cannot be resolved at this stage, the Continuing Care Manager will prepare the necessary documentation of the case and send it to the Local Health Board of the area where the person usually lives. The case will then be considered by an Independent Review Panel.

A review can be requested if:

- The person feels that the proper process has not been followed in reaching a decision about the need for Continuing NHS Healthcare.
- There is doubt that the eligibility criteria for Continuing NHS Healthcare have been properly applied.

The normal NHS complaints process will address concerns related to:

- The content, rather than the application of, the Local Health Board’s eligibility criteria.
- The type and location of the Continuing NHS Healthcare offered to the person.
- The content of any alternative care package that has been offered.
- The treatment of any other aspect of the care the person is receiving or has received.

Details of how to make a complaint will be explained in these circumstances.

**Useful Information:**

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<th>Your Care Coordinator can be contacted on the following phone number:</th>
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<th>Your Care Coordinator can be contacted on the following email address:</th>
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Personal care and treatment takes place as usual everyday and the MDT continue to work towards a planned date of transfer agreed with the patient.

An Assessment of health and social care needs is a normal part of any person’s journey through care.

If not already in place, a Care Coordinator is named to lead the process, arrange the MDT and support the person and their family.

The MDT will identify a person with a primary health need and recommend Continuing NHS Healthcare.

The coordinator collates all of the necessary Assessment Documentation.

The documentation is sent to a CHC Manager at the Local Health Board who oversees the process.

Model Timetable:

Each case is different and this timetable is only an indication of the local timescale for CHC, if everything runs to plan.

It is important to take some time to make sure that every care plan is going to be safe and effective for the person concerned. However, the maximum time this process should take is six to eight weeks.

Some cases, for example people nearing the end of life, will be moved through the system much more quickly using a fast track process.
5. A CHC Panel considers the MDT recommendations and checks that the correct processes have been followed.

6. The Panel will decide if the person is eligible for CHC and consider what Resources are Available to deliver the plan of care.

7. The resources required to safely deliver the plan of care are made available to the MDT. The preferred option is identified and a Detailed Plan of Care agreed with the person and the MDT.

   An MDT care planning meeting may be needed to finalise the detailed care package.

   The coordinator will continue to liaise with the MDT, the person and others throughout the CHC process. The coordinator will also liaise with any external organisations to arrange the final care package.

8. The person has a Successful Transfer to the new care plan on the date agreed in advance.

Model Timetable:

Day 01 - the start of the process and timeline on the day that the MDT decision is reached.

Day 07 - collating document may take up to a week.

Day 08 - the manager checks all the paperwork.

Day 14 - the scrutiny panel meets every week.

Day 15 - the panel’s decision is communicated.

Day 21 - the detailed care plan is completed.

Day 28 - the person is transferred.
1. The role of the Care Coordinator

The Care Coordinator is the main point of contact for the person and professionals involved in the Continuing NHS Healthcare process and they will make sure that the person understands where they are in the process. Throughout the process the Care Coordinator is usually a health professional who is currently involved in looking after and planning with the person for their future care. In hospital it is likely to be the ward manager or another member of the Multidisciplinary Team. In the community it is likely to be a member of the primary health care team, for example a District Nurse.

The role of the Care Coordinator is to:
- Make sure that the views of the person and their family and carers are fully understood and documented
- Make sure that the right people are involved in the MDT
- Make sure that MDT contributions to the assessment are collated and current
- Check that all appropriate documentation is properly completed
- Offer information regarding Continuing NHS Healthcare, advocacy and independent financial advice
- If a person is not eligible for Continuing NHS Healthcare, liaise with the Local Authority case manager responsible for arranging social care services and agree joint packages of care where appropriate
- If Continuing NHS Healthcare eligibility is agreed and in-patient care is required, ensure the person’s name is placed on the list for transfer to the appropriate NHS unit.
- If Continuing NHS Healthcare is agreed and discharge from in-patient setting indicated, identify appropriate services and costs, and send these with the care plan, and the comprehensive Unified Assessment to the Health Board.
- Ensure that the person or their representative is informed of the decision and have received a copy of the assessment documentation.

2. The role of the Multi Disciplinary Team

The Multidisciplinary Team is responsible for undertaking the assessments and making a recommendation to the Local Health Board about a person’s eligibility for Continuing NHS Healthcare. The assessment process should start when:
- Any clinical care is nearing completion and it is clear to the Multidisciplinary Team that a person’s current needs are unlikely to change in the next few months.
- Irrespective of setting, a person’s needs have altered and there needs to be changes made to any existing care arrangements.

3. The Assessment Documentation

The assessment documentation will record a holistic assessment of all of the person’s health and personal care needs. This will be recorded using all the domains within the Unified Assessment Process, Decision Support Tool, and any other appropriate assessments. If some domains are not relevant they will be recorded as such.

The person and their chosen representative will be invited to help complete documentation particularly the sections for the Service Users perspective, and the Carer’s perspective. Other information that can help to give a full picture of the person’s needs should be included as part of the assessment, such as a diary or 24 hour care plan. The assessment
documentation will also explain how problems affect the person and what the implications would be if their needs were not met. All documentation must be clearly dated and signed.

4. Continuing NHS Healthcare Manager

This is the person appointed by the Health Board to oversee the Continuing NHS Healthcare process and its legal responsibilities. These include ensuring information is available; processes have been properly followed; assisting when complex issues arise; dealing with reviews and appeals; and liaising with the service planners and others where additional services for the person are identified.

5. The CHC Panel

This is usually made up of a group of senior clinicians and managers in the Local Health Board who look closely at applications for Continuing NHS Healthcare funding beyond local NHS provision. The first function of the panel is to decide whether a person is eligible for Continuing NHS Healthcare. The Panel will scrutinise the MDT recommendations to ensure that the correct processes have been used and may ask the MDT to undertake further work or provide additional information before a decision can be reached.

6. Resources Available

Once the decision has been made, the panel then has to consider the care plan and balance the needs of each person eligible for Continuing NHS Healthcare against the availability of resources and staff with the right expertise. When eligible for Continuing NHS Healthcare, the person may:

- Need in-patient hospital care, for example, when frequent medical review is required
- Be cared for at home by District Nurses or other community based healthcare staff
- Be fully funded in a nursing or residential care home or specialist placement

The NHS is not obliged to offer choice but will consult with the person and their family about preferences.

If a person does not meet Continuing NHS Healthcare eligibility but does require a placement in a nursing home, the Health Board will contribute to the Funded Nursing Care.

7. Detailed Plan of Care

This is a care plan drawn up by the Care Coordinator and agreed with the person addressing all their needs and how they will be met and by whom. It will stipulate frequency over a full 24 hour period and ensure that a person who is unable to communicate their needs will continue to receive complete and safe care. It will also consider the support those caring for the person, for example what family are willing to provide and what support families may need to help with their caring role.

8. Transfer of Care

Transfer of care happens when all equipment and services are in place to provide for the safe and smooth transfer of a person’s care from one setting to another and where appropriate from one funding organisation to another.
## Continuing NHS Healthcare Record Sheet

A copy of this sheet should be filed in the person's medical notes and the original booklet (including this sheet) given to the person or their family or carers.

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