

Factsheet 20

NHS continuing healthcare and NHS-funded nursing care

November 2016

About this factsheet

This factsheet explains what NHS continuing healthcare is; how the NHS decides whether you are eligible to receive it and what to do if dissatisfied with the eligibility decision.

It explains NHS-funded nursing care – a weekly payment made to nursing homes by the NHS, towards their costs of providing residents with nursing care.

The following factsheets may also be of interest:

6 Finding care at home

10 Paying for permanent residential care

22 Arranging for others to make decisions on your behalf

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 reablement

The information in this factsheet is applicable in England. If you are in Scotland, Wales or Northern Ireland, please contact Age Scotland, Age Cymru or Age NI for their version of this factsheet. Contact details can be found at the back of this factsheet.

Contact details for any organisations mentioned in this factsheet can be found in the Useful Organisations section.

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1 Recent developments

- NHS-funded nursing care rates changed for the year 2017/18. The single band rate from 1 April 2017 is £155.05 per week. If you have been in a care home since October 2007 and are still on the high band in place at the time, the new rate is £213.32 per week.

2 Continuing care terminology

Health and social care professionals use these terms to describe support from the NHS and/or local authority social services department.

Continuing care is a general term describing care provided over a period of time to meet physical, mental health and personal care needs arising as a result of a disability, accident or illness.

Continuing NHS and social care is care available in a range of settings that may involve NHS and social care services. It may be described as a '*joint package of care*'.

NHS continuing healthcare – a complete package of on-going care arranged and funded by the NHS.

Note

Residential home refers to a residential care home, **nursing home** refers to a care home providing nursing care and **care home** refers to both of these as appropriate.

NHS continuing healthcare is referred to as **NHS CHC** and **PG** refers to Practice Guidance.

3 NHS continuing healthcare

Background

If you have complex needs, the boundary between NHS and social care responsibilities may not always be clear. Services provided by the NHS are free whereas those arranged by social services are means-tested, so decisions about who has overall responsibility for your care can have significant financial consequences.

In the early 1990s, the Parliamentary and Health Service Ombudsman received complaints about local criteria and processes used in making NHS CHC eligibility decisions. The legality of some eligibility decisions was challenged in the courts. In October 2007, the Department of Health introduced a *National Framework for NHS continuing healthcare and NHS-funded nursing care*.

3.1 What is NHS continuing healthcare?

NHS continuing healthcare (NHS CHC) is a package of care arranged and funded solely by the NHS in England if you are aged 18 or over to meet physical or mental health needs arising because of a disability, accident or illness.

You can receive NHS CHC in any setting. Whether you live at home or in a residential care or nursing home, the NHS funds a care package or a care home place to meet your assessed health and personal care needs.

3.2 How is NHS CHC eligibility decided?

NHS CHC eligibility decisions are '*needs based*' and rest on whether your needs for long term care are primarily health related because of complicated, intense or unpredictable healthcare needs. This is referred to as having a '**primary health need**'.

Having a particular diagnosis does not determine eligibility - people with the same health condition can have very different needs. However staff responsible for making an eligibility recommendation should indicate they have information about or an understanding of any underlying condition(s) you have, and/or its fluctuating nature.

The term '*primary health need*' comes from a 1999 Court of Appeal case known as the *Coughlan* case, which ruled there was a legal limit on what sort of nursing care assistance a local authority could provide and said 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**).

To decide if the quantity and/or quality of care needed to manage your needs is beyond the limits of a local authority's responsibilities and thus fulfils criteria for a '*primary health need*', assessors consider your needs, in combination or alone, in terms of the following:

Nature - the type and features of your needs, be they physical, mental or psychological, and the kind (quality) of interventions required to manage them.

Intensity - this relates to both the extent (quantity) and severity (degree) of your needs and support required to meet them on an on-going basis.

Complexity - how different needs present and interact to increase the knowledge and skills staff need to a) monitor your symptoms b) 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 - the degree to which unexpected changes in your condition mean your needs fluctuate and create challenges because of the timeliness and skill mix required to manage them. It affects the level of monitoring required to ensure you and others are safe and the level of risk to you or others unless adequate and timely care is provided. Someone with unpredictable healthcare needs is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Descriptions of the different levels of need in the **Checklist** and **Decision Support Tool (DST)** reflect these characteristics.

3.3 Understanding the decision making process

Staff must follow the process described in the *National Framework for NHS continuing healthcare and NHS-funded nursing care* and use one or more of its Tools – **Checklist, DST and Fast Track Tool**.

The chart on page 7 outlines this process.

You can download a basic guide for the public at www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet

Beacon, a social enterprise, provides up to 90 minutes free independent advice (NHS England-funded) to help you, your family or representatives navigate and understand the decision-making and appeals process.

3.4 What is the National Framework?

The *National Framework for NHS continuing healthcare and NHS-funded nursing care* is a document that:

- Sets out clear principles and processes that *must be* followed to establish NHS CHC eligibility. See sections 4 & 7.
- Clarifies the interaction between assessment for NHS CHC and for NHS-funded nursing care.

It minimises local interpretation and improves transparency and consistency of the decision-making process by providing:

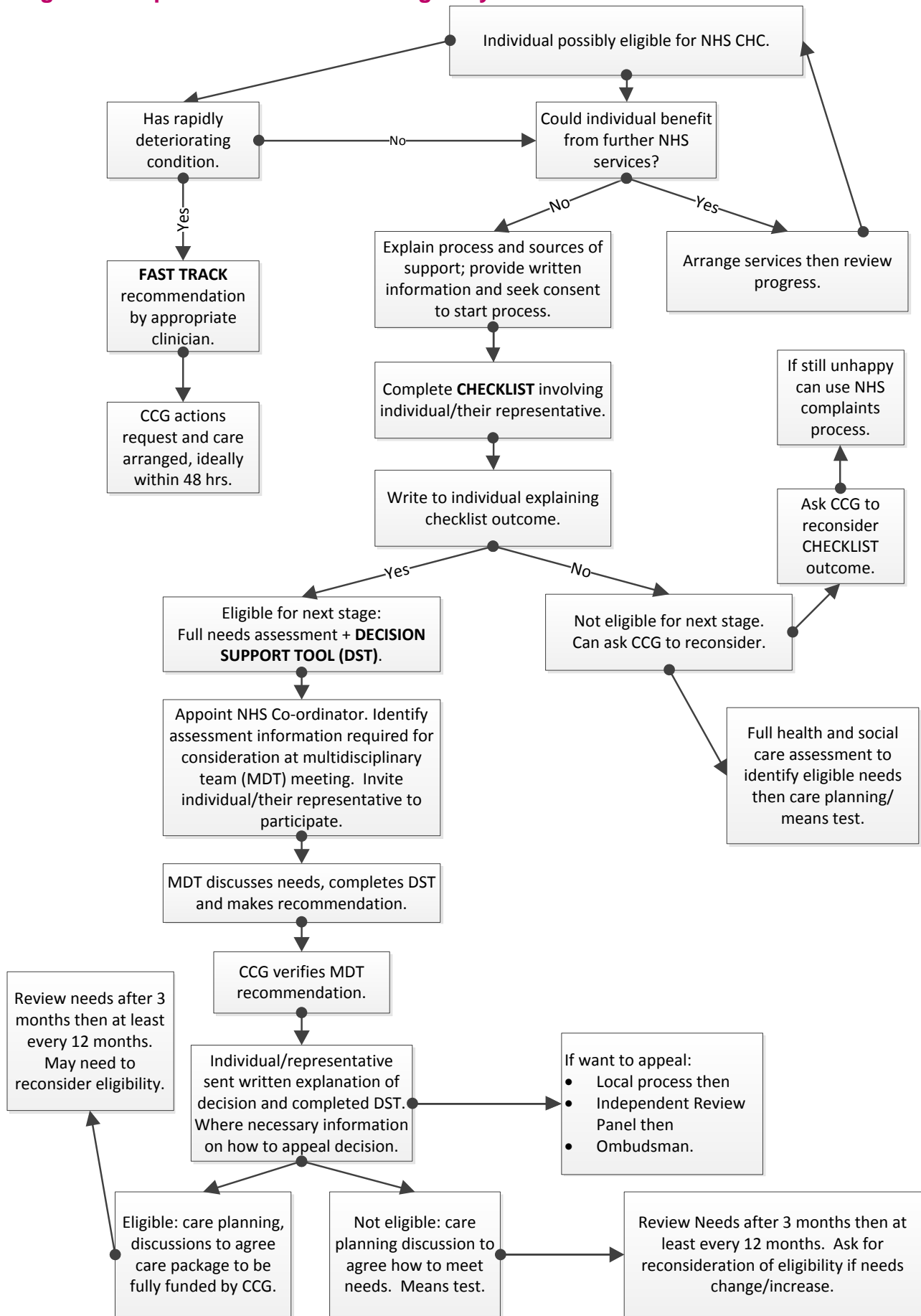
- a *national* process, guidance and tools to support decision-making – the **Checklist, DST and Fast Track Tool**
- *common* paperwork to record evidence that informs decision-making.

The current Framework explains more clearly what staff are looking for and must record to support an evidence-based recommendation about your eligibility. It includes **general guidance**, numbered **Practice Guidance (PG)**, **appendices** and the **Tools** that *must be* used.

You can read the Framework and Tools at:

www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Stages in the process to determine eligibility for NHS CHC



3.5 Who decides NHS CHC eligibility and funds your care?

Each GP practice is a member of a Clinical Commissioning Group (CCG). The CCG manages the process for patients registered with its member practices - making eligibility decisions, funding and unless you choose a personal health budget as described in section 9.4, arranging your care package. Eligibility decisions must be independent of a CCG's budget constraints. Each CCG has a manager responsible for NHS CHC.

To identify your CCG, insert your GP practice postcode into the NHS Choices website: www.nhs.uk/Service-Search/Clinical-Commissioning-Group/LocationSearch/1

3.6 Routes to reaching an NHS CHC decision

If you have a rapidly deteriorating condition and appear to be reaching the end of your life, staff can use the '**Fast Track Tool**', (see section 5.4), to recommend you move quickly onto NHS CHC.

Fast tracking is not the usual way and in most cases:

- the type and level of your needs should prompt staff to apply the **Checklist**
- a positive Checklist triggers a full assessment of your needs
- a multi-disciplinary team (MDT) uses this assessment information to complete the **DST**, which informs their eligibility *recommendation* to your CCG
- CCG makes the final eligibility *decision* but only in exceptional circumstances would it not follow the MDT recommendation.

You have a right to challenge a decision:

- a) where a full assessment is not offered after completing the Checklist
- or
- b) on learning the final eligibility decision.

Where there is a clear need, staff can recommend a full assessment without completing the Checklist.

3.7 When should eligibility be considered?

A CCG must take reasonable steps to ensure it conducts an NHS CHC assessment where it appears there may be a need for such care. Not everyone with on-going health needs is likely to be eligible but ask NHS or social care staff to *consider* whether you may be eligible and whether they should apply the Checklist:

- when your long term needs are clear and staff are planning your hospital discharge
- at the end of a period of intermediate care, rehabilitation or other NHS services and no further improvement in your condition is likely
- whenever staff review your health and social care needs 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, staff review your nursing care needs - this should happen at least annually
- if your condition is rapidly deteriorating and you may be approaching the end of your life – in this case you may be eligible for ‘fast tracking’.

Note

If staff propose a permanent place in a *nursing* home, they must consider your NHS CHC eligibility before deciding your need for NHS-funded nursing care and where possible, do this before you move into the home.

4 National Framework principles

4.1 A person-centred approach involving you and your carers

Staff should tell you if they think you may be eligible for NHS CHC. They should ensure you and your family or representative understands the process used to reach an eligibility decision and receive advice and information you need. This includes asking about and addressing hearing or visual difficulties or language preferences, supporting you to play an active part and taking full account of your views on your needs and how they might be managed alongside those of professionals.

You should be made aware of key milestones and timeframes they are working to and alerted to delays as they occur.

You can, if you wish, ask a family member or representative to support you throughout the assessment process with staff giving you reasonable notice of key events, such as dates for completing the Checklist or DST, so they can make arrangements to be there.

The Framework PG 4 fully explores key elements of a person-centred approach to NHS CHC.

Note

The Framework says a '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.*'

4.2 Deciding if you have mental capacity to give consent

At the outset, staff must seek your informed consent to be considered for NHS CHC and be clear whether they are asking for consent to the whole process or a particular stage. You must be asked to give consent for them to share necessary personal information about you between the individuals and organisations likely to be involved in your care. They must ensure you are aware of the range of organisations this could be.

You can refuse to give or withdraw consent at any stage but if you do, staff should explore your reasons, aim to address any concerns and explain that a local authority cannot take responsibility for meeting needs that are the NHS's responsibility.

If there is concern about your ability to consent to an assessment or share personal information, staff must apply a two stage test when deciding if you have capacity to make a *particular* decision under the *Mental Capacity Act 2005*:

Stage 1 Is there an impairment of or disturbance in the functioning of your mind or brain? If so,

Stage 2 Is the impairment or disturbance sufficient that you lack the capacity to make the *particular* decision?

If the answer to both questions is yes, the Act says you are unable to make the decision in question if unable to do one or more of the following:

- understand information given to you
- retain that information long enough to be able to make the decision
- weigh up the information and make a decision
- communicate your decision – talking, sign language or muscle movements such as blinking or squeezing a hand are acceptable.

Staff must take all practicable steps at all stages to help you make a decision yourself.

If it is agreed you lack capacity to give consent, staff must check whether you have appointed someone to act on your behalf on health and care matters under a Lasting Power of Attorney (LPA) or if the Court of Protection has appointed a personal welfare deputy. A partner, family member or 'third party' can act on your behalf and give consent only if appointed to do so.

If there is no one to act in one of these ways, the person leading your assessment is responsible for making a '*best interests*' decision on your behalf. To inform their decision, they must consult you and those with a genuine interest in your welfare, which usually includes family and friends. Staff should record the outcome in your medical notes.

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 does not have the authority to give consent or make decisions about your health and welfare. This is explained in Framework PG 7.3.

4.3 Confidentiality and sharing information

Staff must share information with an attorney under a registered LPA (health and care) or with a Court Appointed Deputy (welfare). Family members or carers should have information relevant to their caring role.

Sharing information in the absence of formal authority

There are circumstances where it is acceptable for a third party, who assumes responsibility for acting in a person's '*best interests*' but without formal authority of an LPA or Deputyship on health and care matters, to legitimately request and receive information.

When deciding whether to share personal/clinical information with a family member or someone chosen to represent you, the information holder must act within the following principles:

- any decision to share information must be in your '*best interests*'
- they must only share information which is necessary for a third party to act in your '*best interests*'.

Subject to these principles, staff should not unreasonably withhold information. Examples where a third party may legitimately be given information include:

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

5 Process for reaching an eligibility decision

5.1 Apply the Checklist

The Checklist helps staff identify who should have a full assessment to determine NHS CHC eligibility. The threshold is set deliberately low, so all who require a full assessment have this opportunity.

The assessor should ask if you want to be involved when they complete the Checklist and if you would like a family member, advocate or other representative with you. Seeing the Checklist beforehand helps you and your family prepare for and contribute to its completion.

Note

A decision to apply the Checklist does not imply that you should or will be eligible for either a full assessment or NHS CHC.

Who can apply the Checklist?

As far as possible, the assessor should be someone who assesses or reviews care needs as part of their day-to-day work - a doctor, nurse, other health professional or social worker - and is familiar with the guidance and more detailed DST. The CCG or local authority decides who can apply the Checklist in a hospital or non-hospital setting.

Applying the Checklist as part of hospital discharge

If you are about to be discharged from an acute hospital and have significant health and care needs, before applying the Checklist, staff should consider whether you have the potential to improve if they offer NHS-funded services such as rehabilitation or intermediate care in a community hospital or other setting. This is particularly important when discharge to a care home is a real possibility. If they offer additional services, staff should apply the Checklist at the end of this period, when your needs are clearer.

The Framework recognises being in unfamiliar surroundings and on a busy hospital ward can cause disorientation and/or atypical behaviour if you have dementia. Offering intermediate care then applying the Checklist in less stressful surroundings is likely to better reflect your needs.

If a Checklist completed on an acute hospital ward indicates a need for a full assessment, staff may propose intermediate care services before carrying this out. This is to see if further improvement is possible and enable them to make a reasonable judgement about your long term needs away from the hospital setting.

If staff are not intending to offer additional NHS services but intend to alert social services of your need for support on discharge, they must know if you have been considered for NHS CHC and the outcome of that consideration. They must include this information in paperwork sent to social services.

For information about intermediate care see factsheet 76, *Intermediate care and reablement*.

Applying the Checklist if you live in a care home

There may be a CCG protocol for completing the Checklist if you live in a care home. If there is not and your care needs change significantly and/or increase, the home can ask the CCG continuing healthcare team to complete one.

Applying 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 trained to complete the Checklist. If they are not, they should notify the CCG continuing healthcare team.

You cannot self-refer to the CCG by completing the Checklist but you or your carer can contact the CCG continuing healthcare team to explain why you think someone should visit you to complete one.

Completing the Checklist

The **12 'domains'** or '*areas of need*' in the Checklist are the same as those in the DST (see section 5.3.)

Each domain has descriptions representing '**no and low**' needs in column C; '**moderate**' needs in column B and '**high**' needs in column A.

The assessor completes the Checklist by choosing the description most closely matching your needs. They must take account of well-managed needs as these are still needs and any needs that might be expected to increase over the next three months. The Checklist aims to be relatively quick and straightforward to complete but staff must have evidence to back up their choices.

Checklist outcome

You require a full assessment if the Checklist shows:

- two or more domains rated as **high** or
- five or more domains rated as **moderate or**
- one domain rated as **high** and four rated as **moderate or**
- a **high** in one of four domains carrying a priority level in the DST (marked by an ►► in section 5.3) plus any level 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.

A positive Checklist

A positive Checklist triggers a full assessment. In most cases, it should not take more than 28 days between the CCG receiving the Checklist and them making eligibility and funding decisions. Staff should tell you, and as appropriate your family, the timescales they are working to and if it is likely to take longer than this.

Your care and support arrangements remain the responsibility of the NHS while waiting for an eligibility decision but you may have to pay for support during this time. If the CCG unnecessarily takes longer than 28 days to reach a decision, you are found eligible and have funded care while awaiting the decision, you can apply for a refund of charges paid.

A negative Checklist

If the Checklist indicates no need for a full assessment, you should receive a written explanation of the CCG's decision and be told of your right to ask them to reconsider. This written explanation may take the form of a covering letter and completed Checklist.

When reconsidering, the CCG must take account of any additional information you or your representative provide. You should receive a written response of their findings and be told of your right to use the NHS complaints procedure, if you remain dissatisfied with their decision.

If 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.

5.2 Undertake a full multi-disciplinary needs assessment

On receiving a referral, the CCG appoints a co-ordinator to manage your case and to ensure you and your representative understands the process, are asked to provide your views and perspectives on your needs, participate as much as you can and wish to, and keep you informed until the eligibility decision is reached.

The co-ordinator must gather up-to-date information about your physical, mental health and social care needs. They invite relevant health and social care professionals to assess your needs and prepare an evidence-based report using their skills to indicate what this information signifies in relation to your needs and wishes. Those invited should include staff caring for you at the moment and those with a direct knowledge of your needs but not currently caring for you. This might be a consultant, specialist nurse or community mental health team.

Framework PG 28.1 and 29 describe potential sources of information and what a good multidisciplinary assessment looks like.

5.3 Complete the Decision Support Tool (DST)

The co-ordinator selects a multi-disciplinary team (MDT) and arranges a meeting at which the MDT use your evidence, assessment reports and their professional judgement to complete the DST, which informs their eligibility *recommendation* to the CCG.

The DST

The DST features 12 '*domains*' or areas of need the MDT consider when deciding whether you have a 'primary health need. Each domain has descriptions of between four and six levels of need:

'No need' 'low' 'moderate' 'high' 'severe' 'priority'

The different levels reflect changes in the nature, intensity, complexity or unpredictability of the need. 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 ►

►► indicates this domain goes up to priority level of need

► indicates this domain goes up to severe level of need

The role of you and your representative at the MDT meeting

The co-ordinator should explain the meeting format to you and/or family members or your representative in advance. They should invite you to contribute to the discussion in person and give your representative sufficient notice of the date to be able to make arrangements to attend if they wish to.

Copies of assessments circulated to MDT members at the meeting, should be given to you and your representative if you are present. If you, a family member or your representative cannot attend, the co-ordinator should obtain evidence and views from you or your representative so they can be actively considered when completing the DST.

The DST has space to record whether and how you and your representative contributed and if you were not involved, to record whether it was because you were not invited or declined to participate.

The multidisciplinary team (MDT)

A MDT is defined as:

- two professionals from different health professions or
- one professional from a healthcare profession and one who is responsible for assessing individuals for community care services.

As a minimum, an MDT can comprise two professionals from different healthcare professions, but the Framework makes clear it should usually include both health and social care professionals who are knowledgeable about the individual's health and social care needs. The names, job titles and signatures of multidisciplinary team members should be recorded on the DST.

Completing the DST

When completing the DST, the MDT should ensure they:

- complete all care domains
- use assessment evidence and their professional judgement to select the level most closely describing your needs
- choose the higher level and record any evidence or disagreements if they cannot decide or agree the level

- consider interactions between needs as appropriate
- do not marginalise needs because they are successfully managed. Well-managed needs are still needs and should be recorded appropriately
- take account of needs not covered by the 11 domains and record them in a 12th domain to consider when making their eligibility recommendation.

Once all information is complete, the MDT can have a discussion without you or your representative present to reach their recommendation. The DST has a section for you and your representative to give your views, not recorded elsewhere in the document, on the completion of the DST including whether you agree with domain levels selected and if you disagree, the reasons why. Arrangements should allow you to give your views on the completed domain levels before you leave the meeting.

If you have concerns about aspects of the MDT meeting or DST process that are not resolved at the meeting, staff should record them, with reasons, in the DST. This ensures the CCG is aware of them when making the final decision.

The completed tool should give an overall picture of your needs. If MDT anticipates your condition will deteriorate and your needs in certain domains increase in the near future, they should record this and take it into account when making their final recommendation. This may influence the time of your next review.

If you are not present for the part of the meeting where the MDT agrees its recommendation, the outcome should be communicated to you as soon as possible.

Alzheimer's Society guidance is available to help evaluate emotional and psychological needs of people in later stages of dementia.

www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2565

The MDT's recommendation to the CCG

The DST includes a summary sheet to record an overview of levels chosen for each domain and a summary of your needs. Having considered what this information signifies in terms of the nature, intensity, complexity and unpredictability of your needs, the MDT agrees and provides reasons for its recommendation about your eligibility.

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

- **priority** level of need in any of the four domains with a priority 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 indicate a primary health need, depending on the combination of needs. Staff should always consider the interaction between needs in various domains and evidence from risk assessments and base their judgement about whether you have a 'primary health need' on what the evidence indicates about any combination of the nature, complexity, intensity and unpredictability of your needs.

If your needs in all domains are low needs, this is unlikely to indicate eligibility. If your needs in all domains are no need, this indicates ineligibility.

The CCG's decision

The CCG should only not follow the MDT's recommendation in exceptional circumstances. Exceptional circumstances include: DST not completed fully, gaps in the evidence or an obvious mismatch between evidence and the recommendation.

The CCG may share its decision with you or your representative verbally but 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 referencing all evidence relating to your care needs. The letter should tell you who to contact for further clarification or in the case of a negative outcome, how to request a review of the decision.

Note

An eligibility decision is not permanent. It can be overturned at a later date if a review shows your needs have changed and no longer meet the primary health need threshold. On-going case reviews are built into the process.

Not eligible for NHS CHC but with specific health needs

Completion of DST may identify that although you are not eligible for NHS CHC, some of your healthcare needs are beyond the powers of a local authority solely to meet and therefore the responsibility of the NHS. The authority and CCG should work together to agree their respective responsibilities within a joint package of care and explain whether a CCG contribution reduces how much you must pay following a mean-test.

Use of a panel

Panels are not required as part of the decision-making process. CCGs can use them to ensure consistency and quality of decision-making across the CCG but not as a financial gate-keeper. The CCG and local authority may use a panel as part of their local dispute resolution process when they disagree about your eligibility.

If a person dies while waiting for an eligibility decision

If you die while waiting for an eligibility decision and were receiving services that could have been funded through NHS CHC, the CCG must complete the decision-making process and where necessary arrange appropriate reimbursement. If you did not receive such services, there is no need to continue the decision-making process.

5.4 When to use the Fast Track Tool

If you are approaching the end of your life, you may be eligible for '*fast tracking*'. This means receiving prompt NHS funding for your end of life care and by-passing the full assessment process described above.

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

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

If staff caring for you in any location observe such changes, they should contact an 'appropriate clinician' and ask them to consider completing the Fast Track tool and where possible supporting it with a prognosis. An 'appropriate clinician' is a doctor or nurse responsible for your diagnosis, treatment or care or with a specialist role in end-of-life needs and an appropriate level of knowledge or experience.

CCGs should make decisions to fast track on a case by case basis but not impose strict limits that base eligibility on a specified, expected length of life remaining. CCGs should accept and promptly action a Fast Track tool recommending eligibility and be able to put a suitable care package in place, preferably within 48 hours of receiving it.

When developing your care package, staff should ask if you have an advance care plan and take account of any expressed care preferences and wishes it contains. For example if you live in a residential home and have expressed a preference to remain there, staff should make every effort to enable this to happen, if it is clinically safe and within the home's terms of registration.

Once appropriate care is in place, the CCG can take steps, where appropriate, to reach a decision on your longer term eligibility. Even at the end of your life your needs may stabilise so you no longer meet fast track criterion. In this case the CCG should continue to support you without disruption while they assess your needs and arrange for a MDT to complete the DST. They should tell you the outcome in writing. If they propose a change in your funding, they should explain your right to request a review of their decision.

Note

National Institute for Health and Care Excellence Quality Standard for end of life care describes how good quality end of life should be organised for people thought likely to die in the next 12 months. See www.nice.org.uk/guidance/qs13/informationforpublic

6 Regular reviews of eligibility decisions

Regular reviews are part of the NHS CHC process and you have the right to be represented by a person of your choice. If you were considered for NHS CHC and the NHS subsequently provides or funds *any* part of your care package, **your case review should take place no later than three months after the initial eligibility decision and then at least annually**. The MDT making the original recommendation may specify a different timing for your first review.

The focus should be on whether your needs have changed and consequently whether your care plan needs revising and not on whether you remain eligible for NHS CHC. Any decision to remove eligibility should be undertaken jointly by the CCG and relevant local authority and involve completion of the DST. They should use their local disputes procedure to resolve disagreements between them about your eligibility. During that time the CCG must continue to fully fund your care.

If the CCG and local authority agree you are no longer eligible, the CCG should inform you in writing, with their reasoning, and explain your right to request a review of their decision. A month's notice of a change of funding responsibility would be reasonable.

7 If you want to challenge an eligibility decision

Submitting a request for a review of the decision

If you want to challenge a decision following a full assessment and completion of DST, you or your representative **must write to the CCG no later than 6 months from the date you received written notification of the decision**. You may wish to contact Beacon if considering whether to appeal. The CCG should acknowledge your letter in writing within 5 working days and explain the appeal process.

When writing to the CCG, be sure you explain *why* you are challenging the decision, providing as much evidence as you can. Where possible, relate it to DST domains. Give examples from your experience or from a report that you believe are not captured in the DST and illustrate why you believe you should have been placed in a higher level for a particular domain. Highlight any gaps in evidence used to support the rationale for the overall decision or failures to adhere to the Framework process.

This is particularly important when the person making the request is a close relative or representative but does not have a LP A or court deputy status. In this situation, if the person to whom the decision relates does not have capacity to instruct their relative to request a review, the CCG must adopt a '*best interests*' process when considering whether to accept their request. This is discussed in Framework PG 68.2.

The 6 month deadline does not apply if you satisfy the CCG you had good reasons for missing it and the CCG believes it can access relevant information and records that informed the original decision.

Funding your care once you challenge the CCG decision

The CCG decision remains valid and in place unless or until either stage of the process outlined below recommends you should be eligible.

You should receive appropriate care while awaiting the outcome but may have to contribute towards the cost of your care package during this time. Your financial circumstances affect who is responsible for arranging and/or paying for your care while waiting for the outcome of the review. If a local authority means-test shows you are responsible for funding your care during this time, you can claim costs incurred if your appeal is successful, provided you keep receipts. (See section 8 for more information).

7.1 The Review process

The Review process following a full assessment can only help if you are dissatisfied with:

- the procedure followed by the CCG in reaching the eligibility decision, including how eligibility criteria were applied or
- the CCG's 'primary health need' decision.

There are two stages in the review process:

- A Local Review managed by the CCG.
- If you remain dissatisfied following the Local Review, you request an Independent Review managed by NHS England who may appoint an Independent Review Panel (IRP).

If going to local review would cause undue delay, NHS England has discretion to put your case straight to an IRP.

Note

If you are unhappy 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. For more information, see factsheet 66, *Resolving problems and making a complaint about NHS care*.

Local Review stage and timescales

Each CCG should agree a local review process with timescales against various stages and make it publically available. The process usually involves a review meeting where you can ask questions and try to gain a better understanding of their decision and try to resolve the matter at this stage. It can include referring your case to a neighbouring CCG for their consideration or advice and you can ask to be present when they meet.

The CCG is **expected to investigate and make a decision in relation to a local review within 3 months of receipt of the request**, unless there are good reasons for extending it. Reasons can 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. Their letter should explain how to request an independent review should you remain dissatisfied. If the 3 month time period cannot be met, the CCG should explain in writing the reason for the delay and commit to a written response as soon as it reasonably can.

Independent Review Panel stage and timescales

You must **request an independent review in writing no more than 6 months after hearing the final outcome of the local review decision and it should be arranged and completed within 3 months of your request being received**, unless there is good reason for the delay.

NHS England, via regional teams, is responsible for arranging IRPs and can decide not to convene a panel. Before doing so, it should seek advice from an independent individual 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 this further.

The role of the Independent Review Panel and your contribution

The IRP consists of a chair independent of the NHS and experienced health and social care professionals independent of the CCG that made the eligibility decision. It has a scrutiny and reviewing role and so it is not necessary for you or the CCG to be legally represented when the panel meets, although you may wish a family member, advocate or advice worker to represent you. If you want advocacy support, your CCG has details of local services.

You are invited to attend part of the panel hearing to explain why you are appealing the decision and to answer questions the panel may have. You may want to contact Beacon to discuss how to prepare your case and for the meeting. The points made in section 7 about challenging decisions are equally as important when preparing for the IRP.

If the thought of being present and involved in such a meeting feels daunting, you can watch a 10 minute video prepared by NHS England to help you understand what to expect. You can watch it on You Tube <http://bit.ly/1MxfRz8>

Both the IRP and local procedures should follow key principles for dispute resolution outlined in annex E of 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 you; from the 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
- involving you or your representative as far as possible, including the opportunity to contribute to and comment on information at all stages
- making 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.

The IRP makes 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.

Independent Review Panel recommendation

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.

If the CCGs decision is upheld and you remain dissatisfied, their letter should explain how to ask for your case to be referred to the Parliamentary and Health Service Ombudsman (PHSO). You or your representative are entitled to contact the PHSO within 12 months of receiving written notification of the outcome of the independent review.

8 Refunds of care charges if the NHS should have paid

You may be entitled to a refund to cover care 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.

You may be entitled to a refund if a retrospective review of your situation indicates you should have been considered for NHS CHC and were found eligible when you were assessed. Guidance on refund responsibilities when an NHS CHC eligibility decisions are delayed or disputed are described in Annex F of the 2012 National Framework document.

Refunds for unjustifiable delay in reaching a decision

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 have contributed towards the cost of your care**, the authority should reimburse your contributions in full.

If you funded all your care, you should receive an ex-gratia payment from the CCG 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 'justifiable' delays 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. To avoid this, CCGs should aim to develop protocols to help meet the 28 day deadline.

Refunds following a revised decision

If you dispute a CCG's initial eligibility decision and this decision is revised, the CCG should reimburse any costs incurred by the local authority. **If you were contributing to the cost of your care**, the authority should reimburse you.

If you funded all your care costs, you should receive an ex-gratia payment from the CCG aiming to restore your finances to the state they would have been in had the correct decision been made at the outset and remedy any injustice or hardship because 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.

Refunds following a retrospective review

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

Redress guidance

The purpose of redress is solely to restore you to the financial position you would have been in had NHS CHC been awarded at the appropriate time. Remedies should not lead to a complainant or the NHS making a profit or gaining an advantage.

Refreshed Redress Guidance, published by NHS England on 1 April 2015 must be followed where:

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

This guidance advises CCGs to apply the Retail Price Index for calculation of compound interest for the period under consideration. The aim is to achieve an outcome that is fair and reasonable to you and demonstrates an appropriate use of public funds.

You can find the 2015 NHS England guidance at:

www.england.nhs.uk/ourwork/pe/healthcare/redress-guidance-ccgs/

Note

To dispute a CCG decision on whether to provide redress or on the amount provided, you should use the NHS complaints procedure.

9 Care planning if you are eligible for NHS CHC

When deciding where you should live and your care package, the start point should be your views and preferences. The care package agreed must be one the CCG believes, having taken into account any risks associated with different options, is appropriate to meet your assessed health and social care needs and the outcomes you want to achieve. The budget must be sufficient to pay for services or a care home in the CCG area or anywhere outside the CCG area it agrees you may live.

The CCG deciding your eligibility is responsible for arranging and funding your care package and should tell you who to contact with any concerns and who is responsible for monitoring your care and arranging regular reviews. It remains responsible for funding and monitoring care associated with your NHS CHC eligibility even if it is agreed you can live outside its area.

If you are to live outside the CCG area you will need to register with a GP there. Any NHS community, dental, optical or hospital services you need that are unrelated to your eligibility for NHS CHC are the responsibility of your new GP practice's CCG.

Advocacy when you lack capacity to consent to a care plan

A CCG or local authority must instruct or consult an Independent Mental Capacity Advocate (IMCA) to act on your behalf when they:

- must make a '*best interests*' decision that involves an accommodation change, hospital admission for more than 28 days or other accommodation for more than 8 weeks or serious medical treatment **and**
- you have no family member or friend willing and able to represent you or be consulted while they reach such an important '*best interests*' decision.

This is relevant if staff propose you move from your own home to a care home, whether or not you are eligible for NHS CHC.

An IMCA must find out your views, wishes and feelings about the issue by talking to you, people close to you and professionals who know you. Their report must be used to help decision-makers reach a '*best interests*' decision. IMCAs can challenge a decision that appears not to be in your '*best interests*'.

For more information, see factsheet 22, *Arranging for others to make decisions on your behalf*.

Advocacy if you have capacity

When you have capacity to make care decisions, you can ask family members to help make your views known or ask the person coordinating your assessment about local advocacy services.

Care can be provided in a range of settings:

9.1 In a care home

The CCG is responsible for meeting the cost of your assessed care needs and accommodation if you are to live in a care home. Some issues to be aware of if a care home is the preferred or best option include:

- **The CCG has block contracts with several care homes in an area.** This may be so but it is your assessed needs that determine whether any of these homes are suitable. There may be '*needs based reasons*' for the CCG to consider homes or more expensive accommodation than it usually would. Examples include where there is a recognised link between feeling confined in a small room and displaying behaviour that challenges those caring for you 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. When the CCG that decided your eligibility agrees you can live in a care home in another CCG area, it remains responsible for your care home fees.
- **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 self-funded your care home place or if social services contributed to the cost of your care and a friend or relative paid a 'top up', or 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 why you want to stay in your current home or same room and consider if there are clinical or over-riding needs-based reasons for you to do so.

If you live 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 of the care package, notwithstanding that it is a higher rate, such as frailty, mental health needs or other relevant needs of the individual mean that a move to other accommodation could involve significant risk to their health and wellbeing.'*

9.2 In a hospice

Hospice care may be appropriate if you are reaching the end of your life. Your wishes and preferences should be taken into account when deciding the setting and location of your care.

9.3 In your own home

Your CCG must fund a package to meet your identified health and personal care support needs but not rent/mortgage, food and normal utility bills. If running specialist equipment adds substantially to the cost of water or electricity bills, an NHS contribution may be appropriate.

If you lived at home before becoming eligible for NHS CHC, you may have had Direct Payments from the local authority. The CCG should aim to arrange services to maintain a similar package of care to that in place and replicate as far as possible the personalisation and control you have with Direct Payments. The introduction of Personal Health Budgets to support health and wellbeing needs facilitates this.

If a family member is providing care as a part of your care package

When the CCG agrees to your home-based package and a family member/friend is an integral part of your care plan, it should identify and meet training needs that help them carry out this role.

In particular, the CCG may need to provide additional support to care for you whilst your carer(s) have a break from their caring responsibilities and assure them such support will be available when required. This could mean you receive additional services at home or spend a period of time away from home (e.g. a care home).

Note

If your carer provides or is about to provide informal care for you, they have a right to a separate carer's assessment and to have their eligible needs met. They can approach their local authority social services department to arrange one. See factsheet 41, *How to get care and support*.

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

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

Moves within the UK

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

9.4 Personal Health Budgets and NHS CHC

Since October 2014, anyone receiving NHS CHC has the right to have a Personal Health Budget (PHB) with the expectation one will be provided, unless there are clear clinical or financial reasons why it should not.

What is a personal health budget?

A PHB is an amount of money you can spend to support your identified health and wellbeing needs and goals. It is not new money but money the NHS would otherwise spend on your care.

Your care and support plan describes how you would like to meet your goals, using the assigned budget. It is signed off by NHS staff once satisfied the goods or services you intend to purchase can meet your health and wellbeing needs and the budget is sufficient.

Your care manager keeps your care plan and PHB management under review. You do not have to have a PHB and should only be offered as much control over 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 arrangement*, 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 your NHS CHC care package manager to find out more about support you could have to explore how a PHB could work for you and ways the money you are allocated could be spent.

Using a direct payment to manage a NHS CHC PHB

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

Some practicalities

Speak to your care manager to discuss your options and find out what support is available if you have a PHB:

- Is there help to manage a PHB, such as a local brokerage service?
- Is there a suitable nominee who can take on full responsibility if you opt for a direct payment?
- If you lack capacity to consent to or manage a direct payment, is there someone who can act as your representative and take on the responsibilities of someone receiving a direct payment?
- Would one of the others way of managing it prove to be a better option?

Your care manager can explain the duties placed on you, a nominee or representative if you take the direct payment option.

You may consider employing a personal assistant to help manage your health and care and wellbeing needs and want to understand the responsibilities of being an employer such as:

- how to recruit a personal assistant?
- how to pick the right staff and arrange cover for holidays or if they are unable to work due to sickness?
- payroll duties (this can be outsourced to a payroll company)
- do you need to pay into a pension scheme for a personal assistant?

If you have a health direct payment, it must be paid into a separate bank account specifically for this purpose and held in the name of the person receiving it. You may need guidance on how to manage the budget and keep records on what you spend money on.

If you are refused a health direct payment, are 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 decision and if unsuccessful, you can use the NHS complaints procedure to try to resolve the problem.

Note

There is more about PHBs on the NHS Choices website including drawing up a care plan, managing your budget and stories from people explaining the difference a PHB has made to their lives. www.nhs.uk/choiceintheNHS/Yourchoices/personal-health-budgets/Pages/about-personal-health-budgets.aspx

10 Effect on state benefits of NHS CHC funding

Disability benefits

If you self-fund 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 care home, notify the Disability Benefits Centre. Your benefit is suspended 29 days after the CCG begins to fund your care or sooner if you have recently been in hospital.

If you live at home and claim a disability benefit but will receive NHS CHC in a nursing home, notify the Disability Benefits Centre. Your benefit is suspended 29 days after the CCG begins to fund your care or sooner if you have recently been in hospital.

If you live at home and claim a disability benefit and will continue to live at home with an NHS CHC care package, you can continue to receive the benefit

State Pension

State Pension is not affected by eligibility for NHS CHC.

Pension Credit

You lose the severe disability element of your Pension Credit award if no longer entitled to AA or DLA (care), PIP (daily living component).

11 Care planning if you do not progress beyond Checklist

If you do not progress beyond the Checklist, a joint health and social care assessment identifies your needs. Subject to national social services eligibility criteria, your needs and views on how they can best be met form the basis of your agreed care plan.

Your care package may include community equipment such as aids and minor adaptations to assist with home nursing or daily living. You should not be asked to pay for aids or minor adaptations with fitting charge, if the cost is £1000 or less.

If you need services from the NHS and social services, you undergo a means-test for support needs that are the responsibility of social services. NHS services may be provided in their own right on a regular or ad-hoc basis alongside social care services and include:

- care provided in a nursing home by a registered nurse
- rehabilitation and recovery services such as physiotherapy
- assessment and/or support from community-based NHS staff such as district nurses, continence nurses, specialist diabetic nurses
- palliative care services such as emotional support and pain management if you have been diagnosed with a terminal illness.

For more information, see factsheet 41, *How to get care and support*.

12 Retrospective reviews of NHS CHC eligibility

If you think you should have been considered for NHS CHC, you can raise this with social services or your care home manager and CCG continuing healthcare manager. If seeking a review in respect of a deceased relative, the CCG may require evidence to prove you are entitled to any money that may be forthcoming. This could be the Grant of Probate or Letters of Administration.

12.1 Cases of 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 CHC 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 deadline has passed but cases submitted for these periods continue to be investigated. CCGs must complete them by March 2017.

13 NHS-funded nursing care

Nursing homes must employ registered nurses. NHS-funded nursing care is a flat rate contribution paid by a CCG directly to local nursing homes, for the care registered nurses provide to eligible residents. A registered nurse is likely to:

- provide hands on nursing care
- supervise and monitor care provided by a non-registered nurse
- plan and review health needs in a care plan
- monitor and review medication needs
- identify and address potential health problems.

Note

Residential homes do not employ registered nurses. Residents receive necessary nursing care from NHS nurses based in the community, such as district nurses. These homes do not receive a NHS-funded nursing care payment from their CCG.

13.1 How is eligibility for NHS-funded nursing care decided?

Staff should not consider your eligibility for NHS-funded nursing care until it is agreed 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 in the DST. Staff can use this information when drawing up your care plan.

Other times when staff can decide you are not eligible for NHS CHC and a move to a nursing home is appropriate include:

- after a period of rehabilitation or intermediate care – prior to which staff flagged up they should wait and see if there is any improvement in your condition before completing the Checklist or offer a full assessment to consider your eligibility
- 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 you are not potentially eligible for NHS CHC.

Payment of NHS-funded nursing care to the nursing home

Once it is agreed a place in a nursing home is appropriate, the CCG establish a contract with your nursing home to pay NHS-funded nursing care and pays the home directly. If you self-fund your care, ask the home to tell you how the amount they ask you to pay takes account of this CCG payment. They should include this information in your contract.

13.2 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 nursing needs, make sure they are being met and confirm 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 CHC. This involves using the Checklist or where indicated, carrying out a full consideration, including completion of the DST by an MDT.

One situation where completion of a new DST is not required is where:

- staff reached their initial decision 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.

In this situation the reviewer must have a copy of the DST and consider each domain and previously assessed need levels, in consultation with you and any relevant people present then who knew you. The reviewer should annotate and sign each domain, confirming they have considered each one and indicating any changes in need levels.

After the review, the CCG should tell you that despite meeting the Checklist threshold, they have not completed a new DST because there has been no significant change in your need levels.

You should receive a copy of the annotated, signed DST, told you can ask for a review of this decision and if you remain dissatisfied after local reconsideration, can use the NHS complaints procedure. Your local Healthwatch or NHS independent advocacy service can help with the complaints process.

If you did not have a full assessment with completion of the DST or where a review indicates a possible change in eligibility, a positive Checklist must be followed by an MDT completed DST and recommendation on eligibility for NHS CHC.

Following this three month review, you should have a review at least annually. It may be clinically appropriate to have more frequent reviews and you should have one if your healthcare needs change significantly.

If you self-fund your care in a nursing home, ensure you have a review three months after you first move in and annually thereafter. The care home manager should explain CCG arrangements for reviews.

13.3 NHS-funded nursing care payments

Following a review of funded nursing care rates, updated rates apply from 1 April 2017.

If you moved into a nursing home on or after 1 October 2007, you are on the single band of nursing care. The weekly rate is £155.05, paid directly to the nursing home.

If you moved into a nursing home before October 2007 and were on the high band in place at the time, the weekly rate is £213.32, paid directly to the nursing home.

Residents remain on this high band until:

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

Self-funding residents living in nursing homes receiving NHS-funded nursing care payments from the CCG 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.

13.4 Admission to hospital or a short stay in a nursing home

If you are admitted to hospital, the home does not receive funded nursing care payments during your hospital stay. The NHS-funded nursing care guidance says CCGs should consider paying a retainer to help safeguard residents care home places while they are in hospital.

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 for a nursing needs assessment if 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.

Useful organisations

Beacon

www.beaconchc.co.uk/

Telephone 0345 548 0300

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.

Disability Benefits Helpline

www.gov.uk/disability-benefits-helpline

DWP helpline providing advice or information about any claim for Disability Living Allowance, Personal Independence Payment or Attendance Allowance that you have already made.

Attendance Allowance (AA)

Telephone 0345 605 6055

Disability Living Allowance (DLA)

If you were born on or before 8 April 1948

Telephone 0345 605 6055

If you were born after 8 April 1948

Telephone 0345 712 3456

Personal Independence Payment helpline

Telephone 0345 850 3322

Local Healthwatch

www.healthwatch.co.uk

Telephone 03000 683 000

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.

NHS Choices

www.nhs.uk/

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

Office of the Public Guardian

www.gov.uk/browse/births-deaths-marriages/lasting-power-attorney

Telephone 0300 456 0300

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*.

Parliamentary and Health Service Ombudsman

www.ombudsman.org.uk

Telephone 0345 015 4033

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.

Age UK

Age UK provides advice and information for people in later life through our Age UK Advice line, publications and online. Call Age UK Advice to find out whether there is a local Age UK near you, and to order free copies of our information guides and factsheets.

Age UK Advice

www.ageuk.org.uk

0800 169 65 65

Lines are open seven days a week from 8.00am to 7.00pm

In Wales contact

Age Cymru

www.agecymru.org.uk

0800 022 3444

In Northern Ireland contact

Age NI

www.ageni.org

0808 808 7575

In Scotland contact

Age Scotland

www.agescotland.org.uk

0800 124 4222

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