



British Geriatrics Society Best Practice Guide

Assessment of Older People for Continuing Care

(Best Practice Guide 4.6 published September 2009)

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1. Executive Summary

A national framework for determining the criteria to qualify for NHS-funded continuing health care was issued in 2007 and revised in July 2009 for England and Wales. This has led to an increase in the number of people receiving such funding, and a more equitable system across the country. Although the system is far from perfect, decisions can be challenged by patients, their families and by professionals.

Multidisciplinary teams should contribute to the assessment process, and geriatricians should be familiar with the principles and practice embedded within the system and the Decision Support Tool.

2. Introduction

The issue of funding Continuing Health Care has been controversial and a postcode lottery for many years. In 1996, following a successful case challenged by the Ombudsman, the DOH required each HA to devise eligibility criteria. There was a strong call, including from many geriatricians, for a universally applied assessment tool, yet the DH continued to expect Health Authorities to interpret legal guidance in a consistent way without any clearly understood criteria for continuing health care. The Royal Commission into long-term care recommended in 1999 that nursing care should be paid for by the State. The Coughlan case was a legal challenge as to whether nursing care could be provided by the Local Authority in a private nursing home. This led to a restatement of the definition of NHS-funded continuing care in 2001 – where the nursing component of the person's care can no longer be considered ancillary to the person's overall need for care. On behalf of thousands of families, the Ombudsman has been challenging the application of the DH guidance by Health Authorities, and revealed that assessment systems and appeals mechanisms were far from satisfactory. Inconsistencies were shown by a small study by Tony Luxton (*Age and Ageing* 2006 35: 313-6), and BBC Panorama programmes.

In June 2006, a consultation document was published. The BGS and around 500 other people and organisations responded. The new policy for continuing health care was published in 2007 and revised in July 2009.

3. Definitions / Terminology

NHS continuing health care [1] is fully-funded care, which may be provided at home or within a long-term care setting. The funding is given to provide for the person's identified care needs. The central assessment is whether the person's primary need is a health need. If it is, then the person should receive NHS Continuing Healthcare; if not, then the nursing care must be considered only ancillary to the overall social care required, and the person may be eligible for care provided by the Local Authority. Characteristics of the needs of the individual help determine this: the *nature*, the *intensity*, the *complexity*, and the *unpredictability* of their needs. Assessing the overall needs leads to a decision, and this will be assisted by using the national Decision Support Tool.

Having determined whether the patient qualifies for NHS continuing health care, the Primary Care Trust must determine how the identified needs are to be met. This is decided bearing in

mind the PCT's responsibility to ensure that the needs are fully and properly met, often for a person with loss of capacity for themselves, and taking into account the views of the patient and carers. The PCT must also use their public finances judiciously.

NHS-funded Nursing Care provides NHS support for those patients ineligible for NHS Continuing Healthcare yet requiring some degree of nursing care in a Care Home. They receive a single band of financial support, regardless of the patient's personal finances. The payment is currently around £110 per week. This replaced, and greatly simplified the previous 3-band structure known as the Registered Nursing Care Contribution.

4. Models of Service Provision

Primary Care Trusts are responsible for ensuring delivery of the national framework locally. They are responsible for making the decision of eligibility. The preferred model of care is through a team of specialist nurses skilled in the assessment of complex nursing care, mental health needs, and needs in the context of learning disability. Prior to discharging someone from hospital, and especially if they require ongoing care of any sort, there should be a consideration of whether the person might qualify for continuing care. In practice, this assessment is most likely to be undertaken when providing a complex care package, or transfer to long-term care. The screening tool should be used for the purpose. If it is clear the person would not qualify, there is no need to undertake a screening assessment. The screen may be undertaken by a member of the MDT, or by a discharge coordinator/assessor.

If the person passes the screening test, they should be formally assessed, using the Decision Support tool.[2] This is not a validated assessment tool, yet provides a structure for the assessment of 11 domains of health need, based around the four factors described above. The outcome remains descriptive rather than a score. It has been modified following a period of piloting. The DST will usually be completed by the assessing CHC nurse, in conjunction with other assessment information from the MDT. The framework, and best practice, advises that this should be carried out near the patient i.e. on the ward, rather than from a distant office.

Some, but not all, PCTs have found it helpful to establish one or more panels to consider the recommendations they receive from the assessor and MDT and make the final decision on behalf of the PCT. The National Framework states that Panels should not be used as a gatekeeper, or as a financial monitor. There are detailed procedures in the framework enabling families to challenge the decision, establishing independent review panels etc.

Practical issues on the delivery of the policy can be viewed online [3].

In Scotland, new guidance was issued in 2008 [4]. This guidance covers healthcare that would only be provided in hospitals or care homes. The decision for eligibility rests with the consultant or GP in conjunction with the multidisciplinary team. The process of assessment and decision making should be person-centred and needs-led where there is a need for ongoing and regular specialist clinical supervision of the patient as a result of the complexity, nature or intensity of the patient's health needs; the need for frequent, not easily predictable, clinical interventions; the need for routine use of specialist health care equipment or treatments which require the supervision of specialist NHS staff; or a rapidly degenerating or unstable condition requiring specialist medical or nursing supervision.

A generic decision support tool has been developed to assist in the assessment [5]. 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.

5. Responsibilities / Role of the Geriatrician

The consultant geriatrician will often discuss the need for long-term care with patients and families, and the options for where that care may be delivered. It is crucial that the consultant should be familiar with potential funding arrangements, and is able to provide guidance to the MDT and the family. He/she should seek to achieve an efficient and speedy decision-making process within their locality, where the MDT contributes fully to the decision-making process. He/she should also be keen to see a fair and equitable process in place, which is open to scrutiny.

6. Audit

The PCT is required to monitor the outcomes of their assessments, and report the numbers of patients receiving NHS continuing healthcare, along with the reason for funding. The PCT is also required to review all individuals receiving funding on a regular basis.

7. Training

It is good practice to provide at least rudimentary training and understanding of the DST to all core members of an MDT wherever patients are frequently found, such as on an elderly care ward. Such training should be provided by the specialist nurses or manager from the PCT.

8. Recommendations

In many parts of the country delays are being experienced in the delivery of this framework. However, the BGS welcomed the new policy as a large step towards equity in the provision of fully-funded care. There has been a large increase in the number of individuals receiving fully-funded care since the introduction of the framework in 2007. Departments of geriatric medicine should seek to work with their PCT to streamline the decision-making process, ensuring that patients and families are well-informed and receive their entitlements.

9. References

1. The National Framework for NHS Continuing Health Care
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103161.pdf
2. Decision Support Tool for NHS Continuing Healthcare
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103329.pdf
3. FAQ's on the framework.
www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/FAQ/DH_082598#_16
4. NHS Continuing Healthcare in Scotland
http://www.sehd.scot.nhs.uk/mels/CEL2008_06.pdf
5. NHS Continuing Healthcare Decision Support Tool
<http://www.scotland.gov.uk/Topics/Health/care/17420/AssessmentSummary>

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