NHS continuing healthcare and NHS-funded nursing care

About this factsheet

This factsheet explains what NHS continuing healthcare (NHS CHC) is, the process for deciding whether you are eligible to receive it and what to do if you are unhappy with the decision reached. It also explains NHS-funded nursing care – the NHS’s financial contribution towards the cost of meeting the nursing care needs of nursing home residents.

The following Age UK factsheets may also be of interest:

10 Paying for permanent residential care
22 Arranging for others to make decisions about your finances or welfare
39 Paying for care in a care home if you have a partner
41 Local authority assessment for community care services
76 Intermediate care and re-ablement

The information given in this factsheet is applicable in England. Different rules may apply in Wales, Northern Ireland and Scotland. Readers in these nations should contact their respective national Age UK organisation for information specific to where they live – see section 9 for details.

For details of how to order other Age UK factsheets and information materials go to section 9.
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Recent developments

- NHS re-organisation in England on 1st April 2013 transfers responsibilities for NHS continuing healthcare and NHS-funded nursing care, previously held by Primary Care Trusts, to Clinical Commissioning Groups (CCGs).
- Responsibility for the Independent Review part of the process to decide eligibility transfers from Strategic Health Authorities to the National Commissioning Board (known as NHS England).

To take account of these changed responsibilities, a revised version of the 2009 National Framework for NHS continuing healthcare and NHS-funded nursing care was published in November 2012 for use from 1st April 2013. Documents published in support of the 2009 National Framework document - the 2010 Practice Guidance, 2010 Refunds Guidance and 2011 FAQ – are incorporated into the 2012 Framework.

- There is now useful cross referencing from the main body of the Framework, to relevant sections in the Practice Guidance.
- The three tools – Checklist Tool, Decision Support Tool and Fast Track Tool have seen slight revisions to the wording in some of the domains.
- There has been no change in Policy as a result of these revisions.

For more information about the new NHS organisations and structures go to www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx

- There is a new publication about NHS continuing healthcare written for the public available in electronic format. See section 3.7

- Following the ‘Personal health budget pilots final evaluation report’ in November 2012, the Government announced that those already receiving NHS CHC at home will have the right to ask for a personal health budget from April 2014. See section 5.5.

- Rates payable from April 2013 for NHS-funded nursing care in a care home have increased for year 2013/14. The new single band rate is £109.79 per week. For those in a care home prior to October 2007 and who remain high band the rate is £151.10. See section 7 for further information.
2 Continuing care

Health and social care professionals may use the following terms to describe support from the NHS or a local authority social services department.

**Continuing care** is a general term describing care provided over a period of time to meet physical and mental health needs that have arisen as a result of disability, an accident or illness.

**Continuing NHS and social care** is care available in a range of settings and may involve services from the NHS and social services. It may also be described as a ‘joint package of continuing care’.

**NHS continuing healthcare** – a complete package of on-going care arranged and funded by the NHS. See sections 3 to 5.

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**Note:** For ease of reading we use the shorter terms: residential home (care home) or nursing home (care home with nursing), or care home if it can be either. The bracketed terms are used by the Care Quality Commission when describing care home registration.

For brevity, **NHS CHC** is used instead of ‘NHS continuing healthcare’.

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3 NHS continuing healthcare

3.1 **Background to NHS continuing healthcare**

When you have long-term care needs it is usually obvious whether the help you need is the responsibility of the NHS or of social services. However, if you have complex needs, the boundaries between health and social care may not always be clear. As services provided by the NHS are free whereas those arranged by social services are means tested, the outcome of any decision as to who has overall responsibility for your care can have significant financial consequences.

Since the early 1990s, the Parliamentary and Health Service Ombudsman has investigated a large number of complaints about local criteria and processes followed when making NHS continuing healthcare eligibility decisions. The legality of some decisions was challenged in the courts.
It was against this background that the National Framework for NHS continuing healthcare and NHS-funded nursing care was developed and first introduced in England in October 2007.

3.2 **What is NHS continuing healthcare?**

“NHS continuing healthcare (NHS CHC) is a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs that have arisen because of disability, accident or illness.” (2012 Standing Rules Regulations – see section 3.6)

Eligibility places no limits on the settings in which the package of support can be delivered or the type of service delivery. If you are to receive care in your own home, the NHS funds an appropriate care package to meet your assessed health and personal care needs. If you are to live in a care home, the NHS contracts with the home and pays for accommodation, board and to meet your assessed health and personal care needs.

3.3 **Who arranges and funds NHS continuing healthcare?**

Your GP practice will be a member of a **Clinical Commissioning Group (CCG)**. This CCG is responsible for managing the process and making decisions about NHS CHC eligibility of patients registered with its member practices. It is also responsible for both funding and arranging care packages, unless the individual is eligible to be offered a personal health budget (see section 5.5).

Prisoners and military personnel are an exception. Following NHS re-organisation, their NHS CHC and other healthcare needs are the responsibility of NHS England.

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**Note:** A tool to help you identify your CCG is available on NHS Choices website. [http://www.nhs.uk/Service-Search/Clinical-Commissioning-Group/LocationSearch/1](http://www.nhs.uk/Service-Search/Clinical-Commissioning-Group/LocationSearch/1)

Your CCG should be able to signpost you to a manager with NHS CHC responsibility.
3.4 What is the National Framework?

The National Framework for NHS continuing healthcare and NHS-funded nursing care is a Department of Health policy document that:

- sets out clear principles and processes to be followed throughout England for establishing eligibility for NHS continuing healthcare. See sections 4&5
- clarifies the interaction between the assessment for NHS continuing healthcare and NHS-funded nursing care. See section 7.

It aims to minimise local interpretation and improve the transparency and consistency of the decision-making process by providing:

- guidance to be followed by all involved in the assessment process
- a national assessment process and three tools to support decision-making – the Checklist tool, Decision Support Tool and Fast Track Tool
- common paperwork to record evidence that will inform decision-making.

The Framework and three tools to support decision-making were first introduced in England on 1 October 2007 and revised in October 2009.

Revisions to both the Framework and tools clarified the process and explained more clearly the types and levels of need that staff look for and record when they assess your needs, complete the tools and ultimately make an eligibility recommendation.

A further revision to the Framework and practice guidance - and the three tools - was published in November 2012 for use from 1st April 2013 to take account of the abolition of PCTs and SHAs. See: Recent developments.

3.5 **Who is eligible for NHS continuing healthcare?**

The diagnosis of a particular disease or condition does not determine eligibility. People with the same diagnosis or health condition can have very different needs. Eligibility decisions for NHS CHC are ‘**needs based**’ and rest on whether your need for care is primarily due to your health needs. This is referred to as having a ‘primary health need’.

Certain characteristics of your needs, in combination or alone, may demonstrate a ‘primary health need’ because of the quantity and/or quality of care needed to manage them. So when assessing your needs, staff consider them in relation to the following characteristics:

- **nature**: the particular characteristics and type of an individual’s needs that can be physical, mental or psychological and the overall effect on their health and wellbeing. The type (quality) of interventions required to manage them.

- **intensity**: both the extent (quantity) and severity (degree) of an individual’s needs and the need for regular interventions to manage them.

- **complexity**: how different needs present and interact to increase the knowledge and skill needed to monitor symptoms, treat individual and/or multiple conditions and/or the interaction between them, and manage care.

- **unpredictability**: unexpected changes in your condition that are difficult to manage and challenge staff required to care for you; the level (quantity) of monitoring required to ensure you and others are safe and the degree of risk to you or others if adequate and timely care is not provided. Someone with unpredictable healthcare needs is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

These characteristics are reflected in descriptions of the different levels of need that feature in the Checklist tool and Decision Support Tool (DST). These tools help inform staff making a recommendation about your likely or actual eligibility for NHS CHC. See sections 5.1 and 5.3.

These characteristics are also considered when staff decide whether to recommend ‘fast tracking’ a patient so they can receive an urgent package of NHS CHC in an appropriate location. See section 5.7.
Note: Eligibility does not depend on who provides your care, where care is provided or on having a particular condition or diagnosis. Eligibility decisions should always be independent of budgetary constraints.

3.6 **When should eligibility be considered?**

The 2012 Regulations say a CCG must take reasonable steps to ensure that an assessment for NHS CHC is carried out in all cases where it appears to them that there may be a need for such care.

Note: The duties of CCGs and NHS England in relation to NHS Continuing healthcare and NHS-funded nursing care are laid down in *The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*.

Regulation 12 says that in carrying out duties, a relevant body must have regard to the National Framework, which means they are under a legal obligation to follow the Framework unless they have a good reason not to.

Not everyone with on-going health needs is likely to be eligible but there are times when it would be appropriate to consider whether you may have a need for such care:

- when ready to be discharged from hospital and your long term needs are clear. Practice Guidance PG 18.3 in the 2012 Framework document says: CCGs should ensure that NHS CHC is clearly built into local agreed hospital discharge pathways, including when NHS CHC assessments and care planning will be carried out in the hospital setting.

- once a period of intermediate care or rehabilitation or other NHS-funded services, offered at the end of a period of acute hospital treatment, has finished and it is agreed no further improvement in your condition can be expected. Your eligibility must be considered before a decision to find a permanent place in a nursing home is made.

- whenever your health and social care needs are being reviewed as part of a community care assessment.
• if your physical or mental health deteriorates significantly and your current level of care – at home or in a care home – seems inadequate.

• when, as a resident of a nursing home, your nursing care needs are being reviewed. This review should happen at least annually. See section 7.2.

• if you have a rapidly deteriorating condition and may be approaching the end of your life. In this case you may need fast tracking. See section 5.7.

In the above circumstances raise the issue of NHS CHC eligibility and application of the ‘Checklist Tool’ with discharge staff, staff co-ordinating your intermediate care, your GP or social services. See section 5.1.

3.7 How is eligibility decided?

Staff should follow the Framework guidance, using one or more of the three tools provided – Checklist, Decision Support Tool (DST) and Fast Track Tool.

Note: You may find it helpful to see a copy of the Tool(s) in advance. They should be available from the staff who will be using them and can be found on the Gov.uk website (see section 3.4).

A short guide written for the public that describes the process is available in electronic format and can be found at www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet

The process for deciding eligibility is described in the following sections.

4 National Framework principles and process

4.1 A person-centred approach involving you and your carers

Staff should ensure that you and your family / representative understand at the outset how eligibility decisions are reached, are aware of key milestones and timeframes and alerted to delays as they occur.
Staff should make sure they ask about any hearing or visual difficulties or language preferences you may have and take steps to help you play an active part at all stages of the process. Your views on your needs and how they might be managed should be treated equally alongside those of any professionals involved.

If you wish, a family member or representative can be invited to help and support you throughout the process. You should be given reasonable notice of key events – completion of the Checklist Tool or DST – so if appropriate, you and/or your representative can make arrangements to be available.

**Note: Para 44 in the 2012 Framework document says** “Assessment of eligibility for NHS CHC and NHS-funded nursing care should be organised in such a way that the individual being assessed and their representative understand the process, and receive advice and information that will maximise their ability to participate in informed decision-making about their care. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike.”

In the footnote it says “In this Framework the term **representative** is intended to include any friend, unpaid carer or family member who is supporting the individual in the process as well as anyone acting in a more formal capacity (e.g. a welfare deputy or power of attorney), or an organisation representing the individual.”

**Giving consent**

You should be told if staff think you may be eligible for NHS CHC. At the outset, staff should seek your informed consent to the assessment process and the necessary sharing of personal information about you between individuals and organisations involved in your care. You should be clear whether you are being asked to give consent for the whole process or for a particular stage only and the range of individuals / organisations likely to be involved. You can withdraw your consent at any stage in the process.

If you decide not to give consent, the local authority cannot take responsibility for meeting needs that would be the responsibility of the NHS. Therefore the consequences of not giving consent should be clearly explained to you.
4.2 **When you lack capacity to give consent**

If there is concern about your ability to give consent to an assessment and for the sharing of information, your capacity to make this particular decision should be determined according to the Mental Capacity Act 2005. This means taking account of the five principles of the Act, and includes taking all practicable steps to help you make the decision yourself.

**Note:** Para 48 of the 2012 Framework document gives more information about compliance with The Mental Capacity Act 2005 and the five principles.

If it is agreed that you lack capacity to give consent, staff should check whether you have appointed a Lasting Power of Attorney (LPA) to act on your behalf on health and welfare matters or whether someone has been appointed a ‘personal welfare deputy’ by the Court of Protection. A partner, family member or other ‘third party’ cannot act on your behalf and give consent unless appointed to do so as described in the previous sentence.

If no one has been appointed to act in one of these ways, the person leading the assessment will be responsible for making a **‘best interest’ decision** on your behalf. To inform their decision, they must consult with those who have a genuine interest in your welfare. This will usually include consulting family and friends. The outcome of a ‘best interest’ decision should be recorded.

The expectation is that everyone who is potentially eligible for NHS continuing healthcare should have the opportunity to be considered.

**Note:** A person appointed as attorney or deputy in relation to your property and financial affairs only, would not have the authority to make decisions about health and welfare. See Framework Practice Guidance PG 7.3.

4.3 **Confidentiality and sharing information with a third party**

Where an individual lacks capacity to give consent to the sharing of information, a ‘best interest’ decision about sharing information with relevant third parties must be made by the person leading the process.

Information must be shared with a person who has a registered Lasting Power of Attorney (welfare) or is a Court Appointed Deputy (welfare).
Note: The Framework Practice Guidance (PG 5.10 – 5.11) recognises there are circumstances where it would be acceptable for a third party, who is assuming responsibility for acting in a person’s ‘best interest’, (but may not have the formal authority of LPA or Deputyship on health and welfare matters) to legitimately request information.

PG5.10 – 5.11 says that in deciding whether to share personal/clinical information with a family member or someone purporting to be representing the individual, the information holder must act within the following principles:

- any decision to share information must be in the individual’s best ‘interest’
- information shared must only be that which is necessary in order for the third party to act in the individual’s best ‘interest’.

Subject to the above principles, information should not be unreasonably withheld. It gives some common examples where, if the above principles are followed, a third party may legitimately be given information:

- someone making care arrangements who requires information about the individual’s needs to arrange appropriate support
- someone with a LPA (Finance), Deputyship (Finance), registered Enduring Power of Attorney (EPA) seeking to challenge an eligibility decision, or other person acting in the person’s ‘best interest’ to challenge a decision

**Advocacy when someone lacks capacity**

If a CCG (or local authority) has to make a ‘best interest’ decision that involves a change of residence or serious medical treatment – it may be considering whether a permanent move to a care home is appropriate - and you do not have a family member or friend who is willing and able to represent you or be consulted during the process of reaching such an important ‘best interests’ decision, it has a duty under the Mental Capacity Act to instruct / consult an Independent Mental Capacity Advocate (IMCA).

The IMCA’s role is to seek information about what would be in their client’s ‘best interest’, represent their interests and challenge any decision by the CCG that does not appear to be in their ‘best interest’. The individual is the IMCA’s client, not the CCG.
Even when you have capacity to make your own decisions, you can ask a family member to act as an advocate and help you make your views known. Alternatively you can ask the person co-ordinating your assessment about local advocacy services.

**Note:** You can find out more about LPAs, IMCAs and the Mental Capacity Act 2005 by reading Age UK Guide: Putting your affairs in order or, for more detailed information, Age UK’s Factsheet 22, *Arranging for others to make decisions about your finances or welfare*. You can also contact the Office of the Public Guardian. See section 8.

5 **Routes to reaching an NHS CHC decision**

Times when it is important to ensure that your eligibility is considered are raised in section 3.6.

If you have a rapidly deteriorating condition and appear to be reaching the end of your life, staff can use the ‘Fast Track Tool’ to recommend you move quickly onto NHS continuing healthcare. See section 5.6.

However this is not the usual route. For most people the type and level of their needs should prompt the completion of the ‘Checklist tool’. This in turn may trigger a full assessment of needs and completion of the ‘Decision Support Tool’ (DST) by a multi-disciplinary team (MDT) who then make a recommendation to the CCG about NHS CHC eligibility.

You can be recommended for a full assessment without completion of the Checklist Tool.

5.1 **Applying the Checklist Tool**

This Tool is designed to help staff identify who should have a full assessment to determine their eligibility and to record the rationale for their decision. It can be applied in a hospital or non-hospital setting by a doctor, nurse, other health professional or social worker who is familiar with the guidance and the more detailed DST. As far as possible, this should include staff who assess or review care needs as part of their day-to-day work.
The threshold has been set deliberately low to ensure that all those who require a full assessment have the opportunity. You would expect the Checklist to be applied if an individual needs a care home place or has significant support needs.

**Note:** A decision to apply the Checklist tool should not be taken to imply that you should or will be eligible for either a full assessment or NHS CHC itself.

You should be offered the opportunity to be involved when the Checklist is completed and asked if you would like a family member, advocate or other representative present.

**Application of the Checklist as part of hospital discharge**

The Framework recognises it is preferable for eligibility for NHS CHC to be considered after discharge from hospital. An assessment on a busy acute hospital ward may not allow your potential for further recovery to be recognised or adequately reflect your needs. It may be the cause of disorientation and/or atypical behaviour due to being in unfamiliar surroundings.

If you are about to be discharged from hospital and have significant health needs, staff should consider - before applying the Checklist - your potential to improve if further NHS-funded services, such as rehabilitation or intermediate care services, are provided. If such services are offered, a note should be made to apply the Checklist in the most appropriate setting once your period of rehabilitation is complete and your needs are clearer. Intermediate care should be considered if you are at risk of entering a care home and require your needs to be assessed in a non-acute setting.

If completion of the Checklist indicates the need for a full assessment, staff may wish to offer further NHS-funded services before carrying this out. Again a note should be made to carry this out in the most appropriate setting once it is possible to make a reasonable judgement about your on-going needs.

**Application of the Checklist for care home residents**

The CCG may have protocols for completing the Checklist for care home residents. If it does not and your condition deteriorates, the home should contact the CCG continuing healthcare team and ask for it to be completed.
Application of the Checklist if you live in your own home

If it appears you may be eligible during an initial assessment or review of your care needs, staff may be able to complete the Checklist themselves. If not, they should ask the CCG continuing healthcare team to arrange this.

You cannot self-refer to the CCG by completing the Checklist yourself. But you or your carer can contact the relevant CCG continuing healthcare team and explain why you think it should be completed.

Completing the Checklist tool

The Tool is based on the 12 ‘domains’ or ‘areas of need’ that feature in the Decision Support Tool. These are described in section 5.3.

For each domain, there are descriptions that represents ‘no and low’ needs found in column C; ‘moderate’ needs in column B and ‘high’ needs in column A.

Staff must choose the description that most closely matches your current needs, taking account of well-managed needs and any increased needs that might be expected over the next three months. Their choices must be backed up by evidence.

A full assessment is required if there are:

- **high** (column A) in two or more domains or
- **moderate** (Column B) in five or more domains or one **high** (Column A) and four **moderate** levels (Column B) or
- a **high** (column A) in one of the four domains that carries a priority level in the DST (marked by an *) and any levels of need in other domains.

Checklist outcome and right to request a review of the decision

The assessors should inform you and/or your representative of their decision as soon as reasonably practicable. You should be given a copy of the completed checklist, which should give enough detail to enable you and your family to understand why that decision was made.
If the decision is not to proceed to a full assessment, the response should tell you of your right to ask the CCG to reconsider it. The CCG should give your request due consideration, taking account of any new information, including extra information you or your representative provide.

**Note:** Once the CCG has reconsidered its decision, you should receive a clear, written response and be told of your right to pursue the matter using the NHS complaints procedure should you remain dissatisfied with their position.

**If the decision not to offer a full assessment is upheld**

Once it is agreed that a full assessment for NHS CHC is unnecessary, you should be offered an appropriate health and social care assessment to identify your future needs and eligibility for social care support.

**Time from referral for full assessment to NHS CHC eligibility decision**

If a full assessment is indicated, the completed Checklist should be sent to the CCG. Time between receipt of the Checklist and a funding decision being made should, in most cases, not normally exceed 28 days.

If it is likely to take longer, you and where appropriate your family should be advised of timescales for this next stage. You should not be left without appropriate support while waiting for an eligibility decision. See section 5.11 for information about refunds when the 28 days is unnecessarily exceeded.

### 5.2 Multi-disciplinary assessment

The CCG should appoint someone to co-ordinate the process from receipt of the referral for a full assessment until the funding decision has been made and a care plan agreed. Ask for the co-ordinator’s contact details.

To ensure all your physical, mental health and social care needs can be evaluated individually and together – including ways they interact with each other - an appropriate range of health and social care professionals should be invited by the co-ordinator to contribute to your assessment. This would include those not currently caring for you but who have a direct knowledge of you and your needs. Your views on your needs and how they might be managed should be considered alongside those of professionals involved.
Such an assessment is crucial to determining your eligibility for NHS CHC and considering how your needs can best be met.

**Note:** In the 2012 Framework document and Practice Guidance PG4 describes the key elements of a person centred approach to NHS CHC. PG 28.1 and 29 describe potential sources of information and what a good multidisciplinary assessment would look like.

### 5.3 Decision Support Tool (DST)

It is helpful to read the user notes at the beginning of the DST and read descriptions used to describe the levels of need.

The DST features 12 ‘domains’ or areas of need – 11 specific domains and a 12th for recording needs that don’t readily fit into the other 11.

Each domain is broken down into between four and six levels of need:

- **‘No need’**
- **‘low’**
- **‘moderate’**
- **‘high’**
- **‘severe’**
- **‘priority’**

The levels reflect the nature, intensity, complexity and unpredictability of a need. Medical terms have been kept to a minimum when describing the levels of need in each domain.

The domains are:

- **1** Behaviour ►►
- **2** Cognition ►
- **3** Psychological and emotional needs
- **4** Communication
- **5** Mobility ►
- **6** Nutrition – Food and Drink ►
- **7** Continence
- **8** Skin including tissue viability ►
- **9** Breathing ►►
Completing the DST

A multi-disciplinary team (MDT) identified by the co-ordinator uses information collected during the assessments to complete the DST.

The 2012 Standing Rules Regulations define a MDT as

- two professionals who are from different health professions or
- one professional from a healthcare profession and one who is responsible for assessing individuals for community care services under section 47 NHS and Community Care Act 1990.

However the Framework Practice Guidance PG 30.2 says: ‘Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the Framework makes it clear that the MDT should usually include both health and social care professionals who are knowledgeable about the individual’s health and social care needs.’ There is space at the end of the DST paperwork for the names, job titles and signatures of both health and social care professionals.

In advance of the DST meeting, the co-ordinator should explain the format and how you and/or your representative can participate. You or your representative should be fully involved in the process and invited to contribute to the discussion in person or be represented where possible. You should be given sufficient notice of the date, so you can make arrangements to attend. If this is not possible, your views or those of your representative should be obtained and actively considered when completing the DST. (See User notes accompanying DST)

When completing the tool, the following points are important:

- all care domains should be completed
• the team should use the assessment evidence and their professional judgement to select the level that most closely describes your needs

• interactions between needs should be considered as appropriate

• needs should not be marginalised because they are successfully managed. Well-managed needs are still needs and should be recorded appropriately. (See 2012 Framework practice guidance PG 11)

• needs not covered by one of the 11 domains should be recorded in the 12th domain and taken into account when making an eligibility decision.

If it can reasonably be anticipated that your condition will deteriorate and your needs in certain domains will increase in the near future, this should be recorded and taken into account when the final recommendation is made. Such knowledge may also influence the time of your next review.

The completed tool should give an overall picture of your needs.

Those completing the tool should state whether you or your representative were present and/or represented when the DST was completed.

If you have concerns about any aspect of the MDT or DST process that are not resolved by discussing them at the time, your concerns should be noted within the DST, so they can be brought to the notice of the CCG when making their final decision.

Practice guidance PG30.3 says it is acceptable for the MDT to have a discussion without you or your representative present, in order to reach their recommendation. However if you are not present for the part of the meeting where a decision is reached, the outcome should be communicated to you as soon as possible.

**The MDT’s recommendation**

The DST includes a summary sheet to record an overview of the levels chosen for each domain, a summary of your needs and the MDTs recommendation about your eligibility or ineligibility. There is also space for recording your views or those of your representative, including any disagreements along with reasons, about levels chosen by the MDT.

A clear recommendation of eligibility would be expected if you have:

• **priority** level of need in any of the four domains with that level
• **two or more instances of severe** needs across all domains.

If there is:

• one domain recorded as **severe** together with needs in a number of other domains, or

• a number of domains with **high and/or moderate** needs.

This may also, depending on the combination of needs, indicate a primary health need. In all cases the interaction between needs in various domains and evidence from risk assessments should be considered when reaching an eligibility decision. Judgement about whether you have a ‘primary health need’ must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of your needs.

**Note:** The MDT is also asked to indicate whether they expect your needs to improve or deteriorate before the three-month review, how they are likely to change and why and whether they would recommend an earlier review.

If all are ‘low’ needs, this is unlikely to indicate eligibility. If needs in all domains are ‘no need’, this would indicate ineligibility.

**The CCG’s decision**

The Framework states that only in exceptional circumstances and for clearly explained reasons, should the MDT’s recommendation not be followed.

Exceptional circumstances under which the CCG may question a recommendation might include: DST not completed fully, significant gaps in evidence to support the recommendation or mismatch between the evidence and the recommendation. In such instances these matters should be referred back to the MDT to be addressed.

**Note:** A decision that you are eligible for NHS CHC is not a permanent one. It can be overturned at a later date if a review of your condition shows your condition has improved and your needs changed.

If the recommendation is that you are not eligible but that you may need care in a nursing home, the completed MDT should contain sufficient information to determine the need for NHS-funded nursing care. See section 7.
Use of a panel

There is no requirement in the Framework to use a panel as part of the decision-making process. In some CCG areas, decisions are scrutinised by a ‘panel’ to ensure consistent decision-making.

Panels may also be part of the local protocol for dispute resolution and used if there is disagreement between the CCG and local authority.

**If a person dies while awaiting an eligibility decision**

If services were provided prior to their death that could have been funded through NHS CHC, then the decision-making process should be completed and appropriate payment made to reimburse you.

If no such services were provided, it is not necessary to continue with the decision-making process.

5.4 **Arranging care if you are eligible**

The CCG may communicate its decision verbally but it should always be confirmed in writing, giving clear reasons for the decision and accompanied by a copy of the completed decision-support tool.

**Note:** The CCG is responsible for ensuring you are told who is responsible for monitoring your care and arranging regular reviews. A decision that you are eligible is not necessarily a permanent one as your condition and needs may change. On-going reviews are built into the process. See section 5.8.

When agreeing the setting and package of care, the starting point should be your preferences. However the package agreed must be one that the CCG believes is appropriate to meet your assessed health and social care needs and the ‘outcomes’ your care package aims to achieve. Account should also be taken of any risks associated with different types of care and fairness of access to CCG resources.

The funding provided should be sufficient to meet needs identified in the care plan, based on the CCG’s knowledge of the costs of services for the relevant needs in the locality where they are to be provided.
Note: If you are dissatisfied with the care package proposed by the CCG and cannot resolve your concerns informally, you should be told how to access and use the NHS complaints procedure. This is not an issue for the Independent Review Panel (section 5.6) to consider.

Care can be provided in a range of settings:

5.4.1 In a care home

The CCG is responsible for meeting the cost of your assessed care needs and accommodation in a care home. It is more usual for this to be a nursing home but it does not have be. Here are some issues to be aware of if a care home is the preferred / best option.

- The CCG may have a contract with one or more nursing homes in an area but your assessed needs will determine whether they are suitable. There may be ‘needs based reasons’ for the CCG to consider more expensive than usual accommodation. Examples are given in the Framework Practice Guidance in PG99.2 - where there is a recognised link between challenging behaviour and feeling confined in a small room or identified benefits of a specialist rather than generic care provider.

- It may seem more appropriate for you to move to a home closer to relatives who live in a different CCG area. You may submit reasons for this but cannot assume it will be acceptable to the funding CCG.

- If it is agreed you can live in a care home in another CCG area, your care home fees remain the responsibility of the CCG that decided your eligibility. Once you move into the care home, you must register with a local GP practice. Once registered, NHS services or treatment unrelated to the reason for your placement in the care home become the responsibility of your new GP practice’s CCG.

- If your current care home cannot meet your assessed needs you would need to discuss your options with the CCG.
You may find your **current care home can meet your NHS CHC needs** but is more expensive than the CCG would normally pay to meet needs such as yours. This can happen if you are a self-funder or when a relative or other third party is ‘topping up’ to meet the care home fees in your chosen home. ‘Topping up’ is legally permissible in legislation governing social care, but not allowed under NHS legislation.

2012 Framework Practice Guidance **PG99** says: “Funding should be sufficient to meet needs identified in the care plan in the locality they are to be provided. It is also important that the models of support and provider used are appropriate to the individual’s needs and have the confidence of the person receiving services. Unless it is possible to separately identify and deliver the NHS-funded elements of the service, it will not usually be permissible for you to pay for higher-cost services and/or accommodation.”

In reviewing your current accommodation, the CCG should explore your reasons for wishing to remain in your current home/room and consider if there are clinical or over-riding needs-based reasons for you to remain there.

If you are currently a self-funder or in receipt of a ‘third party top up’, the CCG may propose you move to a different home. **PG99.4** says: “In such situations, CCGs should consider whether there are reasons why they should meet the full cost, notwithstanding that it is a higher rate, such as frailty, mental health needs or other relevant needs of an individual mean that a move to other accommodation could involve significant risk to their health and wellbeing.”

### 5.4.2 In a hospice

Hospice care may be appropriate if you are reaching the end of your life. However, government policy is, where possible, to allow you to be at home at this time if you prefer.

### 5.4.3 In your own home

Your CCG is responsible for funding a package to meet your identified health and personal care needs but not rent/mortgage, food and normal utility bills. If extra utility costs are incurred due to the running of specialist equipment a contribution to related bills may be appropriate.
If you were living at home prior to being eligible for NHS CHC, you may have been receiving Direct Payments from your local authority. CCGs should aim to arrange services to maintain a similar package of care to that already in place and replicate as far as possible the personalisation and control you enjoyed with direct payments. See section 5.5.

**If a family member is to provide care as a part of your care package**

The Framework practice guidance says at **PG89:**

“When a CCG decides to support a home-based package where the involvement of a family member/friend is an integral part of the care plan then the PCT should give consideration to meeting any training needs that the carer may have to carry out this role.

In particular, the CCG may need to provide additional support to care for the individual whilst the carer(s) has a break from his/her caring responsibilities and will need to assure carers of the availability of this support when required. This could take the form of the cared-for person receiving additional services in their own home or spending a period of time away from home (e.g. a care home). Consideration should also be given to a referral for a separate carer’s assessment.”

**If at a later date you want to move to another CCG area**

If you wish to do this, you should raise it with your funding CCG in plenty of time. It will need careful discussion between the CCG currently providing your services and the CCG responsible for them after you move. The CCGs will want to ensure continuity of care, that arrangements represent your best interests and any associated risks are identified. This issue is raised in a document produced for CCGs by NHS England and can be found at www.england.nhs.uk/wp-content/uploads/2012/12/who-pays.pdf

5.4.4 **Moves within the UK**

If you wish, regardless of setting, to receive care in Wales, Scotland or Northern Ireland, there would need to be discussion between your funding CCG and the relevant health body in your chosen country.

**Other NHS services**

You should receive GP, dental and other NHS services as needed.
5.5 **Personal health budgets**

A personal health budget (PHB) is an amount of money to support your identified health and wellbeing needs, planned and agreed between you and the CCG. A PHB gives you more choice and flexibility to meet your needs in a way that suits you.

It can be managed in one of three ways or a combination of them:

- a notional budget where no money changes hands;
- a real budget held by a third party;
- by a direct payment.

These are described further in the leaflet ‘Understanding personal budgets’ mentioned below.

A three year pilot study took place in selected locations across England to explore the PHB method of funding and meeting care needs. People eligible for NHS CHC and with a range of long term conditions took part.

Following the final review of the pilot at the end of 2012, the Government announced that anyone already receiving NHS CHC will have a right to ask for a PHB from April 2014. At present, the direct payment method of managing a PHB is only lawful in areas that were part of the pilot. Following a consultation based on learning from the pilots, the Government’s intention is to make changes to the current Regulations so that direct payments are available more widely from Autumn 2013.

If you have a ‘direct payment’ it means you are allocated a sum of money to buy the health and care support that you and your NHS care team agree will meet one or more of your identified needs and achieve the outcomes you want. You or your representative buy and manage services but are offered help to manage the budget, arrange services and provide evidence showing what you have spent the money on.

If you do not want a PHB, you will be able to have your care package arranged and funded by your CCG.
5.6 What happens if you wish to challenge a decision?

If you wish to challenge an eligibility decision reached after 1st April 2012, you or your representative must write to the CCG requesting a review, no later than 6 months from the date you receive written notification of the decision. The letter should briefly explain your reasons for the challenge. Your request should be acknowledged in writing within 5 working days of receipt and include a brief explanation of the process to be followed.

The time limit will not apply if the CCG is satisfied there were good reasons for you missing it and it believes that it is still possible to access relevant information and records that informed the original decision.

**Funding your care once you challenge the CCG decision**

Once the CCG tells you that you are not eligible, this decision remains in place unless or until the local review process or Independent Review Process recommends that you should be eligible.

You should receive appropriate care while awaiting the outcome of the review but may have to contribute towards the cost of your care package during this time. Your circumstances when you ask for a review, affect who is responsible for arranging and/or paying for your care. The local authority and/or NHS may be involved or you may already be arranging and/or funding your own care.

5.6.1 The Review process

There are two stages in the review process.

● a **local review** managed by the CCG.

● a request to NHS England which may then refer the matter to an **Independent Review Panel (IRP)**.
If using the local review process would cause undue delay, NHS England has the discretion to put your case straight to the IRP stage.

**Note:** The Framework Practice Guidance PG 68 addresses disputes and says in 68.2: “On some occasions CCG may receive requests for an independent review or other challenge to an eligibility decision from a close relative, friend or other representative who does not have a Lasting Power of Attorney or deputy status. Where the individual has capacity, the CCG should ask them whether this request is in accordance with their instructions, and where they do not have capacity, a ‘best interests’ process should be used to consider whether to proceed with the request for an independent review or other challenge.” See also section 4.3 in this factsheet about sharing of confidential information.

**Local review stage**

The Framework says each CCG should agree a local review process with timescales against the various stages. It could include referring your case to a neighbouring CCG for consideration or advice. The review process should be made publically available.

**The CCG is expected to investigate and make a decision in relation to any local review within 3 months of receipt of the request,** unless there are good reasons for extending it. Reasons might include difficulty accessing relevant information or lack of availability of non CCG members of the MDT.

You should be **notified in writing of the outcome of the local review** as soon as practicable but **no later than 3 months after the date of your request.** The letter should also explain the process for requesting an Independent Review, should you remain dissatisfied. If the 3 month time period cannot be met, you should receive a written explanation for the delay and a response in writing as soon as reasonably practicable.

**Independent Review Panel stage**

The Independent Review process can only help if you are dissatisfied with:

- the procedure followed in reaching the eligibility decision
- application of the criteria of eligibility, ie the primary health need test.
Note: If you are dissatisfied with issues other than the process followed or application of the criteria – issues such as the type, location or content of your care package – you should be told how to raise these using the NHS complaints procedure. This is explained in Age UK’s Factsheet 66, *Resolving problems and making a complaint about NHS care*.

A request for an IRP can be made no later than 6 months following notification of a local review decision.

The **IRP should be arranged and completed within 3 months of the request being received**, unless there is good reason for the delay.

NHS England can decide not to convene a panel but before doing so should seek the advice of one of the individuals who can chair a panel.

If it decides not to convene a panel you, your family or representative should have a full written explanation explaining why and be told of your rights to use the NHS complaints procedure to take it further.

The IRP has a scrutiny and reviewing role. It is therefore not necessary for any party to be legally represented at an IRP hearing, although you may wish to be represented by a family member, advocate or advice worker. If you wish the support of an advocate, your CCG should have details of local advocacy services. The IRP is required to make a recommendation to NHS England in the light of its findings. Its role is advisory but the CCG should accept its recommendations in all but exceptional circumstances.

Both the IRP and local procedures should follow the key principles for dispute resolution that are outlined in the Framework. They include:

- gathering and scrutiny of all available and appropriate evidence, whether oral or written, from relevant health and social care professionals, as well as information submitted by the individual, completed tools and the deliberations of the multi-disciplinary team
- compilation of a robust and accurate identification of care needs
- audit of any attempts to gather records said not to be available
- involvement of the individual or their representative as far as possible, including the opportunity for them to contribute to and comment on information at all stages
● a full record of deliberations to be made available to all parties
● clear, evidenced written conclusions on the process followed and on the individual’s eligibility for NHS CHC, together with recommendations and appropriate action to be taken in the light of the Framework rationale.

**Note:** IRP procedures can be found in Annex E of the 2012 Framework.

The **time limits for requesting a review of an eligibility decision** can be found at www.gov.uk/government/publications/guidance-on-the-time-limits-applicable-from-april-2012-for-requests-on-review-of-eligibility-decisions-for-nhs-continuing-healthcare-funding

**Outcome of the review**

You should be **notified of the findings of the IRP** as soon as practicably possible and **no later than 6 weeks after the panel decision**.

**If the CCG’s decision is overturned** as a result of the IRP’s recommendation, the cost of services that you have paid for since the CCG’s ‘not eligible’ decision should be refunded. Annex F of the 2012 Framework explains the circumstances and method of reimbursement. It is also described in section 5.10 of this factsheet.

**If the CCGs decision is upheld**, you should be told that if you remain dissatisfied, you can ask for it to be referred to the **Health Service Ombudsman (HSO)**. You or your representative is entitled to contact the HSO within 12 months of notification of the independent review.

5.7 **Fast Track Tool**

When you have a rapidly deteriorating condition and may be approaching the end of your life, urgent consideration of your eligibility would allow an appropriate care package to be arranged as quickly as possible.

Such changes in your condition could be observed while you are in hospital or by staff caring for you at home or in a care home. If this happens, they should contact an ‘appropriate clinician’ and ask them whether it would be appropriate to consider completion of the Fast Track tool’.

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An ‘appropriate clinician’ would be a doctor or nurse responsible for your diagnosis, treatment or care or with a specialist role in end-of-life needs, who would have an appropriate level of knowledge or experience to review your current type of needs.

Decisions to ‘fast track’ should be made case by case and supported by a prognosis, where possible. Strict time limits that base eligibility on some specified, expected length of life remaining should not be imposed.

CCGs should accept and immediately action a properly completed Fast Track tool recommending NHS CHC eligibility. They should have processes in place to enable appropriate care packages to be introduced preferably within 48 hours of receiving the completed tool. Care planning should reflect the approaches in the End of Life Care Strategy.

If you have drawn up an ‘advance care plan’, your care package should take account of your preferences and wishes. For example if you are awarded NHS continuing healthcare through the ‘fast track’ route and are living in a residential home, you may have expressed a preference to remain there. Every effort should be made to reflect the approaches set out in the End of Life Care strategy and enable this to happen if it is clinically safe and within the home’s terms of registration for you to remain there.

Once your care plan is in place, the CCG can then proceed, where appropriate, to reach a decision on your longer term eligibility.

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**Note:** NICE has produced a Quality Standard for end of life care. This describes how good quality end of life should be organised for people thought likely to die in the next 12 months, their family and carers. See http://guidance.nice.org.uk/QS13

5.7.1 **Review of a fast track decision**

Care should be taken to explain why a fast-track decision has been made and to minimise the chance of needing to reverse it within a short time.

The fast track decision may be subject to a review but no one who has been identified as eligible for NHS continuing healthcare through the fast-track process should have their funding removed without going through the usual review process set out in the National Framework.
This means having an appropriate level of assessment information available, selection of a MDT, completion of the DST, followed by the MDT’s eligibility recommendation.

If as a result of a review, there is a dispute between the CCG and Local Authority (LA) about your eligibility, your case should go through the CCG/LA’s agreed disputes process. Your care should continue to be fully funded by the CCG until the matter has been resolved.

If as a result of a review, the CCG and LA agree you are no longer eligible, the CCG should inform you in writing and explain that you have the right to request a review of their decision by an Independent Review Panel (IRP). This process is explained in section 5.5.1.

The CCG’s decision that you are no longer eligible remains in place unless or until the IRP recommends that you should be eligible. Responsibility for your care transfers to the LA from the date of this CCG decision. If the LA’s financial assessment shows you should contribute towards the cost of your care or that you are a self-funder, you must pay the appropriate amount while the IRP is in progress; although services the NHS provides or funds during this time eg NHS funded nursing care in a nursing home.

**If the CCG’s decision is overturned** as a result of the IRP’s recommendation, the cost of services you have paid for since the CCG’s ‘not eligible’ decision should be refunded. See section 5.11.

**If the CCG’s decision is upheld** and you still wish to challenge it, you can ask for it to be referred up to the Health Service Ombudsman.

### 5.8 Effect on state benefits of NHS continuing healthcare

**Attendance Allowance**

**If you are self-funding your care in a care home** and receive Attendance Allowance (AA) or Disability Living Allowance (DLA) and will receive NHS continuing healthcare in a care home, you should notify the Disability Benefits and Attendance Allowance helpline (see section 8). Your benefit will cease on the 29th day after the CCG begins to fund your care or sooner if you have recently been in hospital.
If you are living at home and claiming AA or DLA but will receive NHS continuing healthcare in a care home, you should notify the AA helpline. Your benefit will cease on the 29th day after the CCG begins to fund your care or sooner if you have recently been in hospital.

If you are living at home and claiming AA or DLA and will continue to live at home with an NHS continuing healthcare package, you can continue to receive AA and DLA.

**Other benefits**

**Your State Pension** is not affected by your eligibility for NHS continuing healthcare.

You lose the severe disability element of your Pension Credit award when you are no longer entitled to AA or DLA (care), and this may affect the amount of Pension Credit you receive.

### 5.9 Regular reviews of eligibility decisions

If you have been considered for NHS continuing healthcare and the NHS is providing or funding any part of your care package, a case review should be undertaken no later than three months after the initial eligibility decision. Reviews should take place annually after that, as a minimum.

The multi-disciplinary team making the original recommendation after a full determination of your eligibility for NHS continuing healthcare may have made a specific recommendation about the timing of your next review.

The review is to decide whether your needs have changed and consequently whether your care plan needs revising. Any decision to remove eligibility should be undertaken jointly by the CCG and relevant local authority. There should be a dispute resolution process in place for use when the CCG and local authority disagree about eligibility.

If you are receiving NHS continuing healthcare as a result of ‘fast tracking’ see section 5.7.1.
5.10 **Your care package if you are not eligible**

If application of the checklist, indicates you are not eligible for a full assessment, a joint health and social care assessment will identify your needs. Your needs and your views on how they can best be met will form the basis of your agreed care plan. Your care package may include the provision of equipment. You are likely to need services from both the NHS and social services. You will be means-tested for services that are the responsibility of social services.

NHS services that may be provided in their own right on a regular or ad-hoc basis alongside social care services include:

- care provided in a nursing home by a registered nurse (see section 7)
- rehabilitation and recovery services such as speech therapy
- assessment and/or support from community-based NHS staff such as district nurses, continence nurses, specialist diabetic nurses
- palliative care services.

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**Note:** For more information about care assessments and charging procedures when care services are provided by a local authority see the other Age UK factsheets listed on the front page.

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5.11 **Refunds for unreasonable delay in reaching an initial decision or when disputing a decision**

Refunds guidance covering the following situations can be found in Annex F in 2012 Framework. It is described below.

You may be entitled to a refund to cover any costs you have incurred when a CCG eligibility decision is:

- unjustifiably delayed or
- revised following reconsideration by the CCG or as a result of an Independent Review Panel (IRP) recommendation.
Refunds for unjustifiable delay

The National Framework states that in most cases the CCG decision on eligibility should take no longer than 28 days from the date it receives either the completed Checklist or a request for a full assessment.

If a CCG decides you are eligible but ‘unjustifiably’ takes longer than 28 days to reach the decision, it should refund to the local authority the costs of services provided from day 29 to the date the decision was reached. **If you and the local authority have been contributing towards the cost of your care**, the local authority should reimburse you in full.

**If you were funding all your care**, you should receive an ex-gratia payment from the CCG. This is to restore your finances to the state they would be in had the delay not occurred and to remedy any injustice or hardship you suffered as a result of the delayed decision.

Examples of ‘unjustifiable’ delays might include delays in receiving records or assessments requested from a third party or delays outside the CCG’s control, in convening a multi-disciplinary team. However the CCG should aim to develop protocols to help it meet the 28 day deadline.

Refunds following a revised decision

If you dispute a CCG’s initial eligibility decision and this decision is revised following further consideration or as a result of a recommendation by an IRP, the CCG should reimburse any costs incurred by the local authority. **If you and the local authority were contributing to the cost of your care**, the local authority should reimburse you.

**If you were funding all your care costs**, you should receive an ex-gratia payment from the CCG. This should aim to restore your finances to the state they would have been in had the correct decision been made at the outset and to remedy any injustice or hardship as a result of the incorrect decision.

The period of reimbursement or ex-gratia payment should start from the date the initial CCG decision was made (or earlier if an unjustifiable delay has been acknowledged) until the date the revised decision comes into effect.

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**Note:** If you wish to dispute a CCG decision on whether to provide redress or the amount to be provided, you should use the NHS complaints procedure.
### 6 Deadlines for raising new cases involving care between 1\textsuperscript{st} April 2004 and 31\textsuperscript{st} March 2012

In March 2012 the Department of Health announced deadlines for individuals (or their representatives) who wished to request an assessment for NHS continuing healthcare for periods of care between 1\textsuperscript{st} April 2004 and 31\textsuperscript{st} March 2012. The announcement related to previously un-assessed periods of care, where evidence suggests an assessment should have been conducted.

The deadlines have now passed and were:

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Cases submitted within these deadlines are still being investigated and are with the CCG now responsible for PCT area that received the request.

**Note:** The letter from the NHS Chief Executive announcing the deadlines and accompanying FAQ can be found at: [www.gov.uk/government/publications/guidance-on-the-time-limits-applicable-from-april-2012-for-requests-on-review-of-eligibility-decisions-for-nhs-continuing-healthcare-funding](http://www.gov.uk/government/publications/guidance-on-the-time-limits-applicable-from-april-2012-for-requests-on-review-of-eligibility-decisions-for-nhs-continuing-healthcare-funding)

### 6.1 Redress when a retrospective review delivers a positive outcome

If a retrospective review shows that an individual was eligible for NHS CHC, the CCG is required to determine and be able to justify, based on the circumstances of the case, what is a fair and reasonable amount to offer the individual (or their estate) who should not have had to pay for their own care during the period under review.
In support of a previous retrospective review exercise, the Department of Health issued guidance in 2007 – NHS continuing healthcare: continuing care redress - to guide PCTs, who at that time were responsible for NHS CHC. This guidance is due for review in 2013 but remains applicable and can help put into perspective offers of redress made by CCGs.


7 **NHS-funded nursing care**

NHS-funded nursing care is funding paid by the CCG directly to a nursing home for care provided to residents by registered nurses employed by the home. Services provided regularly by a registered nurse are likely to involve:

- provision of nursing care
- supervision or monitoring of care provided by a non-registered nurse
- planning and reviewing a care plan
- monitoring and reviewing medication needs
- identifying and addressing potential health problems.

**Note:** Residential homes do not employ registered nurses. Residential home residents receive nursing and other health related care from NHS staff based in the community and so the CCG does not pay such homes a NHS-funded nursing care contribution.

7.1 **How is eligibility for NHS-funded nursing care decided?**

Eligibility for NHS-funded nursing care in a nursing home should not be considered until it has been agreed that you are not eligible for NHS continuing healthcare and that a place in a nursing home is the best option for meeting your needs.
If you are found not eligible for NHS CHC following a full assessment, your need for registered nursing care should be recorded on the DST by the MDT. This information should then be used to draw up your care plan.

Other times when a decision that you are not eligible for NHS continuing healthcare could have been made include:

- following application of the Checklist
- following a period of rehabilitation or intermediate care – before which it was flagged up as appropriate to wait to see if there is any improvement in your condition before considering your eligibility. See section 5.1
- as part of a joint NHS and social care assessment to assess or review your needs.

When carrying out a joint health and social care assessment, your nursing needs should be identified. It may be useful to consider and document your needs based on the ‘domains’ featured in the DST. A template for recording nursing care needs can be found in NHS-funded Nursing Care Practice Guide July 2013 (Revised). This Guide can be found within the general link to NHS Continuing healthcare. See Note in section 3.4.

**Note:** There may be instances when a person’s nursing or health needs do not mean they have a primary health need (and so qualify for NHS CHC) but they are above the level of needs intended to be covered by NHS-funded nursing care. In such cases joint funding by the CCG and local authority will be appropriate. This is raised in Framework Practice Guidance PG 60.2

**Payment of NHS-funded nursing care to the nursing home**

Once it is agreed a place in a nursing home is appropriate for you, the CCG establishes a contract for NHS-funded nursing care with your nursing home and pays the home directly.

**7.2 Regular reviews of NHS-funded nursing care needs**

A case review should be undertaken no later than three months after the initial eligibility decision. This is to reassess your care needs, ensure they are being met and confirm that a nursing home place is still appropriate.
When reviewing your need for NHS-funded nursing care, potential eligibility for NHS continuing healthcare must always be considered (using the Checklist) and a full consideration should be carried out, including completion of the DST by an MDT, where indicated.

There is one situation where completion of a new DST by a MDT will not be required. This is where:

- the initial decision was reached following a positive Checklist and full assessment plus completion of DST by a MDT

and

- there has been no material change in your needs that might lead to a different eligibility decision regarding NHS CHC and (by implication) NHS-funded nursing care.

To determine this, the previously completed DST must be available at the NHS-funded nursing care review. Each of the domains and previously assessed need levels must be considered by the nursing care reviewer, in consultation with the person being reviewed and any relevant people who are present at the review and know the person. The reviewer should annotate and sign each domain to indicate they have been considered, indicating any changes in need levels.

When informed of the outcome of the NHS-funded nursing care review, you should be advised that despite meeting the Checklist threshold, a full new DST has not been completed because there has been no significant change in your need levels. A copy of the annotated, signed DST should be given to you. You should also be told you can ask for a review of this decision and if you remain dissatisfied after local re-consideration, can use the NHS complaints procedure to pursue it further. Your local Healthwatch or local independent advocacy service can help with the complaints process. See section 8.

Where a full assessment and completion of the DST was not undertaken initially or where the NHS-funded nursing care review indicates a possible change in eligibility, a positive Checklist should always be followed by an MDT completed DST and recommendation on eligibility for NHS CHC.
Following this three month review, reviews should take place, as a minimum, at least annually. It may be clinically appropriate to have more frequent reviews and a review should be arranged if your healthcare needs change significantly.

If you fund your own place in a nursing home, you need to ensure you have a review of your needs three months after you first move in and annually thereafter. The care home manager should be aware of the CCG’s arrangements for nursing care reviews.

7.3 **NHS-funded nursing care payments**

If you moved into a nursing home on or after 1 October 2007 you will be on the single band of nursing care. This is reviewed annually in April. From 1\textsuperscript{st} April 2013 the weekly rate, paid directly to the nursing home, is £109.79.

If you moved into a care home before 1 October 2007, a three-band system operated: low – medium – high. With implementation of National Framework, on 1\textsuperscript{st} October 2007, residents on the low and medium bands transferred to the single band. Residents on the high band remained on this band if a review indicated that their needs continued to be equivalent to the high band, based on previous guidance. From 1\textsuperscript{st} April 2013 the weekly rate is £151.10.

Those on the high band remain on this band until:

- they are no longer resident in a nursing home
- they become eligible for NHS continuing healthcare
- death
- a review suggests they no longer need nursing care
- a review suggests their nursing needs no longer match high band criteria; in which case they transfer to the single band rate.

**Note:** If you fully fund your own care in a nursing home and the home receives an NHS-funded nursing care payment on your behalf, you are still able to claim attendance allowance as a self-funder.
7.4 **Admission to hospital or a short stay in a nursing home**

If you are admitted to hospital, the CCG does not pay nursing care costs to the care home during your hospital stay. The NHS-funded nursing care guidance says CCGs may want to consider paying a retainer to help safeguard care home places of residents while in hospital. It also says any arrangements the CCG makes should not disadvantage residents who fund their own care home place.

If you go into a nursing home on a temporary basis for a period of less than six weeks you qualify for NHS-funded nursing care. There is no need to carry out an assessment of nursing needs if it is known at the outset that the stay is for less than six weeks and you have already been assessed for nursing care in the community.

This might apply if you are having a trial period in a home or are admitted to a home for respite care or in an emergency because your carer is ill.

8 **Useful organisations**

**Disability Benefits and Attendance Allowance helpline**

Contact this helpline if you need to give notification of your eligibility for NHS continuing healthcare in a care home or if you are admitted to hospital.

Tel: 08457 123 456  
Website: www.gov.uk/disability-benefits-helpline

**Local Healthwatch**

Each local authority has a local Healthwatch that can give information and signpost to local health and social care services. It may run or can signpost to the local independent advocacy service to help those making an NHS complaint. For your local Healthwatch details, call the customer services department of your local authority or search Healthwatch England’s website.

Website: www.healthwatch.co.uk
**NHS Choices**

A clear and consistent guide to the social care system, advising on the main options available and flagging up appropriate sources of further advice and support. You can also find and compare local care services on this site, based on information from Care Quality Commission assessments.

Website: www.nhs.uk/carersdirect/social-care/pages/social-care.aspx

**Office of the Public Guardian**

The Office of the Public Guardian supports and promotes decision-making for those who lack capacity or would like to plan for their future under the Mental Capacity Act 2005.

PO Box 16185 Birmingham B2 2WH
Tel: 0300 456 0300 - Phone lines are open Monday to Friday 9am - 5pm (Except Wednesday 10am - 5pm)
Email: customerservices@publicguardian.gsi.gov.uk
Website: www.gov.uk/browse/births-deaths-marriages/lasting-power-attorney

**Parliamentary and Health Service Ombudsman**

The Parliamentary and Health Service Ombudsman can investigate complaints about NHS care and may be approached if you remain dissatisfied following an IRP decision about NHS CHC eligibility.

Millbank Tower, Millbank, London SW1P 4QP
Tel: 0345 015 4033
Email: phso.enquiries@ombudsman.org.uk
Website: www.ombudsman.org.uk
9 Further information from Age UK

Age UK Information Materials

Age UK publishes a large number of free Information Guides and Factsheets on a range of subjects including money and benefits, health, social care, consumer issues, end of life, legal, issues employment and equality issues.

Whether you need information for yourself, a relative or a client our information guides will help you find the answers you are looking for and useful organisations who may be able to help. You can order as many copies of guides as you need and organisations can place bulk orders.

Our factsheets provide detailed information if you are an adviser or you have a specific problem.

Age UK Advice

Visit the Age UK website, www.ageuk.org.uk, or call Age UK Advice free on 0800 169 65 65 if you would like:

- further information about our full range of information products
- to order copies of any of our information materials
- to request information in large print and audio
- expert advice if you cannot find the information you need in this factsheet
- contact details for your nearest local Age UK
Age UK

Age UK is the new force combining Age Concern and Help the Aged. We provide advice and information for people in later life through our, publications, online or by calling Age UK Advice.

Age UK Advice: 0800 169 65 65
Website: www.ageuk.org.uk

In Wales, contact:
Age Cymru: 0800 022 3444
Website: www.agecymru.org.uk

In Scotland, contact:
Age Scotland: 0845 125 9732
Website: www.agescotland.org.uk

In Northern Ireland, contact:
Age NI: 0808 808 7575
Website: www.ageni.org.uk

Support our work

Age UK is the largest provider of services to older people in the UK after the NHS. We make a difference to the lives of thousands of older people through local resources such as our befriending schemes, day centres and lunch clubs; by distributing free information materials; and taking calls at Age UK Advice on 0800 169 65 65.

If you would like to support our work by making a donation please call Supporter Services on 0800 169 87 87 (8.30 am–5.30 pm) or visit www.ageuk.org.uk/donate
Legal statement

Age UK is a registered charity (number 1128267) and company limited by guarantee (number 6825798). The registered address is Tavis House, 1-6 Tavistock Square, London, WC1H 9NA. VAT number: 564559800. Age Concern England (charity number 261794) and Help the Aged (charity number 272786) and their trading and other associated companies merged on 1 April 2009. Together they have formed Age UK, a single charity dedicated to improving the lives of people in later life. Age Concern and Help the Aged are brands of Age UK. The three national Age Concerns in Scotland, Northern Ireland and Wales have also merged with Help the Aged in these nations to form three registered charities: Age Scotland, Age Northern Ireland, Age Cymru.

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