APPENDIX 1

NORTH WEST LONDON PRIMARY CARE TRUSTS & NORTH WEST LONDON BOROUGHS[1]

Section One
AGREEMENT ON CONTINUING CARE

This agreement relates to revised eligibility criteria for NHS funding of continuing health care needs for younger and older adults with

- **physical disabilities**
- **learning disabilities**
- **mental health problems, including mental illness associated with old age.**

The criteria should also be used where the level of need requires specialist palliative care services.

Criteria for access for children with special needs are being developed. Bearing in mind that clients may have a dual diagnosis, and the need for a smooth transition for children into adulthood, and for younger adults into old age, the criteria should be used flexibly to reflect the primary needs of the clients at the time of assessment.

1. **Introduction**

1.1. In 1996/97 the four Health Authorities in North West London[2] developed Criteria for Continuing Care in response to the Department of Health's guidance *NHS Responsibilities for Meeting Continuing Health Care Needs HSG [95] 8*. These were developed in partnership with local authorities and in consultation with the local communities and covered all care groups.

1.2. Each of these criteria were slightly different, but a number included a system of categorisation into three or four bands, based on a person's level of dependency derived through the multi-disciplinary assessment process. These defined the level of dependency essential to accessing fully NHS funded continuing health care and also the level of dependency for joint funded care of community based Local Authority clients.

[1] Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, Westminster
[2] Brent & Harrow Health Authority, Ealing, Hammersmith & Hounslow Health Authority, Hillingdon Health Authority, Kensington, Chelsea & Westminster Health Authority

2. The Need to Review the Continuing Care Criteria

2.1. Following the Coughlan Appeal Court judgement *(R v North & East Devon Health Authority ex parte Coughlan)* in 1999, all Health Authorities were asked to reassess their criteria to ensure that they were consistent with the recommendations deriving from that judgement. This process of legal assessment identified a number of problem areas and inconsistencies, some of which were dealt with immediately on a local basis.

2.2. In June 2001 the Department of Health issued new guidance: *Continuing Care: NHS and Local Councils' Responsibilities HSC 2001/015: LAC (2001) 18*. This consolidated previous guidance and set out a range of actions for Health Authorities (and subsequently Primary Care Trusts) to take with local councils, to ensure that local policies comply with the guidance. It also advised that there should, in time, be one set of criteria in place across a whole Strategic Health Authority area[3].

2.3. In North West London it was agreed to work together to develop revised continuing care criteria to meet the requirements. As a first step the four health authorities and eight local authorities met and agreed the following statement.

2.4. The aim of continuing care is to provide the right long term support to clients, to promote independence, prevent deterioration and maximise their health and quality of life. In order to achieve this, the criteria for continuing care should meet the following principles:

CONTINUING CARE – CORE VALUES AND PRINCIPLES

- ❑ needs led (acknowledging layers of complexity)
- ❑ equitable (not age related)
- ❑ culturally sensitive
- ❑ client centred
- ❑ single assessment process the key to accessing continuing care
- ❑ assessment for continuing care should follow assessment for rehabilitation
- ❑ regular review built into the process
- ❑ easily understood (clear definition of terms)
- ❑ administratively simple
- ❑ building on guidance and good practice
- ❑ criteria should not relate to the anticipated location of care
- ❑ a change of funding agency should not necessarily mean a change of home

2.5. It was agreed that the new criteria would be implemented from the same date across North West London. A transitional period would be agreed locally in each borough so that implementation could reflect the differential impact of the new criteria in different areas.

2.6. The initial work undertaken by the four health authorities has been continued by the eight Primary Care Trusts which have replaced them from April 2002.

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[3] In North West London, the Strategic Health Authority area covers the eight boroughs of Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, and Westminster.

3. Changes to the Continuing Care Criteria for North West London

3.1. During 2002/03, the North West London Primary Care Trusts and Local Authorities revised the 1997 criteria for the client groups 'young people with a physical disability' and 'older people (including those with a mental health problem associated with old age)'[4], including those with palliative care needs, and those for younger adults with mental health problems or learning disabilities.

3.2. We have received legal advice and are confident that the criteria are in line with the Coughlan judgement in identifying two categories of people being:

- ❑ those who because of the scale, range, continuity and intensity of their health needs meet the criteria for NHS fully funded continuing health care; and
- ❑ those who require additional health care support (NHS funded) within a privately funded or Social Services funded package but do not meet the criteria for NHS fully funded continuing health care

3.3. Clients meeting the full NHS continuing health care criteria set out in Paragraphs 1-4 of Section Two, will be eligible for NHS funded care within a care facility approved by the Primary Care Trust. NHS continuing care may be provided in a hospital, a care home, a hospice or an individual's own home, subject to assessment of need and to clinical safety and resource issues. The relevant Primary Care Trust will fund this care in full.[5]

3.4. Clients who do not meet these criteria will not be eligible for continuing care fully funded by the NHS but may be entitled to funding of the nursing element of their care or require additional specialist health care services, which are set out in Paragraph 5 of Section Three. These will be purchased through the responsible Primary Care Trust's service level agreement at no charge to the client and will normally be provided by NHS trusts or other designated providers such as a registered care home where the client is placed.

3.5. All clients, whether they are fully NHS funded or not, are entitled to a Social Services assessment in order to ascertain their need for both residential and non-residential community care services.[6] Where the Local Authority provides services (residential or non-residential) there will be appropriate oversight of such services from a Local Authority Care Manager in order that an individual's social needs are met. In addition the Local Authority will offer advice and support to ensure:

- ❑ protection for vulnerable clients, and
- ❑ access to other community services, eg benefits advice.

3.6. Pending a review of any client's needs through a multi-disciplinary assessment, there shall be no change to the current funding arrangements.

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[4] In revising our criteria we have drawn heavily on the work undertaken by East and West Surrey Health Authorities and Surrey County Council, for which we thank them.

[5] The relevant Primary Care Trust will need to be confirmed and notified in accordance with paras 65-70 of the *Establishing the Responsible Commissioner* guidance October 2003 www.doh.gov.uk/pricare/responsiblecommissioner

[6] See Fair Access to Care Services, Guidance on Eligibility Criteria for Adult Social Care at www.doh.gov.uk/scg/facs

3.7. It is expected that the regular review procedure will be the method by which decisions relating to existing clients are reviewed. All clients are entitled to an assessment under the new criteria and to a change in funding arrangements if that is indicated by the assessment.

3.8. In addition, should a client's needs reduce, and their eligibility for NHS funded care be removed, they will be transferred to Local Authority funding (and liable to contributions depending on financial assessment). It should therefore be made clear to clients that an assessment that someone is eligible for NHS continuing care is not necessarily "NHS funding for life", since their eligibility will change should their care needs diminish.

3.9. In addition, assessment for continuing care eligibility will take place for individuals who are new to health and social services or for those in transition from child to adult services.

4. **Predominant needs**

4.1. The Local Authority Social Services Department is responsible for the provision of services to meet all personal care needs where those needs have been assessed to be a need that it is necessary for the Local Authority to meet under s21 National Assistance Act 1948.

4.2. The Court of Appeal judgement in R v North and East Devon Health Authority ex parte Coughlan (July 1999) clarified that where the predominant need for care home accommodation is a health need, the nursing services must be provided by the NHS. In addition HSG (92) 50 para.7 confirmed that where a client's need is primarily for health care, the whole cost of the placement in a care home must be borne by the NHS.

4.3. The converse is also true: where the predominant need for the provision of accommodation is for personal/social care reasons the whole cost of the placement must be borne by the Local Authority in accordance with its duties under S21 NAA 1948. However, the introduction of "free nursing care" under HSC 2001/017 allows for a fixed contribution from the NHS to the costs of the nursing element of a person's care.

4.4. In forming a judgement as to whether a person has predominantly health care or personal care needs, in particular where a care home placement is being proposed, the multi-disciplinary assessment team[7] must use the criteria set out in Section Two and then address the following two questions:

? are the nursing services being purchased merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide under S21 NAA 1948; and

? are the services being purchased of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide?

[7] Multi-disciplinary assessment – this is likely to include a doctor, nurse, therapist and social worker plus others such as psychogeriatrician or community psychiatric nurse if relevant.

4.5. Personal care is defined as: any care that requires the physical touching of that person but is distinct from treatment or therapy and is of a nature that does not require to be carried out by a qualified nurse (or someone trained to carry out a particular task in place of qualified nurse).

4.6. The Local Authority will purchase services in a care home in order to meet both the personal care needs and the ancillary nursing care needs of a person where:

- the personal care needs have been assessed to be the predominant care needs; and
- the ancillary nursing care needs have been assessed to be able to be best met in a registered care home.

4.7. Where the Local Authority purchases services in a care home the NHS will contribute to the costs of the nursing care in accordance with the framework of contributions set out in the guidance on NHS Funded Nursing Care[8] (see Section Four).

4.8. For care packages in the client's own home we have been advised by our lawyers that jointly funded packages can be provided so long as the Local Authority is paying for recognised community care/social care provision and the NHS for the assessed healthcare needs. HSC 2001/015 (LAC2001)(18) requires there to be a clear audit trail for NHS and Local Authority funding input, since no client can be charged for healthcare services.

5. Self - funding clients

5.1. These criteria apply to self-funding residents in residential care and care homes in the same way as they apply to Local Authority funded clients.

[8] HSC 2002/017 LAC (2001)26 Guidance on Free Nursing Care in Nursing Homes see www.doh.gov.uk/jointunit/nhsfundednursingcare

6. Review and Complaints

6.1. North West London Health Authority has established a Review Panel whose role is :

- to check that proper procedures have been followed in reaching the decision about NHS continuing care, and the NHS services contributing to health and social care;
- to ensure that the North West London Criteria have been properly and consistently applied.

6.2. Clients, their carers and advocates who have a concern regarding

- the content, rather than the application of the criteria
- the type and location of any offer of NHS funded continuing care
- the content of any alternative care package which they have been offered,
- their treatment or any other aspects of the service they are receiving:

may use the existing complaints and review procedures for each respective agency:

- Primary Care Trust complaints through the statutory NHS complaints procedure.
- Social Services complaints through the statutory social services complaints procedure
- Complaints about the standard of care provided within any care package can be directed to the National Care Standards Commission.

7. Audit

7.1. The eight Local Authorities and Primary Care Trusts originally agreed to implement these new criteria and assessment tool as from 1st April 2003 on a trial basis. An internal review has been carried out to monitor the implementation process and assess the impact of the new criteria on individual clients and overall funding responsibilities.

7.2. The feedback from this review informed the revisions prepared and discussed in December 2003 and led to a number of amendments to the text of the criteria, primarily providing clarification. There have been no substantial changes to the criteria.

7.3. Further audit of the implementation of the criteria will be carried out in 2004 and this will be reviewed again periodically by the North West London Continuing Care Review Group.

7.4. The criteria and assessment tool have now been agreed for implementation across North West London as from April 2004 (subject to ratification by Primary Care Trusts and NWLHA and endorsement by Directors of Social Services).

7.5. In approving and implementing these criteria the NWLHA and Primary Care Trusts are meeting their obligations in relation to *The Continuing Care (National Health Service Responsibilities) Directions 2004*[9].

8. Further Information

8.1. Further information on the Continuing Care Criteria can be obtained from:

Continuing Care Lead
North West London Health Authority
Victory House
170 Tottenham Court Road
London W1T 7HA

8.2. Email: michael.young@nwlha.nhs.uk Tel: 020 7756 2500

[9] See www.doh.gov.uk/jointunit/ccnhsrdirections04.pdf

Section Two

NORTH WEST LONDON CRITERIA FOR NHS FUNDED CONTINUING CARE

FOR YOUNGER ADULTS (AGED 18 AND OVER) AND OLDER PEOPLE WITH A PHYSICAL DISABILITY, A LEARNING DISABILITY OR A MENTAL HEALTH PROBLEM, INCLUDING A MENTAL ILLNESS ASSOCIATED WITH OLD AGE

1 To be considered under these criteria, clients must be over 18 years old and registered with a GP in one of the Primary Care Trusts within the North West London sector[10] or unregistered but at the point of initial assessment considered "usually resident" in one of these boroughs.

2 In all cases, a multi-disciplinary assessment must be carried out, convened by the Local Authority, in order to determine the application of the criteria to any particular client.

3 Clients who have on-going neurological dependency, characterised by any of the following will automatically be eligible for NHS continuing care:

- ❑ Unconsciousness
- ❑ Need for mechanical ventilation via a tracheostomy
- ❑ Persistent vegetative state following diagnosis by a consultant during the multi disciplinary assessment

4 Depending on the nature and intensity of their needs, there will be an additional group of clients who may be eligible for fully funded NHS continuing care. Such eligibility will be determined by the multi-disciplinary assessment carried out for each such client.

5 In making its decision, the multi-disciplinary team will identify whether the client has needs relating to the conditions listed below and will take into account the nature or complexity or intensity or unpredictability of the individual's healthcare needs (and any combination of these needs). This will enable them to make a professional judgement as to whether such needs are predominantly health care needs (in which case the placement will be funded by the Primary Care Trust) or whether the client's nursing needs are merely incidental or ancillary to the client's accommodation/personal care needs. In the latter case the placement will be made and funded by the Local Authority, subject always to the provisions of paragraph 2 of this Appendix.

6 A need for care or supervision from a registered nurse and/or a GP is not, by itself, sufficient reason to receive NHS continuing care.

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[10] The eight Primary Care Trusts in the North West London Sector are: Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, Westminster

7 NHS funding will not be agreed without a Specialist Health Assessment[11] and report using the North West London Continuing Care Assessment Tool[12] which covers the domains listed below.

- ❑ **Palliative Care**
- ❑ **Communication**
- ❑ **Cognitive Impairment**
- ❑ **Challenging Behaviour**
- ❑ **Functional Mental Illness**
- ❑ **Mobility**
- ❑ **Food and Drink**
- ❑ **Skin (wound/ulcer care)**
- ❑ **Drug Therapies and Medication**
- ❑ **Seizures**
- ❑ **Breathing**

[11] A Specialist Health Assessment may be carried out by a nurse, a doctor or a therapist.
[12] attached

Section Three
ADDITIONAL NHS HEALTH CARE SUPPORT FOR CLIENTS NOT MEETING CRITERIA FOR FULL NHS FUNDING

1 All clients covered by the Primary Care Trusts are eligible for the full range of general community health care services that are provided. Clients who receive Local Authority funded care may need additional specialist health care services, examples of which are set out below.

2 All clients will be offered a multi-disciplinary assessment appropriate to their needs. The assessment will identify any specialist health care needs beyond that which general community health services and a client's General Practitioner can meet.

3 The multi-disciplinary team will agree the frequency of a client re-assessment in order to ensure that the appropriate level of health care and social care input for the client is maintained. An identified lead professional from the multi-disciplinary team will be responsible for co-ordinating the client assessment. This does not preclude an earlier re-assessment of the client's needs, should any of the professionals from the multi-disciplinary team consider it appropriate.

4 The host Primary Care Trust[13] is responsible for meeting the general health needs of people placed by the Local Authority in care homes outside the areas of the Primary Care Trust. Specialist health care funded at the time of out-placement will continue to be funded by the host Primary Care Trust provided that, prior to placement, the relevant Primary Care Trust has approved the placement. The originating Primary Care Trusts are not permitted to fund new specialist health care needs arising after placement, which will be the responsibility of the new Primary Care Trust as assessed in accordance with that Primary Care Trust’s eligibility criteria.

5 The range of specific NHS funded services that may be provided is as follows, (the list is not exhaustive):

- ❑ Additional nursing care over and above that normally provided by a care home. This may be provided by specialist nurses such as Macmillan nurses, dementia support nurses and nurses with specific training in Parkinson's Disease, palliative care, or another disease area.

- ❑ Specialist pain relief.

- ❑ Additional specialist mental health treatment or care.

- ❑ Assessed and prescribed specialist therapy services over and above those normally provided by primary health care.

- ❑ Specialist nursing equipment or care not normally provided in a care home, a residential home or in a client's own home (e.g. PEG feeding equipment or management of a ventilator or dialysis).

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[13] Host PCT means the PCT to which the client’s GP is attached, which will usually (but not always) be the PCT in which the home is located. See Establishing the Responsible Commissioner guidance October 2003 for further details www.doh.gov.uk/pricare/responsiblecommissioner.pdf

- ❑ Specialist advice, e.g. psychology, on the management of cognitive/behavioural problems associated with disability or traumatic head injury.

- ❑ Specialist advice generally provided via the local community health services, for matters such as tissue viability issues, continence, and dietetics. Training and education support for carers and care workers may also be accessed.

6 Under normal circumstances, such additional services will be provided by NHS Trusts (or other designated providers), at no charge to the client, within existing service agreements or as agreed between the Primary Care Trust and the other NHS Trust in question.

7 In addition, under the Free Nursing Care guidance, the Primary Care Trust will contribute to the funding of nursing care for Local Authority or self-funded clients in care homes, within the framework of contributions set out in the guidance. Such contributions will be confirmed following the Specialist Health Assessment.

Section Four
NHS FUNDED NURSING CARE[14]
(previously called FREE NURSING CARE)

1. Under *HSC 2001/017 Free Nursing Care* updated in *HSC 2003/06 Guidance on NHS-funded Nursing Care* the NHS is required to fund care provided by a registered nurse to clients resident in a care home whose care is self funded, or funded by the Local Authority. This does not apply to nursing care provided to someone resident in their own homes.

2. The contribution which the NHS is required to make is fixed by the guidance, against three bands, high, medium or low.

3. The first decision in the assessment process should always be whether or not the individual meets the criteria for fully NHS funded continuing care. The high, medium and low bands for Free Nursing Care should only be used for deciding the NHS funding contribution towards the costs of registered nursing input, where it has been decided that the individual does not qualify for fully NHS funded continuing care, and where they are placed in a nursing home.

[14] see www.doh.gov.uk/jointunit/nhsfundednursingcare.pdf

Section Five
NORTH WEST LONDON
GUIDELINES FOR ASSESSMENT FOR NHS FUNDED CONTINUING CARE

Introduction

1. This document is intended as an operational tool for North West London Primary Care Trusts and Local Authorities to use from April 2003 (amended as from April 2004). It should be read in conjunction with borough based agreements for implementation.

2. This document gives guidance to Primary Care Trust (PCT) and Local Authority (LA) staff who have responsibility for making professional judgements as to the appropriate funding authority, (PCT or LA) when a patient/user is assessed to have continuing health or social care needs. The final decision is a matter of professional judgement. However, where there is dispute as to which authority has funding responsibility for a particular person the agreed local mediation process should be followed.

3. *Note: These are guidelines only, they cannot, and are not meant to, ever be a substitute for the professional judgement that must be exercised in each individual case.*

4. The key to the effective working of this agreement is the Multidisciplinary Team (MDT) assessment and positive partnership working between Health and Social Services.

5. This assessment tool covers the needs of younger adults and older people with physical disabilities, learning disabilities, mental health problems, including mental illness associated with old age.

The Assessment Process

6. Individuals are entitled to an assessment as to their eligibility for community care services irrespective of whether or not they may subsequently receive services arranged and funded by the LA, the PCT or by purchasing services privately. This also applies to reassessments of self-funding individuals or PCT funded patients.

7. A Continuing Care Assessment can be initiated by any of the parties to this agreement at any stage of the assessment process.

8. As part of the single assessment process a health needs assessment will be carried out by, or on behalf of, the Primary Care Trust. If following, or during, this assessment it is considered by either the health professional carrying out the assessment or the care manager that the patient/user may have continuing health care needs a specialist health assessor (continuing care) will be requested to complete an assessment of those specific needs.

9. Additional specialist assessments may also be commissioned by the Primary Care Trust (or requested by the care manager) at the health needs assessment stage, or subsequently, to inform the overall assessment.

Decision Making Guidelines

10. The guidelines cover the eleven categories of need identified in the formal agreement.

11. Each of the categories of need is divided into a number of levels of need and relative weighting given to each level. Also an indication is given as to the patient's/user's likely primary need (i.e. healthcare or social care).

    - ❑ If any of the Relative Weightings are 100 = NHS funding is indicated
    - ❑ If three or more of the Relative Weightings are 60 = NHS funding is indicated
    - ❑ If one or two of the Relative Weightings are 60 = NHS funding may be indicated, if professional judgement suggests that the predominant need is assessed to be "healthcare"
    - ❑ If all Relative Weightings are below 60 = SSD funding is indicated unless the predominant need is assessed to be 'healthcare' as opposed to 'nursing care'

12. The guidance has made it clear that all care packages will have to fall into one of the following categories[15]:

    - ❑ 100% NHS funded care package, including nursing and personal care (though clients can choose to self-fund)
    - ❑ Local Authority funded (or self-funded) care package, with NHS-funded Nursing Care[16] contribution plus other healthcare input (e.g. therapy, specialist nursing etc)
    - ❑ Local authority funded (or self-funded) placement, with the usual NHS services (e.g. GP, hospital) as required.

13. If ***one or no*** categories have a relative weighting of 60 any nursing care needs will be likely to be ancillary to the person's accommodation needs. If this is confirmed by the assessment, and the person's needs are not assessed to be primarily healthcare as opposed to 'nursing care', the Local Authority would be responsible for arranging and funding appropriate services to meet that person's needs, or the package would be self-funded, depending on the subsequent financial assessment.

14. If ***two*** categories have a relative weighting of 60 a professional judgement will need to be made as to the predominant need of the patient/user i.e. social care or health care. This judgement will be made by the Specialist Health Assessor and the designated Care Manager or, where appropriate, the Continuing Care Panel, and will depend on the particular mix of domains.

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[15] A person who does not meet the criteria for NHS funded continuing care or Local Authority Fair Access To Care Services criteria may still choose to enter a care home but will be liable for meeting the entirety of their care home fees from their own resources.

[16] At February 2004 NHS-funded nursing care was only available to those resident in a care home, not to those receiving a package of care in their own homes.

15. In making its decision, the team will consider whether the overall scale of the person's health needs is such that they should be regarded as wholly the responsibility of the NHS, taking into account the nature or complexity or intensity or unpredictability of the individual's health care needs. In addition attention should be paid to the specific categories which have been identified with a higher weighting, for example, it may be possible to weight one category higher or lower than another in a particular situation particularly when specific nursing tasks are directly related to each other.

16. Where the predominant need is judged to be social care the Local Authority will be responsible for arranging and funding the necessary care. Where the predominant need is judged to be health care the Primary Care Trust will be responsible for arranging and funding the necessary care.

17. In other words, individuals who do not have three or more weighting scores of 60 may be entitled to NHS continuing care where the overall scale of the individual's health needs is such that they should be regarded as wholly the responsibility of the NHS.

18. If ***three or more*** categories have a relative weighting of 60 the accommodation needs are likely to be ancillary to the person's nursing care needs and the Primary Care Trust would be responsible for arranging and funding appropriate services to meet that person's needs.

Accounting for Continence Problems

19. Continence problems are common, and figure significantly in care plans for dependent people. All individuals should have access to specialist nurse continence advice and review, wherever they reside. Documentation of bowel or bladder problems is part of normal clinical assessment with a specific care plan to address the problems.

20. The skills required for effective continence management depend largely on associated problems such as:

    - Communication
    - Behaviour
    - Cognitive impairment
    - Mobility
    - Skin

21. Individuals with communication, cognitive or behavioural problems are likely to require the most skilled care and are more likely to require continuous specialist nursing. For each individual, consider the possible impact of continence problems on each of the domains listed (communication, behaviour etc) – and score these accordingly.

22. For example: An immobile man with stroke dementia who has profound comprehension problems, is doubly incontinent and consistently resists toileting / changing by scratching / biting carers. Safe management requires two skilled staff.   In this case:

    Communication – score 60
    Challenging behaviour – score 100
    Cognitive impairment – score 60
    Mobility - score 60
    Tissue viability – score 60

Assessment of Dementia and Mental Health Needs

- Individuals with mental health needs being considered for continuing care are likely to have a range of needs requiring assistance or intervention from others.

- Some needs are consistent and predictable – e.g. the need to be assisted with washing and dressing for an individual with fairly advanced dementia.
- Other needs are less predictable – e.g. unexpected distress, intermittent restlessness or variable resistance to care.

- The skills required to provide core care needs for people with chronic mental health needs most be recognised and maintained.

- Most individuals with persisting mental health problems should be managed in care settings where staff possess these skills.

- The level of skill required (e.g. specialist nursing or not) to manage a particular individual will depend on the complexity of that individual's needs.

- Specialist nursing skills may be required for review and reassessment of care needs rather than being essential for 24 hour care.

- Similarly, specialist psychiatric medical review will be required at different frequencies, generally depending of the clinical stability of the patient.

- The severity of cognitive impairment does not alone determine the need for continuous specialist nursing care, and for this reason it is not possible to Score 100 on cognitive rating alone.

- Similarly the severity of communication deficit does not - on its own - define the need for continuous specialist nursing care, and it is therefore not possible to Score 100 on communication alone.

- However, it is essential that where there are behavioural problems associated with meeting basic care needs or in communication with an individual, that the behavioural scale is used and scored.

- A feature of mental illness or disorder is that some individuals are liable to relapse or develop serious clinical symptoms with changes in care routines, care setting or when carers change. This factor needs to be taken into account primarily in the behaviour rating.

Mental Health Act 1983

In assessing funding responsibilities for continuing care, consideration needs to be given to the legal status of the client who is or has been subject to section 3, 37, 45A, 47 or 49 of the1983 Mental Health Act. Clients who are detained under the Act have their hospital treatment and care fully funded by the NHS.

While liable for detention under section patients may be entitled to S17 leave in the community. In this situation their NHS bed is usually retained for them,(in case the S17 leave fails). If they are returning to accommodation already funded by a Local Authority that will usually continue. Section 17 leave may be regarded as preparation for return to community living and in these circumstances the continuing care criteria need to be applied to decide funding.

Once clients have been discharged from S3, 37, 45A, 47 or 49 the Local Authority and the PCT have a duty to assess their need for aftercare under S117 of the Mental Health Act.

The NHS and the Local Authority, in cooperation with relevant voluntary agencies, have a duty to provide aftercare services for people to whom this section applies (people detained under Sections 3, 37, 45A, 47 and 49) until such time as the health authority and the local social services authority are satisfied that the person concerned is no longer in need of such services.

This can continue for an indefinite period but will be reviewed on a regular basis through the Care Programme Approach process. It is usually funded by the Local Authority and the NHS.[17] The client is not liable to be charged while under S117. Criteria for discharge from S117 need to be agreed by the local health and social care providers.

This was set out in HSC 2000/003 After-Care Under the Mental Health Act 1983 and reinforced by the recent judgement in R v Manchester City Council ex parte Stennett and two other actions.

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[17] The guidance is unclear about how the costs of aftercare should be divided although some authorities have read it as indicating a 50/50 split. Since the client is not liable to charges the issue is simply between the local PCT and the Local Authority to agree. However, the principle of funding implications flowing from the assessment of needs shuld be applied.

Learning Disabilities

Learning disabilities means:

- a significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning),
- which started before adulthood, with a lasting effect on development

The Government's white paper, Valuing People, challenges local services to ensure that they build upon it's four key principles of Legal and Civil Rights; Independence; Choice; Inclusion. It is important to recognise that the development of person centred planning will mean that a greater variety of service responses are required than have traditionally been provided. Increasing numbers of non medical staff are being trained to support people with learning disabilities who experience difficulties with behaviour and as a result some people whose needs indicate a case for full NHS funding will have services delivered by non health care staff.

Specialist Palliative Care

Where a person has needs that require the input of specialist palliative care services they should be referred to the specialist services for an assessment. The specialist service will assess both immediate needs and continuing care needs, in the light of the person's diagnosis and prognosis. Where the person's health needs are increasing rapidly and a delay in assessment at panel is anticipated the specialist service, in consultation with the care manager, may wish to recommend them for full NHS funding through a fast track process, to avoid delays in discharge from hospital or hospice to home.

Each borough will need to confirm the arrangements for fast tracking people with such needs and establishing more frequent reviews. It is not the case, however, that all clients with palliative care needs will immediately meet the criteria for full NHS funding, since the levels of need identified within the domains still need to be applied.

Sensory Impairment

Sensory loss can be overlooked during the course of an assessment but it is likely to be an issue across all service user groups. For example, consider those who have had a stroke may experience speech loss, those with diabetes may have sight impairments, those with neurological damage may lose their sense of touch.

Assessors should consider the impact of the sensory loss on the individual's ability to cope, risk of harming themselves, psychological health, sensitivity to moving and handling etc. Although communication needs are dealt with as a domain in their own right assessors should remember the needs of deaf people who are British Sign Language users.

NORTH WEST LONDON CONTINUING CARE ASSESSMENT TOOL
ASSESSMENT SUMMARY

Name of Patient/User ______________________ DOB _________________

Address __________________________________ GP ________________________

If any one care category in this first assessment summary is ticked the NHS is responsible for arranging funding and the person's care needs in full.
If none are ticked please complete the second assessment summary.

Tick	Category	Relative Weighting
	Patient is unconscious	100
	Patient has mechanical ventilation via tracheotomy	100
	Patient is in Persistent Vegetative State	100

Each applicable category in this second assessment summary must be completed showing the relative weighting. If a category is not applicable put NA . This summary must be backed up with detailed assessments in relation to each applicable domain.

	Category	Relative Weighting
1	Palliative Care	
2	Communication	
3	Challenging Behaviour	
4	Cognitive Impairment	
5	Functional Mental Illness	
6	Mobility	
7	Food and Drink	
8	Tissue Viability (wound/ulcer care)	
9	Drug Therapies and Medication	
10	Seizures	
11	Breathing	

Please put any additional comments overleaf. Date _________________

Signed: Health Assessor ____

Designated Care Manager ____

Other assessors involved ____

Note 1: The 'Relative Weightings' are NOT cumulative scores.
Note 2: If the patient has, or will soon have, range 3 palliative care needs (score 100) they should be fast-tracked

DECISION: Agreed Funding Authority:
(To be completed by the Panel, not the assessor)

Primary Care NHS Trust ☐
Local Authority & FNC ☐
Local Authority ☐

Palliative Care

Patients whose disease is not responsive to curative treatment, who require control of pain and/or other symptom control, taking into account psychological, social and spiritual problems. Note: if a patient currently falls within range 2 but is likely to be in range 3 very soon and is known to the specialist palliative care team they should be fast-tracked for NHS funded care while awaiting a formal funding decision based on current need at the subsequent panel meeting. Care may be provided in their own homes or in a care home.

Range	Level of Need	Relative Weighting
1	Stable pain and other symptom control requiring regular (less than weekly) clinical review Symptoms causing occasional bad days with some limitation of activity	40
2	Pain control and other symptom control (e.g. dyspnoea, nausea and/or vomiting etc.) requiring regular (weekly) clinical review by specialist palliative care team. Severe symptoms or level of dependency, so that activities and concentration are markedly affected	60
3	Pain control and other symptoms (e.g. dyspnoea, nausea and/or vomiting), requiring clinical review by specialist palliative care team twice or more a week OR severe and continuously deteriorating physical condition resulting in increasing dependency	100

Communication

People who do not use speech to communicate or who have difficulty with communication, who may require a care plan delivered by carers with communication skills to ensure basic physical and psychological care needs are met (e.g. avoidance of thirst, pain, toileting need). The skill required is largely determined by the complexity of the communication difficulty. Where behaviours are associated with communication – e.g. resistiveness or aggression – also use the Behaviour Domain. This domain should also be used for people with sensory impairments where this impacts on their communications. It should not be used if communication issues arise only because English is not the client's first language.

Range	Level of need	Relative Weighting
1	Able to communicate (verbally & non verbally) all care needs safely, consistently and effectively	0
2	Needs prompting to communicate basic needs clearly. Special effort and skill may be needed by carer (e,g, simple phrasing, repetition) to achieve understanding.	20
3	Communication about basic needs often difficult to understand / interpret and requires additional carer training / skill to ensure care needs met.	50
4	Unable to reliably communicate basic needs even with skilled prompting (comprehension / expression or both), usually associated with serious brain pathology – e.g. dysphasic stroke or severe dementia.	60

Challenging Behaviour

Specialist assessment of people with serious behavioural issues should be required by assessment panels to support this section. This involves overall risk assessment (e.g. violence, self-harm, self-neglect) with additional analysis of context (e.g. triggers), frequency, intensity and the response to interventions. Unpredictability of behaviour, the environment, as well as staff care skills (and numbers) to manage safely may affect the assessment process. Assessors should ensure that such factors do not affect the assessment of need where behaviour issues occur solely in the context of a short-term confusional state (e.g triggered by physical illness).

Range	Level of Need	Relative Weighting
1	No evidence of challenging behaviour, compliant with care	0
2	Some incidents of challenging behaviour occurring occasionally (less than once a week).	20
3	Without specialist support or advice the person would, or does, present with challenging behaviour* on a regular basis (more than once a week).	40
4	Challenging behaviour occurring on most days (5 days or more weekly), or occurring less frequently but of a severity that requires staff with specialist training and requires some clinical input to reduce episodes of challenging behaviour and maintain a manageable level of behaviour	60
5	High level of challenging behaviour, presenting a significant risk to self or others, occurring on most days (5 days or more weekly), or occurring less frequently but of a severity that requires staff with specialist training. Requiring regular and on-going specialist clinical input management to appropriately manage episodes of challenging behaviour.	100

Cognitive Impairment

People may have a cognitive impairment due to a learning disability or physical disability, brain injury, stroke, dementia (e.g. Alzheimer's Disease, vascular dementia) and may need significant support to meet their core care needs. Cognitive impairment is defined here as disorientation, memory loss, impaired problem-solving, perceptual and conceptual difficulties, impairment of intellectual and social functioning. The assessor should avoid simply trying to identify a level of impairment but should assess the need that results from the impairment.

Please score behaviour and communication needs in the relevant domains, and limit this section to core care needs.

Range	Level of Need	Relative Weighting
1	No evidence of cognitive impairment	0
2	Cognitive impairment that may require some weekly supervision and assistance with core care needs and daily living. Awareness of need and basic risks (e.g. hot water, fire, abuse) is evident. Person is able to make choices appropriate to need with limited assistance.	20
3	Cognitive impairment that requires daily supervision and assistance with core care needs and daily living. Limited awareness of need and basic risks. Person is able to make choices appropriate to need with support and guidance.	40
4	Cognitive impairment that requires constant supervision and assistance with core care needs and daily living throughout the day. Minimal awareness of need and basic risks. Person is unable to make choices appropriate to need even with support and guidance.	60
Note: Assessors may wish to use tools such as the Abbreviated Mental Test or the Mini Mental State Examination to measure the degree of cognitive impairment.		

Functional Mental Illness

This domain is only to be used for adults irrespective of age who have been formally assessed and diagnosed with a mental illness (e.g. Schizophrenia or Bi-polar Affective Disorder) and only once all avenues of potential rehabilitation have been explored. When assessing these people, the inputs required should only be those that are over and above what can ordinarily be provided by Community Mental Health Services.

Range	Level of Need	Relative Weighting
1	Has a confirmed diagnosis of mental illness without associated special needs.	0
2	Has a confirmed diagnosis of mental illness, at risk of relapse but can be managed.	20
3	Has a confirmed diagnosis of mental illness with a risk of relapse which could lead to a risk to self and/or others.	40
4	Has a confirmed diagnosis of mental illness where risk of relapse or treatment resistance which could lead to risk to self or others requires staff with specialist training to manage care.	60
5	Has a confirmed diagnosis of mental illness where significant risks are identified, which cannot be managed unless 24 hour specialist care is provided. This is usually associated with a high level of risk to self and/or others which requires interventions needing a regime of close monitoring and supervision.	100

Mobility

Range	Level of need	Relative Weighting
1	Fully ambulant	0
2	Needs some assistance or requires mobility aids	10
3	Able to weight bear but requires mobility aids and/or supervision/assistance of one or two carers to reduce the risk of falls	40
4	Unable, or not consistently able, to weight bear but able to assist or is compliant with transfers / repositioning that requires the use of manual handling equipment	50
5	Unable to assist or is non-compliant with transfers and/or repositioning and therefore presents a risk to themselves or others OR bed-bound and receiving most care in bed for the majority of the time	60
6	Has a clinical condition such that the client is bed bound and who upon being moved or transferred there is a high risk of serious physical harm	100

Food and Drink

Inability to take food and/or drink by mouth.

Range	Level of need	Relative Weighting
1	Able to take food and drink by mouth (to meet full nutritional requirements)	0
2	Able to take food and drink by mouth (to meet full nutritional requirements) but some assistance required e.g. cutting up food, special utensils but thereafter independent. Increased length of mealtimes.	10
3	Needs supervision, prompting, encouraging with meals and drinks, prompting to use compensatory strategies. Requires minimal support/prompting from carer to be able to eat and drink.	20
4	Able to take some food and drink by mouth to meet part of nutritional requirements but may require additional artificial feeding (non problematic) i.e PEG and monitoring of intake of supplements. Physical assistance required in order to be able to eat and drink.	40
5	Unable to take food or drink by mouth to meet any nutritional requirements, although the person may have limited non-nutritive oral intake. All nutrition and hydration via artificial means, (non problematic) e.g. PEG. Plus additional complexity or instability with oral intake due to dysphagia, increased dependency or due to degenerative or terminal condition.	60
6	Unable to take food or drink by mouth to meet any nutritional requirements. All nutrition and hydration intake via artificial means (complex), e.g. Problematic PEG, IV fluids, parenteral feeding. Requires daily specialist nursing supervision and monitoring.	100

Tissue Viability (wound/ulcer care)

Range	Level of need	Relative Weighting
1	Skin intact (Waterlow score a risk indicator guide around 0-9)	0
2	Evidence of pressure damage and/or a pressure ulcer below grade 2 OR minor wound which may require occasional possibly less than daily dressing. (Waterlow risk indicator guide 10-15)	20
3	Open wounds Grade 2-3 pressure ulcers or less that are responding to treatment. (Waterlow risk indicator guide 15+	40
4	Open wounds or Grade 3-4 or more pressure ulcers that are not responding to treatment; that require daily/alternate days dressing for longer than one month; and that are carried out by a level one nurse (excluding leg ulcers). (Waterlow risk indicator guide 20+)	60
5	Multiple pressure ulcers grade 4 and above and require frequent monitoring/re-assessment and intervention by an appropriately trained level one nurse to manage the potential skin breakdown while monitoring other key areas such as incontinence, tissue viability, nutrition, hydration and specialist equipment	100

The Waterlow tool is a risk indicator only that the practitioner can use to support clinical judgement and the selection of specialist equipment based on need. Wound classification grading based on Hibbs 1,2,3,4A& 4B in line with the European Pressure Ulcer Advisory Panel treatment guidelines.

Drug Therapies and Medications

Complexity of drug regime. (Specifically excluding clients whose medication is administered by a level one nurse only as a consequence of them being in a care home)

Range	Level of need	Relative Weighting
1	Able to self medicate	0
2	Requires supervision of and/or prompting with medication by a carer	30
3	Requires administration of medication (such as insulin, lactulose, PRN) by a registered nurse including the administration of enemas and suppositories	40
5	Requires administration of medication by a registered nurse and monitoring because of potential instability of the medical condition	60
6	Has a complex drug regime which requires daily monitoring by a level one nurse and/or monthly consultant review and/or may require adjustment of medication/dosage to maintain stability	100

Seizures

Range	Level of need	Relative Weighting
1	No history of seizures	0
2	History of seizures but none within the past three months. Medication (if any) stable.	20
3	Regular seizures that may require supervision of a carer to minimize the risk of self harm	40
4	Regular* seizures resulting in unconsciousness which require intervention by a qualified nurse or carer specifically trained for this task for this patient to reduce the risk of self harm (ie regular administration of rectal medication)	60
5	Severe uncontrolled seizures resulting in unconsciousness that do not respond to treatment and result in a high probability of risk to self or others and requires Consultant review on a monthly basis and intervention by a qualified nurse or carer	100
**Regular: In the majority of cases this will mean weekly or more frequent*		

Breathing

Range	Level of Need	Relative Weighting
1	Normal breathing, no issues with shortness of breath	0
2	Shortness of breath limiting activities of daily living and/or managing their own oxygen	20
3	A client who has a tracheostomy, which they can manage themselves.	40
4	A client who has continuous ventilation, oxygen or room air ventilators via a facial or nasal mask (i.e. Non invasive intermittent positive pressure ventilation to the lungs) requiring assistance to manage.	60
5	A client who has a tracheostomy, which they cannot manage themselves (due to physical, mental health or learning disabilities).	100