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 dissatisfied with the eligibility decision. 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
37 Hospital discharge arrangements
39 Paying for care in a care home if you have a partner
41 Social care assessment, eligibility and care planning
76 Intermediate care and re-ablement

The information given in this factsheet is applicable in England. Different rules 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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1 Recent developments

- Since October 2014 people eligible for NHS continuing healthcare have had the ‘right to have’ a personal health budget unless there are clinical or financial reasons why this would be inappropriate. See section 5.5.

- CCGs can offer a personal health budget to people with other health conditions if they believe they would benefit from one, if it represents value for money and the individual wishes to have one.

- Rates payable to nursing homes for NHS-funded nursing care have increased for year 2015/16. The new single band rate from 1 April 2015 is £112 per week. For those in a care home prior to October 2007 and who remain on the high band, the rate is £154.14. See section 7.

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 care’.

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

Note: For ease of reading we use the following terms: residential home (residential care home) or nursing home (care home with nursing), or care home if it can be either.

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

3.1 Background to NHS continuing healthcare

If you have complex needs, the boundaries between health and social care responsibilities 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.

From the early 1990s, the Parliamentary and Health Service Ombudsman (PHSO) was receiving a large number of complaints about local criteria and processes followed when making NHS CHC eligibility decisions. The legality of some eligibility decisions was challenged in the courts.

It was against this background that the Department of Health developed a National Framework for NHS continuing healthcare and NHS-funded nursing care. See section 3.4.

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)

NHS funded care can be delivered in any setting. If you are to receive care in your own home, the NHS funds a care package to meet your assessed health and personal care needs. If you are to live in a care home, the NHS pays for a place in a home that is able to meet your assessed health and personal care needs.

3.3 Who arranges and funds NHS continuing healthcare?

Your GP practice is a member of a Clinical Commissioning Group (CCG). That CCG is responsible for managing the process and making NHS CHC eligibility decisions for patients registered with its member practices. It is also responsible for 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. NHS England is responsible for their NHS CHC and other healthcare needs.

**Note:** A tool to help you identify your CCG - by inserting the postcode of your GP practice - is available on the NHS Choices website: www.nhs.uk/Service-Search/Clinical-Commissioning-Group/LocationSearch/1

Your CCG can signpost you to a manager with responsibility for NHS CHC.

### 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 first introduced in October 2007. The document:

- sets out clear principles and processes to be followed throughout England for establishing eligibility for NHS CHC. See sections 4 & 5;
- clarifies the interaction between the assessment for NHS CHC 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, 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 revised in October 2009. This revision clarifies the process and explains more clearly what staff are looking for and what they should record in order to reach an evidence-based recommendation about your eligibility.

The Department of Health published a further revision - to the Framework, practice guidance and the three tools - in November 2012. It incorporates guidance issued separately since the last revision. It also reflects April 2013 changes to the NHS structure that affect NHS CHC - abolition of PCTs and SHAs and their replacement by CCGs and NHS England respectively.
3.5 Who is eligible for NHS continuing healthcare?

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’.

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. However an understanding of any underlying condition(s), and/or its fluctuating nature should be evident during the decision-making process.

The term ‘primary health need’ comes from an important Court of Appeal case (R v Coughlan ex parte North and East Devon Health Authority, ‘the Coughlan case’) about the legal responsibility for care in a nursing home. The court decided that there were legal limits on what sort of nursing care assistance a local authority could provide. It is limited to nursing care which is:

- merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide (the quantity test); and
- of a nature that a social services authority can be expected to provide (the quality test).

Certain characteristics of your needs, in combination or alone, may demonstrate a ‘primary health need’. These characteristics help decide whether the quantity and/or quality of care needed to manage your needs is beyond the limits of a local authority’s responsibility.

So when assessing your needs, the Framework guidance advises staff to consider them in relation to the following characteristics:

- **nature**: the type and particular characteristics of your needs - physical, mental or psychological. This influences the type (quality) of interventions required to manage them.
intensity: this relates to both the extent (quantity) and severity (degree) of your needs and the support required to meet them on an ongoing basis.

complexity: how different needs present and interact to increase the knowledge and skill needed to monitor your symptoms, to treat you and/or any multiple conditions you have and/or the interaction between them, and how this affects the management of your 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.

Note: The different levels of need that feature in the Checklist and Decision Support Tool (DST) reflect these characteristics. These tools are used by the staff who must make a recommendation about your likely or actual eligibility for NHS CHC. See sections 5.1 and 5.3.

Note: Eligibility does not depend on who currently 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?

Not everyone with on-going health needs is likely to need to be considered for NHS CHC. However there are times when it is appropriate for NHS or social care staff to consider whether you may be eligible for such care.

In the following circumstances, ask staff whether they think you could be eligible for NHS CHC and whether they have applied or considered applying the Checklist. This could be the hospital consultant responsible for your care, hospital discharge staff, staff co-ordinating your intermediate care, a member of the social work team or your GP:
• when you are ready to be discharged from hospital and your long term needs are clear. National Framework Practice Guidance PG 18.3 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 you finish a period of intermediate care or rehabilitation or other NHS-funded services, offered at the end of a period of acute hospital treatment, and staff agree no further improvement in your condition can be expected.

• whenever your health and social care needs are 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 nursing home resident, your nursing care needs are being reviewed. This 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 5.6.

**Note:** If staff propose a permanent place in a nursing home, your eligibility for NHS CHC must be considered before reaching any decision about your need for NHS-funded nursing care. Ideally this should happen before you move into the nursing home. NHS-funded nursing care is described in section 7.

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.

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) (Amendment 3) Regulations 2014*.

### 3.7 How is eligibility decided?

Staff must follow the legally prescribed decision-making process described in the National Framework and Practice Guidance and use one or more of the following tools – 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 staff who will be using them. They can also be found on the Gov.uk website (see Note: in section 3.4).


Beacon is a social enterprise able to provide up to 90 minutes of free independent advice (NHS England-funded) to individuals or their families to help them navigate and understand the assessment and/or appeals process. See section 8, Useful organisations.

For more detail about the process for deciding eligibility, see sections 4 and 5.

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 the key milestones and timeframes they are working to and alert you to delays as they occur.

Staff should make sure they ask about any hearing or visual difficulties or language preferences you may have. They should then take appropriate 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, you can invite a family member or representative to support you throughout the assessment process. Staff should give you reasonable notice of key events – such as completion of the Checklist or DST – so you, and where appropriate they, can make arrangements to be there.
**Para 44 in the 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.”

**Note: The footnote in para 44 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**

Staff should tell you if they think you may be eligible for NHS CHC. At the outset, they should seek your informed consent to the assessment process. They should make it clear whether you are being asked to give consent for the whole process or for a particular stage.

Staff should also seek your consent to the necessary sharing of personal information about you between individuals and organisations involved in your care. You should be clear about 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. Staff should therefore clearly explain the consequences of not giving consent.

**4.2 When you lack capacity to give consent**

If there is concern about your ability to give consent to an assessment and to the sharing of personal information, your capacity to make this particular decision should be decided 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 this 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 you and those who have a genuine interest in your welfare. This will usually include consulting family and friends. Staff should record the outcome of a ‘best interest’ decision.

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 your 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, the person leading the process must make a ‘best interest’ decision about sharing information with relevant third parties.

Staff must share information with a person who has a registered LPA (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 an 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. The practice guidance gives common examples where, if staff follow the above principles, 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.

Staff should give a carer, who is acting in your best interests, information relevant to their caring role.

Advocacy when someone lacks capacity

A CCG (or local authority) has a duty, under the Mental Capacity Act 2005, to instruct / consult an Independent Mental Capacity Advocate (IMCA) if:

- it must make a ‘best interest’ decision that involves a change of residence or serious medical treatment for example it may be considering whether a permanent move to a care home is appropriate; and
- the individual does not have a family member or friend who is willing and able to represent them or be consulted during the process of reaching such an important ‘best interests’ decision.
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’. Although instructed by the CCG, 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 set out 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**. This is effectively a screening tool, so a positive Checklist would trigger a full assessment of needs and completion of the **Decision Support Tool** (DST) by a multi-disciplinary team (MDT). The MDT uses the information recorded in the DST to inform the eligibility recommendation they make to the CCG. The CCG makes the final eligibility decision and only in exceptional circumstances would it not follow the MDT recommendation. See section 5.3.4.

Staff can recommend a full assessment should take place without the need to complete the Checklist.
5.1 Apply the Checklist

The Checklist aims to help staff identify who should have a full assessment to determine their eligibility.

The Checklist threshold has been set deliberately low to ensure that all who require a full assessment have the opportunity to be considered.

The Checklist can be applied in a hospital or non-hospital setting by a doctor, nurse, other health professional or social worker who is familiar with both 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.

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

5.1.1 Application of the Checklist as part of hospital discharge

Being in unfamiliar surroundings and/or staying on a busy acute hospital ward may cause of disorientation and/or atypical behaviour, particularly for people with dementia. Therefore to be assessed at the point of discharge may not accurately reflect your long term needs. The Framework recognises this.

If you are about to be discharged from hospital and have significant health and care needs, staff should consider - before applying the Checklist – if there is potential for you to improve if they provide NHS-funded services, such as rehabilitation or intermediate care services. If staff offer such services, they should make a note to apply the Checklist once this additional period of support is complete and your needs are clearer.

Staff should consider intermediate care if you are at risk of entering a care home or if an assessment in a non-acute setting can better reflect your long term needs. (See Age UK’s Factsheet 76, Intermediate care and re-ablement for more information).
Alternatively, if a completed Checklist indicates the need for a full assessment, staff may wish to offer further NHS-funded services, as mentioned in above, before carrying this out. Staff should make a note to do the full assessment in the most appropriate setting once they can make a reasonable judgement about your long term needs.

Where staff believe that a person they are planning to discharge may be eligible for NHS CHC, they should make a decision about their eligibility before notifying social services, under the ‘delayed discharge’ procedure, that they will need some care support on discharge - unless they are intending to offer additional NHS services.

5.1.2 Application of the Checklist for care home residents

Your CCG may have protocols for completing the Checklist for current care home residents. If it does not and your care needs have changed and/or increased, the home can contact your GP or the CCG continuing healthcare team on your behalf and ask them to complete the Checklist. If this does not happen you or a member of your family can approach your GP or CCG. See Note: in section 3.3 to help you identify your CCG.

5.1.3 Application of the Checklist if you live in your own home

If NHS or social care staff think you may be eligible for NHS CHC during an initial assessment or review of your care needs, they may be able to complete the Checklist themselves. If not, they should arrange this with the CCG continuing healthcare team.

You cannot complete the Checklist yourself and self-refer to the CCG. But you or your carer can contact the relevant CCG continuing healthcare team and explain why you think it should be completed. See section 3.3 to help you identify your CCG.

5.1.4 Completing the Checklist

The Checklist is based on 12 ‘domains’ or ‘areas of need’. These domains are common to the Decision Support Tool and are listed in section 5.3.

For each domain, there are descriptions that represent ‘no and low’ needs that are found in column C; ‘moderate’ needs that are found in column B and ‘high’ needs that are found in column A.
Staff must choose the description that most closely matches your current needs. They should take account of well-managed needs as these still constitute needs, and any needs that might be expected to increase over the next three months. They must back up their choice of A, B or C with evidence.

Checklist outcome

A full assessment is required if the Checklist shows:

- two or more domains rated as high (column A); or
- five or more domains rated as moderate (Column B) or one domain rated as high (Column A) and four rated as moderate (Column B); or
- one of the four domains that carries a priority level in the DST (marked by an * in section 5.3) rated as high (column A) and any levels of need in other domains.

Whatever the outcome, the assessor should inform you and/or your representative of their decision as soon as reasonably practicable and give you a copy of the completed Checklist. This should contain enough detail for you and your family to understand why that decision was made.

What happens if Checklist indicates a full assessment is required?

Staff should send the completed Checklist to the CCG. The time between the CCG receiving the Checklist and making an eligibility and funding decision - following a full assessment and meeting of the MDT - should, in most cases, not normally exceed 28 days.

If it is likely to take longer than this, staff should tell you, and where appropriate your family, the timescales they are working to. You should not be left without appropriate support while waiting for an eligibility decision.

Section 5.11 gives information about refunds available if the 28 days is unnecessarily exceeded, you are ultimately found eligible for NHS CHC and have been funding care while awaiting the decision.

Right to request a review of the decision

If the Checklist does not indicate the need for a full assessment, the CCG should tell you of your right to ask it to reconsider its decision. 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 original decision, they should send you a clear, written response that explains their findings. This should also explain your right to use the NHS complaints procedure, if you remain dissatisfied with their position.

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

Staff should offer an appropriate health and social care assessment to identify your future needs and eligibility for support. See section 5.10.

5.2 Undertake a full multi-disciplinary assessment

On receiving a referral for a full assessment, the CCG should appoint someone to co-ordinate the process from this point until they make a funding decision and agree your care plan. You should know who this person is.

To ensure all physical, mental health and social care needs are evaluated – including ways they interact with each other - the co-ordinator should invite an appropriate range of health and social care professionals to contribute to your assessment. This could include those not currently caring for you but who have a direct knowledge of you and your needs. Input from a specialist nurse or the community mental health team who help manage your condition would be particularly relevant. Guidance produced by the Alzheimer’s Society aims to help assessors evaluate the emotional and psychological needs of people in the later stages of dementia.

Staff should consider your views on your needs and how they might be managed and those of your current carer(s) alongside those of the professionals.

Note: In the Framework 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 **Complete the Decision Support Tool (DST)**

It is helpful to read the ‘user’ notes at the beginning of the DST and the descriptions of the levels of need for each ‘domain’.

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, as described in 3.5.

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 ► ►**
10. **Drug therapies and medication: symptom control ► ►**
11. **Altered states of consciousness ► ►**
12. Other significant care needs to be taken into consideration ►

**Note:** ► ► indicates this domain goes up to priority level of need

► indicates this domain goes up to severe level of need
5.3.1 **MDT meeting to complete the DST**

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

The Regulations (see section 3.6) 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*. The *Care Act 2014* replaces the latter Act but social care assessment responsibilities remain the same.

Framework Practice Guidance **PG 30.2** goes on to say: “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.

5.3.2 **Your role / role of your representative at the MDT meeting**

Before 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 have 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. (Read ‘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;
- if the MDT cannot decide or agree on the level, they should choose the higher level, and record any evidence or disagreements;
● 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 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 staff can reasonably anticipate 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.

Staff completing the DST should state whether you or your representative were present and/or represented when they completed it.

If you have concerns about any aspect of the MDT or DST process that are not resolved by discussing them at the time, staff should note them within the DST. This ensures the CCG is aware of them when they make their final decision.

Framework Practice Guidance PG30.3 and 30.4 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.”

5.3.3 The MDT’s recommendation to the CCG

The DST includes a summary sheet to record an overview of the levels chosen for each domain, a summary of your needs and the MDT’s recommendation about your eligibility or ineligibility. It also includes space to record your views or those of your representative, including where and why you disagree with the 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, staff should consider the interaction between needs in various domains and evidence from risk assessments when reaching an eligibility decision. They must base their judgement about whether you have a ‘primary health need’ on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of your needs.

**Note:** Make sure that the MDT have considered this more discretionary area as well as the criteria for a ‘clear recommendation’

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

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.

### 5.3.4 The CCG’s decision

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

Exceptional circumstances under which the CCG may question an MDT recommendation and consequently refer it back to the MDT are explained in Framework Practice Guidance **PG 41**.

The CCG may communicate its decision to you or your representative verbally but it should always confirm it in writing. The correspondence should give clear reasons for the decision and be accompanied by a copy of the completed DST. You should also be told who to contact for further clarification or to request a review of the decision. See section 5.9.
**Note:** A decision that you are eligible for NHS CHC is not permanent. It can be overturned at a later date if a review of your condition shows your needs have changed. Ongoing reviews are built into the process. See section 5.7

If you are found not eligible but may need care in a nursing home, the completed DST should contain sufficient information to determine the need for NHS-funded nursing care. See section 7.

### 5.3.5 Use of a panel

The Framework does not require the decision-making process to use a panel. Where the CCG chooses to use a panel, it must only be used to ensure the consistency and quality of decision-making across the CCG. It cannot be used to fulfill a gate-keeping function, nor as a financial monitor.

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

### 5.3.6 If a person dies while awaiting an eligibility decision

If a person required services prior to their death that could have been funded through NHS CHC, the CCG should complete the decision-making process and arrange appropriate reimbursement as described in section 5.11.

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

When deciding upon the setting and package of care, staff should start with 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’ you want to achieve. Staff should take account of any risks associated with different types of care and of fairness of access to CCG resources.

The CCG should provide sufficient funding to meet the needs identified in your care plan and be based on the CCG’s knowledge of meeting your needs in the locality where they agree you are to live.
The CCG is responsible for ensuring you are told who is responsible for monitoring your care and arranging regular reviews.

You should receive GP, dental and other NHS services as needed.

**Note:** If you are dissatisfied with the CCG’s proposed care package and cannot resolve your concerns informally, the CCG should tell you how to access and use the NHS complaints procedure. This issue is not a matter for an Independent Review Panel 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 it to be a nursing home but it does not have to 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 accommodation than it usually would. The Framework Practice Guidance PG 99.2 gives examples: 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 your CCG agrees 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.
• **Your current care home cannot meet your assessed needs** you would need to discuss your options with the CCG.

• **Your current care home can meet your NHS CHC needs but it is more expensive than the CCG would normally pay to meet needs such as yours.** This can arise if you have been self-funding your care home place or if social services were contributing to the cost of your care and a friend or relative has paid a ‘top up’, also known as a ‘third party contribution’, to meet the higher costs of your preferred home. While ‘topping up’ is legally permissible in legislation governing social care, it is not allowed under NHS legislation.

The Framework Practice Guidance **PG 99** 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 the 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 living in a more expensive home, the CCG may propose you move to a different home. **PG 99.4** 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 for individuals at the end of their life is, where possible, for them to be cared for at home if this is their preference.
5.4.3 **In your own home**

Your CCG is responsible for funding a package to meet your identified health and personal care support needs but not rent/mortgage, food and normal utility bills. If you must pay extra utility costs due to the running of specialist equipment, an NHS contribution to related bills may be appropriate.

If you were living at home before becoming eligible for NHS CHC, you may have had Direct Payments from the local authority to meet your social care and support needs. 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 enjoy with Direct Payments. The introduction of Personal Health Budgets to support health and wellbeing needs facilitates this. See section 5.5.

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

The Framework Practice Guidance **PG 89** says:

“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 CCG 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.”

**Note:** A carer providing or about to provide informal care for an adult with care needs has a right to a separate care’s assessment. Carers should approach their local authority social services department to arrange one. Under the Care Act 2014, carers have a right to have their eligible needs met for the first time. See Age UK’s Factsheet 41 **Social care assessment, eligibility and care planning.**
If at a later date you want to move house and into another CCG area

If you wish to move house, you should raise it with your funding CCG in plenty of time. It will need careful discussion between your current CCG and the CCG responsible for providing your services after you move. Both CCGs will want to ensure continuity of care, that arrangements represent your best interests and that any associated risks are identified.

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.

5.5 Personal health budgets and NHS CHC

Since October 2014, anyone receiving NHS CHC has had the ‘right to have’ a PHB. If an individual comes within the scope of a PHB, the expectation is that one will be provided, unless there are clear clinical or financial reasons why it would not be appropriate.

What is a personal health budget?

A personal health budget (PHB) is an amount of money to support a person’s identified health and wellbeing needs, planned and agreed between the person and their local NHS team.

It is not new money but money the NHS would normally have spent on your care. A PHB allows this money to be spent more flexibly to meet identified needs and health and wellbeing goals that you agree with your NHS team.

Your care and support plan describes how you would like to meet these goals, using the budget assigned to you. Your plan must be ‘signed off’ by NHS staff who must be satisfied that your health and care needs will be met by the goods or services you intend to purchase and the money is sufficient to buy them. Your care plan and PHB management will be kept under review.

A PHB aims to give you more choice and flexibility to meet your needs in ways that suit you. However you do not have to have a PHB if you do not want one. You should have as much control over decisions about and managing your care as you want.
A PHB can be managed in one of three ways or a combination of them:

- **a notional budget**, where the CCG holds the money but you are actively involved in choosing who delivers your care and support;

- **a third party**, where an organisation, for instance a trust, holds the money and manages your care and the budget for you in line with your agreed care plan;

- **a direct payment** where money is transferred to you or your nominee or representative who contracts for necessary services or expenditure.

**Note:** Contact the person responsible for your NHS CHC care package if you want to find out more about the PHB programme, such as the ways the money you are allocated could be spent and what support you could have to explore how a PHB could work for you.

**Using a direct payment to manage a NHS CHC PHB**

The PHB direct payments scheme is broadly similar to that operated by local authorities for social care direct payments. In some areas the NHS and local authority are working cooperatively to support the delivery of PHBs.

**Some practicalities**

Your CCG should consider what support you might need if you think you would benefit from a PHB but find it difficult to manage a direct payment.

You may benefit from the support of a local brokerage service or there may be a suitable ‘nominee’ who could take on full responsibility if you opt for a direct payment? One of the other methods of managing your PHB may prove to be a better option.

If you would benefit from but lack capacity to consent to or manage a direct payment, the CCG should establish if someone could act as your ‘representative’ and take on the responsibilities of someone receiving a direct payment.

The March 2014 guidance explains the duties placed on you, a ‘nominee’ or ‘representative’ if you take up a health direct payment. Staff helping you decide if a PHB would work for you, should explain these to you.
For example: Are you wanting to use an agency or to employ a personal assistant to help you? If you are thinking about employing one or more personal assistants, you, your ‘nominee’ or ‘representative’ are likely to require guidance to help you to understand the responsibilities of being an employer. This would include how to recruit the right staff and arrange cover if they are unable to work due to sickness; payroll duties (this can be outsourced to a payroll company) and requirements to pay into a pension scheme for your personal assistant.

If you choose to have a health direct payment, it must be paid into a separate back account, used specifically for this purpose and held by the person receiving it. You may need guidance on how to manage the budget and provide evidence showing what you have spent the money on.

If you are refused a health direct payment, or asked to pay back any of the money, or the CCG wants to bring the arrangement to an end, you are entitled to a review of the CCG decision. If that is unsuccessful you could go on to use the NHS complaints procedure.

Note: There is more about PHBs on the NHS Choices website. It includes information on drawing up your care plan, managing your budget and stories from people explaining the difference a PHB has made to their lives. It also includes links to video chats with people who took part in the PHB pilot

www.nhs.uk/choiceintheNHS/Yourchoices/personal-health-budgets/Pages/about-personal-health-budgets.aspx

Regulations and Guidance on Personal Health Budgets

Guidance on Direct Payments for Healthcare: Understanding the Regulations was published in March 2014.


Guidance on the “right to have” a Personal Health Budget in Adult NHS Continuing Healthcare and Children and Young People’s Continuing Care was published in September 2014.

http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/2014/Personal_health_budgets_right_to_have_guidance.pdf
5.6 Use of the Fast Track Tool

If you are approaching the end of your life you may be eligible for ‘fast tracking’. This enables you to receive prompt NHS funding for your end of life care and by-pass the full assessment process already described.

The criterion for the Fast Track Pathway Tool has two elements only:

- a rapidly deteriorating condition;
- that may be entering a terminal phase.

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

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 has 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. Staff should not impose strict time limits that base eligibility on some specified, expected length of life remaining.

CCGs should accept and immediately action a properly completed Fast Track tool recommending NHS CHC eligibility. There should be processes in place to enable them to introduce appropriate care packages preferably within 48 hours of receiving the completed tool. Care planning should reflect the approaches promoted 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 to be ‘fast tracked’ and are living in a residential home, you may have expressed a preference to remain there. Staff should make every effort 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 proceed, where appropriate, to reach a decision on your longer term eligibility.

It is possible, even at the end of your life, that your needs may plateau out so that you no longer meet the fast track criterion. If this happens the CCG should continue to support you without disruption while they assess your needs using the DST. They should notify you in writing of any proposed change in your care funding and give you details of your right to request a review of the decision.

Note: National Institute for Health and Care Excellence (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. http://www.nice.org.uk/guidance/qs13/informationforpublic

5.7 Regular reviews of eligibility decisions

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

The MDT that made the original eligibility recommendation 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.
If a review results in a dispute between the CCG and Local Authority (LA) about your continued eligibility for NHS CHC, your case should go through the joint CCG/LA agreed disputes process. The CCG should continue to fully fund your care 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 5.9.1.

5.8 Effect on state benefits of NHS continuing healthcare

Disability benefits

If you are self-funding your care in a care home and receive one of the following disability benefits - Attendance Allowance (AA), Disability Living Allowance (DLA) or Personal Independence Payment (PIP) - and will receive NHS CHC in a nursing home, you should notify the Disability Benefits Centre (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 a disability benefit mentioned above but will receive NHS CHC in a nursing home, you should notify the Disability Benefits Centre. 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 a disability benefit and will continue to live at home with an NHS CHC care package, you can continue to receive a disability benefit.

Other benefits - State Pension and Pension Credit

Your State Pension is not affected by your eligibility for NHS CHC. However you lose the severe disability element of your Pension Credit award when you are no longer entitled to AA or DLA (care), PIP (daily living component) and this may affect the amount of Pension Credit you receive.
5.9 **What happens if you wish to challenge a decision?**

If you wish to challenge an eligibility decision reached following a full assessment and MDT recommendation, 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 notification letter should tell you who to write to.

You may wish to contact Beacon if you are considering an appeal against an NHS CHC decision. See section 3.7 and section 8 Useful organisations.

To support your request for the decision to be reviewed, your letter should explain your reasons for making the challenge. It is important to provide as much evidence as you can to support your case. Where possible relate your evidence to the domains in the DST, e.g. to show why you believe you should have been placed in a higher category in a particular domain. You should expect an acknowledgment in writing within 5 working days along with a brief explanation of the process to be followed.

The 6 month time limit will not apply if you can satisfy the CCG that there were good reasons for you missing it and the CCG believes 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 valid and in place unless or until the Local Review 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.

5.9.1 **The Review process**

There are two stages in the review process:

- a **Local Review** managed by the CCG;
- a request to NHS England who may then refer the matter to an **Independent Review Panel (IRP)**.

Factsheet 20 ● July 2015
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.”

It is therefore particularly important to be able to give clear reasons, supported by evidence, if your status as a ‘representative’ means the CCG must make a ‘best interests’ decision as to whether to agree to your request for a review. 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. The process could include referring your case to a neighbouring CCG for consideration or advice. The CCG should make review process 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.

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

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

- the procedure followed by the CCG in reaching the eligibility decision; or
- the CCG’s ‘primary health need’ decision.

**Note:** If you are dissatisfied with issues such as the type, location or content of your care package, the CCG should tell you how to raise this 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 after the CCG notifies you of a local review decision.

**NHS England should arrange and complete the IRP 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 independent individuals who can chair a panel.

If it decides not to convene a panel, it should give you, your family or representative a full written explanation of the reasons and tell you of your rights to use the NHS complaints procedure to take it further.

**The role of the Independent Review Panel**

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 must 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.

Outcome of the review

**NHS England should notify you of the IRP findings** 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 5.11 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 **Parliamentary and Health Service Ombudsman** (PHSO). You or your representative is entitled to contact the PHSO within **12 months of notification of the outcome of the independent review.**

**Note:** IRP procedures are outlined in Annex E of the National Framework.
5.10 Your care package if you do not progress beyond Checklist

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. Subject to national social services eligibility criteria, 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 community equipment such as aids and minor adaptations for the purpose of assisting nursing at home or aiding daily living. If you need services from both the NHS and social services, you will undergo a means-test for support that is the responsibility of social services. You should not be charges for aids or for minor adaptations costing £1000 or less.

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 or physiotherapy;
- assessment and/or support from community-based NHS staff such as district nurses, continence nurses, specialist diabetic nurses;
- palliative care services.

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

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

Annex F in the 2012 National Framework document is guidance on responsibilities when an NHS CHC eligibility decisions are delayed or disputed. 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 using the CCG local review process or as a result of an 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 (LA) the costs of services provided from day 29 to the date the decision was reached. If you have been contributing towards the cost of your care, the LA 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 on the recommendation of the IRP, the CCG should reimburse any costs incurred by the LA. If you were contributing to the cost of your care, the LA 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.
Note: See section 6.1 for guidance on interest to be paid when considering redress. To dispute a CCG decision on whether to provide redress or on the amount provided, you should use the NHS complaints procedure.

6 Deadlines for raising new cases involving care between 1 April 2004 and 31 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 April 2004 and 31 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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<th>Time period</th>
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<td>1 April 2004 – 30 September 2007</td>
<td>30 September 2012</td>
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<td>1 October 2007 – 31 March 2011</td>
<td>30 September 2012</td>
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<tr>
<td>1 April 2011 – 31 March 2012</td>
<td>31 March 2013</td>
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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. PCTs were abolished and replaced by CCGs on 1 April 2013.

If you seek a review in respect of a relative who is deceased, the CCG may well require evidence to prove that you are entitled to any money that may be forthcoming. This could be the Grant of Probate or Letters of Administration.

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
6.1 Redress following a retrospective review

A retrospective review may show that during the period under consideration, an individual was eligible for NHS CHC. In this case, the CCG must decide what is a fair and reasonable amount to offer the individual (or their estate), as the individual should not have had to fund their own care during that time. When reaching their decision, the CCG must consider the individual circumstances of each case and be able to justify their offer of redress.

The purpose of redress is solely to restore the individual to the financial position they would have been in had NHS Continuing Healthcare been awarded at the appropriate time. As set out in Parliamentary and Health Service Ombudsman's “Principles for Remedy”, “remedies should not lead to a complainant making a profit or gaining an advantage”. This principle also applies to the NHS.

Refreshed Redress guidance from 1 April 2015

When deciding redress for retrospective review decisions reached on or after 1 April 2015, CCGs should apply the NHS Continuing Healthcare Refreshed Redress Guidance, published by NHS England on 1 April 2015. This guidance must be followed where:

- an eligibility decision for NHS CHC has been made on or after 1 April 2015; and
- the need for redress has been identified by the CCG.

The refreshed guidance advises CCGs to apply the Retail Price Index for calculation of compound interest when considering redress cases. The aim is to achieve an outcome that is fair and reasonable to the individual and will demonstrate an appropriate use of public funds.

You can find the refreshed 2015 NHS England guidance at: www.england.nhs.uk/ourwork/pe/healthcare/redress-guidance-ccgs/

Note: CCGs should also use this guidance to assist when settling redress claims arising from NHS Continuing Healthcare eligibility decisions such as the situations described in section 5.11.
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. Their residents receive nursing and other health related care from NHS staff based in the community. Consequently these homes do not receive an NHS-funded nursing care contribution from their CCG.

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

Staff should not consider your eligibility for NHS-funded nursing care until it is agreed that you are not eligible for NHS CHC and that a place in a nursing home is your best option. They may reach this conclusion following completion of the Checklist or after a full assessment and MDT recommendation.

If the ‘not eligible’ decision arises following a full assessment, the MDT should record your need for registered nursing care on the DST. Staff can then use this information when drawing up your care plan.

Other times when staff could have decided that you are not eligible for NHS continuing healthcare and a move to a nursing home is appropriate include:

- after a period of rehabilitation or intermediate care – prior to which staff flagged up that they should wait and see if there is any improvement in your condition before they complete the Checklist or offer a full assessment to consider your eligibility. See section 5.1.1.
● as part of a joint NHS and social care assessment to assess or review your needs. If you are to be appropriately placed in a nursing home, staff should always apply the Checklist to verify this.

You can find a template for recording nursing care needs, based on the domains in the DST, in NHS-funded Nursing Care Practice Guide July 2013 (Revised). This Guide is one of the documents included in 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 mean they do not have a ‘primary health need’ but their needs are clearly above the level 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 all agree that a place in a nursing home is appropriate for you, the CCG establishes a contract with your nursing home to pay NHS-funded nursing care and pays the home directly. The home should tell you how the fees you pay take account of this CCG payment.

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

The CCG should undertake a case review no later than three months after its initial decision to make an NHS-funded nursing care payment. This is to reassess your needs, make sure they are being met and confirm that a nursing home place is still appropriate.

When reviewing your need for NHS-funded nursing care, staff must always consider your potential eligibility for NHS continuing healthcare. This involves using the Checklist or where indicated, carrying out a full consideration, including completion of the DST by an MDT.

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. The nursing care reviewer must consider each of the domains and previously assessed need levels, 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 NHS 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 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 care 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 April 2015 the weekly rate, paid directly to the nursing home, is £112.00.

If you moved into a care home before 1 October 2007, a three-band system operated: low – medium – high. Residents on the high band in October 2007 remained on this band if a review indicated their needs, based on pre-October 2007 guidance, continued to be equivalent to the high band. From 1 April 2015 the high band weekly rate is £154.14.

Residents remain on this high 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:** Self-funding residents living in nursing homes that receive an NHS-funded nursing care payment from the CCG on their behalf, are eligible to claim attendance allowance, DLA (care) or PIP (daily living) as the NHS is not paying for their personal care, accommodation and board.

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 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 self-fund their 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 an NHS-funded nursing care payment. 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

Beacon

Beacon is a social enterprise. It offers a range of free and paid for services including up to 90 minutes of NHS England-funded independent advice about the NHS CHC assessment and appeal process and a full range of low cost advocacy services.

Oxford House, 1600 John Smith Drive, Oxford Business Park South, OX4 2JY
Tel: 0345 548 0300
Email: enquiries@beaconchc.co.uk
Website: www.beaconchc.co.uk

Disability Benefits Centre

Contact these helplines if you need to inform them that you are to receive NHS continuing healthcare in a care home or if you are admitted to hospital.

Disability Benefits Centre, Warbreck House, Warbreck Hill, Blackpool, Lancashire FY2 0YE
DLA helpline: 0845 712 3456 (if born after 08.04.1948)
AA helpline: 0845 605 6055 (also call if DLA claimant born before 08.04.1948)
PIP helpline: 0945 850 3322
Web: www.gov.uk/disability-benefits-helpline
Local Healthwatch

Each local authority has a local Healthwatch. It can give information and signpost to local health and social care services. It may run or can signpost to the local NHS independent advocacy service that can support those making an NHS complaint. To find your local Healthwatch, use the postcode search facility on Healthwatch England’s website or call them.

Tel: 03000 683 000
Email: enquiries@healthwatch.co.uk
Web: www.healthwatch.co.uk

NHS Choices

NHS Choices provides web based information on NHS structures, services, health conditions and healthy living.

Website: www.nhs.uk/

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 - lines are open Monday to Friday 9am - 5pm
Email: opg.safeguardingunit@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 (PHSO) can investigate complaints about NHS care or services if you remain dissatisfied following a local investigation of your complaint. The PHSO 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, 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
by calling Silver Line Scotland: 0800 470 8090
(This line is provided jointly by Silver Line Scotland and Age Scotland.)
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

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