

Factsheet 20

NHS continuing healthcare and NHS-funded nursing care

October 2018

About this factsheet

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

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

The following factsheets may 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*
- 38 Property and paying for residential care*
- 39 Paying for care in a care home if you have a partner*
- 41 How to get care and support*
- 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

- A refreshed *2018 National Framework for NHS continuing healthcare and NHS-funded nursing care* is implemented from 1 October 2018. Amendments and clarifications to 2012 Framework, practice guidance and associated tools are not intended to change eligibility criteria.
- NHS-funded nursing care (NHS FNC) single band rate, for year starting 1 April 2019, is £165.56 a week. If you moved into a nursing home before 1 October 2007 and were on the high band, it is £227.77 a week.
- Local Government and Social Care Ombudsman issued guidance to help nursing homes provide unambiguous, clear information about NHS FNC payments in general and in their contracts.

2 Continuing care terminology

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

Continuing NHS and social care is on-going care involving free NHS and means-tested social care services. It may be called a '*joint package of care*'.

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

Note

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

NHS CHC refers to NHS continuing healthcare, **NHS-FNC** to NHS-funded nursing care, **PG** to Practice Guidance, **DST** to Decision Support Tool, **CCG** to Clinical Commissioning Group, **LA** to local authority.

3 NHS continuing healthcare

Background

If you have complex needs, the boundary between NHS and social care responsibilities is not always clear. Services provided by the NHS are free whereas those arranged by social services are means-tested.

The Department of Health and Social Care *National Framework for NHS continuing healthcare and NHS-funded nursing care* standardises the process that must be followed to decide where care responsibility lies.

3.1 What is 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 and have been assessed having a 'primary health need', as set out in the National Framework. Such care is provided to meet health and associated social care 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 setting such as a care home, the NHS funds a health and social care package it decides is appropriate to meet all your assessed health and personal care needs.

3.2 What is the National Framework?

The *National Framework for NHS continuing healthcare and NHS-funded nursing care* describes a process designed to minimise local interpretation and improve transparency and consistency when deciding eligibility for NHS CHC. The Framework:

- sets out clear principles and processes staff must follow to establish NHS CHC eligibility. See sections 4, 5, 7, 8 and 9
- provides a national process and tools staff must use to support decision-making – the Checklist, Decision Support Tool (DST) and Fast Track Tool
- provides common paperwork staff must use to record evidence that informs decision-making
- clarifies the interaction between assessment for NHS CHC and for NHS-FNC. The latter is a funding CCGs provide to nursing homes, to support provision of nursing care provided by the home's registered nurses.

The Framework includes *general guidance*; *numbered Practice Guidance (PG)* explaining what staff are looking for and must record to support an eligibility recommendation; and *copies of the tools*. There are annexes, including annex F - best practice guide for CCGs when drawing up local protocols and procedures for NHS CHC.

The guidance, appendices and tools for the 2018 Framework and 2012 Framework in use before 1 October 2018 are at www.gov.uk/government/collections/nhs-continuing-healthcare-and-nhs-funded-nursing-care

Understanding the decision-making process

The chart on page 7 outlines the overall process.

Beacon can help you, your family or representatives navigate and understand the decision-making and appeals process. They offer up to 90 minutes free, independent advice funded by NHS England.

For a basic guide for the public see www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet

3.3 How is NHS CHC eligibility decided?

NHS CHC eligibility decisions are '*needs based*' and rest on deciding whether the main aspects or the majority part of the care you need is focussed on addressing and/or preventing health needs. If it does, it means you have 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 contributing to your needs assessment must have relevant skills, knowledge about and understanding of your underlying condition(s) and if and how your needs might fluctuate.

The term '*primary health need*' comes from a 1999 Court of Appeal case known as *Coughlan Judgment*. This found there to be a legal limit on nursing care assistance a LA could provide. It described this to be when taken as a whole, the nursing or other health services you require are:

- no more than incidental or ancillary to the provision of the accommodation which a LA is, or would be but for the person's means under a duty to provide (the '**quantity test**'), and
- not of a nature beyond which a LA, whose primary responsibility is to provide social services, could be expected to provide (the '**quality test**').

When considering NHS CHC eligibility, assessors consider certain characteristics of your needs and their impact on the care you require to manage them. The indicators are:

Nature - the type and features of your needs - physical, mental or psychological, and type of support or treatment needed to manage them.

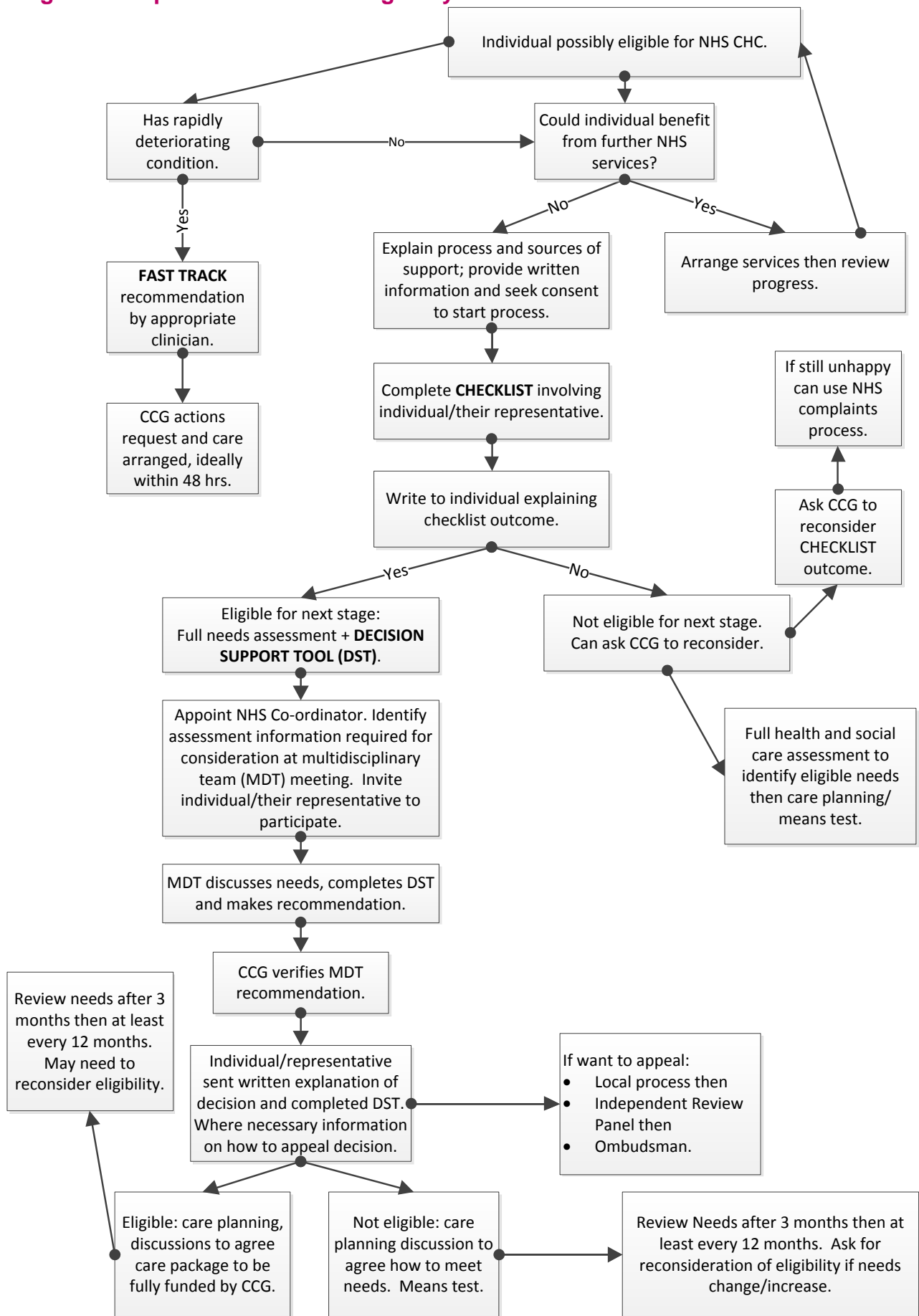
Intensity - relates to the severity of your needs, how frequently and to what extent they vary and the resulting level of support required.

Complexity - how different needs present and interact with each other to increase the knowledge and skills staff need to a) monitor symptoms b) treat any multiple conditions and how this affects management of your care. How your response to your condition impacts your overall physical and mental health needs could be a factor to consider.

Unpredictability – how much, how often and how unexpectedly changes in your condition create challenges because of the timeliness and skills required to manage needs that arise. It can affect the level of monitoring required to ensure you and others are safe and the level of risk to you or others, unless you receive adequate, timely care. Someone with unpredictable healthcare needs is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Each of the characteristics may on their own, or in combination, demonstrate a 'primary health need' because the 'quantity' and / or the 'quality' of care, required to meet them exceeds the limits of a LA's responsibilities. Tools used to inform an eligibility decision seek to identify your needs in terms of these characteristics.

Stages in the process to decide eligibility for NHS CHC



3.4 Who decides NHS CHC eligibility and funds your care?

Your Clinical Commissioning Group (CCG), made up of local GP practices, is responsible for locally managing the NHS CHC process. It makes eligibility decisions on behalf of patients registered with its member practices and agrees and funds NHS CHC care packages.

Each CCG is likely to have a manager responsible for NHS CHC. Find your CCG by entering your postcode at www.nhs.uk/service-search/Clinical-Commissioning-Group/LocationSearch/1

3.5 Routes to reaching an NHS CHC decision

In most cases, staff follow these steps:

- The type and level of your needs prompt application of the **Checklist** which can lead to a *positive* or *negative* decision. Your needs can mean you go straight to a full assessment without completion of a Checklist.
- A **positive Checklist** triggers a full assessment of your needs.
- A multi-disciplinary team (MDT) uses assessment information to complete the **DST**, informing their eligibility *recommendation* to the CCG.
- CCG makes the final eligibility *decision* but only in exceptional circumstances should it not follow the MDT recommendation.

You have a right to challenge the CCG if you receive a negative Checklist decision, or on receiving a final decision following a full assessment. If you have a rapidly deteriorating condition and appear to be reaching the end of your life, staff can use the '**Fast Track Tool**'.

3.6 When should eligibility be considered?

CCGs, in partnership with the LA, should develop processes to identify those who may be eligible, whether in hospital or living in the community.

Not everyone with on-going health needs is likely to be eligible. There is no need to complete the Checklist if it is clear to health and care practitioners there is no need for NHS CHC at this time. If there is doubt between practitioners, they should complete one. A decision not to, with reasons, should be recorded in your medical notes (Framework para 91).

Ask NHS or social care staff if they have *considered* NHS CHC when:

- your condition is rapidly deteriorating and you may be approaching the end of your life. You may be eligible for '*fast tracking*'
- you are ready for discharge from hospital and it intends to issue an Assessment Notice to your LA, requesting a needs assessment
- your physical or mental health deteriorates significantly and your current level of care, at home or in a care home, seems inadequate
- staff propose you move into a nursing home or if you live in a nursing home, they conduct an annual review of your need for NHS-FNC.

4 National Framework principles

4.1 Person-centred approach involving you and your carers

Staff should tell you if they think you may be eligible for NHS CHC. They should organise assessments so that you and your representative understand the process and provide information and advice to maximise your ability to participate in an informed way. This includes asking about hearing or visual difficulties or language preferences and ensuring you are supported to participate.

Staff should take account of how you see your needs, how they affect you and how they might be managed. If you are eligible for NHS CHC, staff should take account of your wishes and ways you would prefer to be supported in deciding where and how to meet your needs, as well as the risks of different care packages and fairness of access to NHS resources. The Framework PG 4 explores key elements of a person-centred approach to NHS CHC.

You can ask a family member or representative to support you or enquire about access to local advocacy services. You should have reasonable notice of key events, such as dates to complete the Checklist or DST, so your representative can arrange to be there if they want to.

Note

A note to para 70 of the Framework states the term '*representative*' is intended to include any friend, unpaid carer or family member who is supporting you in the process as well as anyone acting in a more formal capacity (for example, a welfare deputy, an attorney or an organisation representing the individual).

4.2 Seeking consent to the assessment process

Before arranging the assessment process, staff must seek your consent to be considered for NHS CHC and to sharing necessary personal information with professionals or organisations likely to be involved. They should explain who information might be shared with and how. If information is to be shared for audit and monitoring purposes, staff should explain what this means. Your consent should be recorded in your notes or by using a consent form.

At any stage, you can refuse to give or withdraw consent or to sharing of information essential to the decision-making process. If you do, staff should try to find out why and address your concerns. They must explain that if you have ongoing needs, refusing consent may affect the ability to meet your needs. If you later agree to a LA assessment, the LA cannot take responsibility for meeting needs found to be an NHS responsibility.

4.3 Consent and mental capacity

From the outset, staff must take all practical steps to help you make decisions for yourself. If they have concerns about your mental capacity to give informed consent or to refuse to an assessment or to sharing of personal information, even with support, they should use the two stage test described in *Mental Capacity Act 2005 Code of Practice*:

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 required?

You are considered unable to make the decision if the answer to these questions is 'yes' and you cannot 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.

If staff agree you lack mental capacity to do this, they must record their reasons, in your notes. They must check if there is someone appointed to act on your behalf on health and care matters under a valid and applicable Lasting Power of Attorney (LPA) or is a court appointed personal welfare deputy.

To confirm a person has the authority to consent to an assessment or information sharing on your behalf, staff should request sight of a certified copy of the documentation. A partner, family member or 'third party' can only consent on your behalf, if appointed to do so.

If there is no such individual, the person leading your assessment is responsible for making a '*best interests*' decision on your behalf as to whether to proceed with the assessment and sharing of information.

In doing so, they must consult you and those with a genuine interest in your welfare, usually including family and friends. They should be mindful of the need to respect confidentiality and not share personal information about you with third parties, unless they believe it to be in your '*best interests*' for the purposes of NHS CHC assessment.

Note

An attorney or deputy for property and financial affairs does not have the authority to give consent or make health and welfare decisions. See Framework PG 8.

4.4 Confidentiality and sharing information

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

Sharing information in the absence of formal authority

PG 5.9 – 5.11 discusses circumstances where it is acceptable for a third party, who assumes responsibility for acting in a person's '*best interests*' but does not have formal authority of a LPA or Deputyship on health and care matters, to legitimately request and receive information.

When deciding whether to share personal or 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*'
- only share information necessary for them to act in your '*best interests*'.

Subject to these principles, staff should not unreasonably withhold information and you can expect them to share information with:

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

5 Process for reaching an eligibility decision

5.1 Apply the Checklist

The Checklist helps staff identify who may need a full assessment to determine NHS CHC eligibility. Staff should apply it at the right time and in the right place, once your ongoing long term needs are clear. The threshold is set deliberately low, so anyone who requires a full assessment has this opportunity. The assessor should ask if you want to be involved when they complete the Checklist and have a family member, advocate or other representative with you. Reviewing the tool beforehand, helps you prepare and contribute when staff complete it.

Note

A decision to apply the Checklist does not imply you should or will be eligible for either a full assessment or NHS CHC. If professionals disagree about the need for a Checklist, they should complete one.

Who can apply the Checklist?

A variety of professionals who are trained in its use can complete the Checklist. As far as possible, it should be someone who assesses or reviews care needs as part of their day-to-day work. It is for local CCGs and LAs to identify who can complete it.

Applying the Checklist as part of hospital discharge

When ready for discharge from an acute hospital, it is important to your health and wellbeing that this happens without delay. If staff believe you may be eligible for NHS CHC, the assessment process should not lead to a prolonged stay in hospital.

Completing a Checklist while on a busy acute hospital ward may not accurately reflect your potential for further recovery or long term needs. Being on a busy ward can cause disorientation or atypical behaviour if you have dementia. For these reasons, in the majority of cases, it is preferable to assess eligibility for NHS CHC after discharge.

The 2018 National Framework proposes that CCGs and partner organisations such as hospitals and LAs, develop protocols setting out respective roles and how responsibilities are to be exercised in relation to hospital discharge. It gives examples, in para 114 of processes and pathways that could be considered if you may have a need for NHS CHC including:

- a) if there is potential for further recovery with therapy, rehabilitation or intermediate care, provide this first, then apply the Checklist if still required; or
- b) rather than complete the Checklist in hospital, decide whether to provide interim NHS-funded services after discharge. Before they end, arrange to complete the Checklist if still required and if the Checklist is positive, complete a full assessment; or
- c) following a positive Checklist, offer interim NHS-funded services until a full assessment is completed or it is decided one is no longer needed. If needs change in the interim, it is legitimate to offer a second Checklist rather than go on to full assessment; or
- d) if the pre-admission care package is suitable, discharge back there under the same funding arrangements. If a Checklist is still required, ensure completion within six weeks and if it is positive, carry out a full assessment. If found eligible, any reimbursement is backdated to date of discharge ; or
- e) following a positive checklist in hospital, for exceptionally and clear reasons, complete the full assessment in hospital. It may be appropriate to go straight to full assessment without a Checklist.

If you are offered interim care, always ask for confirmation of who is responsible for funding it.

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

Applying the Checklist if you live in a care home

A care home manager should ensure they contact the CCG CHC team if they believe you may be eligible for NHS CHC. The CCG may have its own procedure for identifying and assessing care home residents.

Applying the Checklist if you live in your own home

NHS or social care staff should contact the CCG CHC team to arrange completion of the Checklist if they think you may be eligible for NHS CHC. They may be trained to complete the Checklist.

Can you or a family member complete the Checklist?

You or a family member cannot complete and submit a Checklist but can contact the CCG CHC team to explain why you think a Checklist is necessary. If NHS or social services staff are involved in your care, discuss this with them and request they contact the CCG on your behalf.

Completing the Checklist Tool

The Checklist Tool and DST use the same **12 ‘domains’ or ‘areas of need’** (see section 5.3). The Checklist has three columns for each domain. Each column has a description representing a level of need: Column A represents **‘high’ needs**. Column B represents **‘moderate’ needs**. Column C represents **‘no and low’ needs**.

The assessor completes the Checklist by choosing the description most closely matching your needs, taking account of well-managed needs. 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
- **high** in one of four DST domains with a priority level of need and any level of need in other domains.

Staff should share the outcome with you and your representative as soon as reasonably practical in writing, giving reasons for reaching their decision. This is normally done by providing a copy of the completed Checklist.

You should have enough information to understand the reasons for their decision. It is good practice for staff to record the decision in your notes.

A positive Checklist

A positive Checklist means you require a full assessment and should be referred to your CCG. In most cases, it should take no more than 28 calendar days from the date the CCG receives a positive Checklist to reaching an eligibility decision. CCG staff should tell you and your representative if it is likely to take longer.

While awaiting a decision, you should not be left without appropriate support. Prior to a decision being made you may have to pay for this support, unless you are to receive NHS-funded interim care as part of your discharge from hospital. If you pay for services while waiting for a decision, are found to be eligible and the CCG unnecessarily takes longer than 28 days to reach its decision, you can apply for reimbursement of services you paid for beyond the 28 days. This is confirmed in the National Framework, Annex E.

A negative Checklist

A negative Checklist indicates you do not need a full assessment and are not eligible for NHS CHC. The CCG should send you a written explanation of the decision, explaining your right to ask for a reconsideration. When reconsidering, it must take account of additional information you or your representative provides. You should receive a clear written response that tells you of your right to use the NHS complaints procedure, if dissatisfied with their final decision.

If a review of a negative Checklist does not alter the decision

You should have an assessment of your health and social care needs to identify your eligibility for ongoing NHS and social care support.

5.2 Undertake a full multi-disciplinary needs assessment

On receiving a positive Checklist, the CCG appoints a case co-ordinator. They must ensure you and your representative understand the process, participate as much as you can and wish to, and keep you informed until there is an eligibility decision. As with the Checklist, completing this stage away from an acute ward is likely to better reflect your needs.

The co-ordinator must gather up-to-date information about your physical, mental health and social care needs, inviting contributions from relevant health and social care professionals, including staff caring for you and those with direct knowledge of your needs but not currently caring for you. This can be a consultant, specialist nurse or community mental health team. Each should consider your views, assess your needs and prepare a report including reasons for their statements and observations, and findings from risk assessments.

Alzheimer's Society produces a guide to help NHS CHC assessors evaluate emotional and psychological needs of people in later stages of dementia. See <https://bit.ly/2N8UZmd> for a copy of the guide.

5.3 Complete the Decision Support Tool (DST)

It is helpful to familiarise yourself with the DST. It has 12 'domains' or areas of need that must be considered:

- 1 Breathing ▶▶
- 2 Nutrition ▶
- 3 Continence
- 4 Skin integrity ▶
- 5 Mobility ▶
- 6 Communication
- 7 Psychological and emotional needs
- 8 Cognition ▶
- 9 Behaviour ▶▶
- 10 Drug therapies and medication ▶▶
- 11 Altered states of consciousness ▶▶
- 12 Other significant care needs to be taken into consideration ▶

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.

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

▶ indicates this domain goes up to severe level of need

The co-ordinator selects a multi-disciplinary team (MDT) to complete the DST, arranges a meeting to complete it and invites you or a representative to attend. They should give reasonable notice of the date, so your representative can arrange to attend if they want to.

At the meeting, the MDT discuss assessment reports, evidence you or your representative submit, and use their professional judgement to complete the DST, which informs their *recommendation* to the CCG.

Your and your representative's role at MDT meeting

The co-ordinator should explain the meeting format and identify support you or your representative need to be fully involved and contribute to the discussion. If present, you and your representative should have copies of assessments circulated to MDT members.

If no one can attend, the co-ordinator should obtain your evidence and views. The DST has space to record whether and how you and your representative contributed at the meeting. If you were not involved, the completed tool should say whether you were not invited or declined to participate.

Multidisciplinary team (MDT)

The Framework defines an MDT as:

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

As a minimum, it can be two professionals from different healthcare professions, but should usually include health and social care professionals, knowledgeable about your health and social care needs and where possible, recently involved in your assessment, treatment or care. If the CCG consults the local authority, it should provide advice and assistance and not allow an individual's financial circumstances to affect its participation.

The Framework does not exclude the case co-ordinator from being an MDT member, but they should be clear about their two different functions. It says: *'they can contribute to decision-making on the recommendation so long as they encourage debate within the MDT and so long as they record a recommendation which genuinely reflects the view of the whole MDT and not just their own view.'* (PG 25)

The DST should record MDT member's names, job titles and signatures.

Completing the DST

When completing the DST, an MDT should:

- complete all care domains
- use assessment evidence and 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 and not marginalise needs because they are successfully managed. Well-managed needs are still needs and should be recorded appropriately (Framework para 143)
- consider needs recorded in domain 12 Other significant care needs.

There is space on the DST to record you or your representative's views on your care needs and whether you consider the assessment and selected domain levels accurately reflects them. This is to ensure the CCG is aware of them when making its final decision.

The completed tool should give an overall picture of your needs. If your condition, and hence your needs, is likely to change in the near future, it should say whether they are recommending eligibility should be agreed now or that an early review date should be set.

5.4 Reaching a decision

MDT recommendation to the CCG

The recommendation should provide a summary of your needs; statements about their nature, intensity, complexity and unpredictability; an explanation of whether and how needs in one domain interrelate with those in another. It says the recommendation should refer to all four characteristics of need, but that any one could on its own, or combination with others, be sufficient to indicate a primary health need (DST para 33)

Clear recommendation of eligibility is usually 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 care domains.

If there is either:

- 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

the Framework requires the MDT to give careful consideration to the key characteristics of the nature, complexity, intensity and unpredictability of your needs and use this to inform whether, in their judgement, you have a primary health need. The overall need, interactions between them and evidence from risk assessments should be considered. It is not possible to equate incidences of one level of need with a number of incidences of another level – cannot say two moderates equate to one high.

The CCG's decision

CCGs are usually expected to respond to the MDT's recommendation within two working days and only in exceptional circumstances go against it. These might be: an incomplete DST, gaps in supporting evidence, or obvious mismatch between evidence and recommendation.

The CCG may share its decision with you verbally but should always confirm in writing, giving clear reasons for the decision and a copy of the completed DST. It should tell you who to contact for clarification and how to request a review, if they decide you are not eligible. If someone is acting as your representative, they are entitled to receive a copy of the DST provided the correct basis for sharing information is established. This is explained in DST paras 37 and 38.

Note

An eligibility decision is not permanent. It can be overturned if needs change and they no longer meet the primary health need threshold.

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, but they should not play a financial gate-keeper role. If the CCG and LA disagree about your eligibility, they may use a panel as part of their local dispute resolution process.

If a person dies while waiting for an eligibility decision

If you die while waiting for an eligibility decision and were receiving means-tested 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 were not receiving such services, there is no need to continue the decision-making process.

5.5 Joint package of health and social care

The CCG may decide you are not eligible for NHS CHC but because some of your needs are beyond the powers of a LA to meet on its own, the CCG is responsible for some of your care. In this case, the LA and CCG must agree their respective responsibilities for a joint package of health and social care; tell you who will lead in agreeing and managing your care plan and whether the CCG contribution towards your care affects how much you pay towards the social care element of the package, following a mean-test (Framework para 263 – 269) .

6 Care planning when eligible for NHS CHC

If you wish, you can ask family members to help make your views known or ask about local advocacy services.

6.1 If you lack capacity to consent to a care plan

A CCG or LA must instruct or consult an Independent Mental Capacity Advocate (IMCA) to act on your behalf if:

- it must make a '*best interests*' decision involving an accommodation change, hospital admission over 28 days, or other accommodation for more than eight weeks, or serious medical treatment, **and**
- you have no family member or friend willing and able to represent you or be consulted while reaching such a decision.

An IMCA aims find out your views, wishes and feelings by talking to you, people close to you and professionals who know you. Staff must use an IMCA report to help reach a best interests decision and an IMCA can challenge a decision if it appears not to be in your best interests. An IMCA must be involved in the above circumstances, even if you are not eligible for NHS CHC. For more information, see factsheet 22, *Arranging for someone to make decisions on your behalf*.

6.2 Your care package and options

The CCG deciding your eligibility is responsible for providing a care package appropriate to meet your eligible health and care needs, taking account of goals or outcomes you want to achieve. The funding must be sufficient, wherever it agrees you may live. Your CCG or care provider should not ask you to pay towards meeting your assessed needs.

If the CCG agrees you can live outside its area, it remains responsible for any care associated with your NHS CHC. It should tell you who to contact with any concerns and who is responsible for monitoring your care and arranging regular reviews. Once in your new area, you must register with a GP. Any NHS services, unrelated to your NHS CHC, are the responsibility of your new GP practice's CCG.

Your care package can be provided in a range of settings.

Care home

Your CCG is responsible for meeting the cost of your accommodation and care needs identified in your care plan. If a care home is the preferred or best option, you should be offered a reasonable choice of care homes, wherever possible. Issues to be aware of, include:

- **CCG has block contracts with several care homes in an area.** There may be reasons, based on your assessed needs, why a CCG should consider more expensive homes or accommodation than it usually does. Examples include a recognised link between feeling confined in a small room and displaying behaviour that challenges those caring for you.
- **It may be appropriate to move to a home closer to relatives who live in a different CCG area.** You cannot assume reasons you give will be accepted. The CCG agreeing you can live in a care home in another CCG area remains responsible for your care home fees.
- **Your current care home cannot meet your assessed needs.** You need to discuss your options with the CCG.
- **Your current care home can meet your NHS CHC needs but is more expensive than the CCG normally pays to meet similar needs.** This can arise if you funded your care home before being eligible for NHS CHC or a relative paid a '*top up*' to meet your preferred home's costs which were higher than your local authority would normally pay.

'*Top ups*' are allowed for social care, but not under NHS legislation, so unless it is possible to separately identify and deliver the NHS-funded elements of a service, it is not usually permissible for you to pay for higher-cost services and accommodation.

When reviewing your current accommodation, the CCG should explore why you want to stay there or keep your room and consider if there are clinical or needs-based or risk-related reasons for doing so. Reasons might include your frailty, mental health needs, or needs that mean a move could involve significant risk to your health and wellbeing.

Hospice

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

Own home

If funding your care at home, your CCG must fund and, if asked, arrange a package to meet your identified health and personal care needs but not pay rent, mortgage, food and normal utility bills. If running specialist equipment adds substantially to utility 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 LA. The CCG should aim to arrange services to maintain a similar package of care and replicate as far as possible, the personalisation and control of Direct Payments.

You can ask for, and the CCG should offer, a Personal Health Budget unless there are clinical reasons why it is not suitable. See section 6.3.

Family member provides care as a part of your care package

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

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

If your carer provides, or is about to provide, informal care for you, they have a right to a separate carer's assessment from the LA and have eligible needs met to support them in their caring role. See factsheet 41, *How to get care and support* for more information.

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

If you receive NHS CHC at home and want to move to a new house outside your CCG area, raise this with your funding CCG in plenty of time. It needs careful discussion between your current CCG and the CCG who would be responsible for providing services after you move. Both CCGs will want to ensure continuity of care, that arrangements represent your best interests, and associated risks are identified.

Moves in the UK

If you want 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.

6.3 Personal Health Budgets and NHS CHC

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 can mean spending money in a way that better suits you. It cannot be used simply to pay care home fees.

You (or someone who represents you) and your NHS team discuss and agree a care and support plan describing how you would like to meet your goals and spend allocated money. Staff sign it off once satisfied the goods or services you intend to purchase can meet your health and wellbeing needs and the budget is sufficient to do this.

Your care manager keeps your care plan and PHB management under review. You cannot be forced to have a PHB and should only be offered as much control over managing your care as you want.

You can manage a PHB in one of three ways or in combination:

- a notional budget - the CCG holds the money, but you are actively involved in choosing who delivers your care and support
- a third party arrangement - an organisation such as a trust, holds the money and in line with your agreed care plan, manages your care and the budget for you
- a direct payment - money is transferred to you or your nominee or representative, who contracts for necessary services or expenditure.

Note

If you already receive an NHS CHC package and do not have a PHB, contact your NHS CHC manager to find out how it could work for you and about ways you could spend an allocated budget.

Using a direct payment to manage PHB

The PHB direct payments scheme is broadly similar to that offered by a LA for social care. In some areas, the NHS and LA 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 choose to have a PHB:

- is there a brokerage service to help you manage your care and PHB?
- if you opt for direct payments, is there a representative or suitable nominee who can take on full responsibility for this?
- would another way of managing your PHB prove to be a better option?
- if you lack capacity to consent to or manage a direct payment, is there someone who can take on the responsibilities of your direct payment?

If you take the direct payment option, your care manager can explain the duties placed on you or nominee or representative acting on your behalf.

You may consider employing a personal assistant to help manage your health, care and wellbeing needs. This means understanding responsibilities of being an employer such as:

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

A PHB direct payment must be paid into a bank account specifically set up for this purpose and held in the name of the person receiving it. You may need guidance on managing the budget and keeping records on what you spend money on.

If you are refused a direct payment, are asked to pay back any 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

For more about PHBs see www.nhs.uk/choiceintheNHS/Yourchoices/personal-health-budgets/Pages/about-personal-health-budgets.aspx

6.4 If unhappy with your NHS CHC care package

If unhappy with issues such as the type, location or content of the care package being offered, the CCG should explain your right to complain using the NHS complaints process. For more information, see factsheet 66, *Resolving problems and making a complaint about NHS care*.

7 Using the Fast Track Tool

As there are various end-of-life care pathways, not everyone at the end of their life is eligible for, or requires, NHS CHC. However, if you have:

- a rapidly deteriorating condition, **and**
- may be entering a terminal phase

you may be eligible for fast tracking for prompt provision of NHS CHC, with no requirement to complete the DST.

Staff caring for you in any setting who believe you have needs for which the fast track pathway may be appropriate, should contact an '*appropriate clinician*' and ask them to consider completing the Fast Track tool. An '*appropriate clinician*' is a doctor or nurse knowledgeable about your health needs, diagnosis, treatment or care and able to provide an assessment of why you meet fast track criteria.

The CCG should accept and promptly action a fast track recommendation, so that a suitable care package is in place, preferably within 48 hours. The tool should be supported by a prognosis, but the CCG should not impose strict limits basing eligibility on a specified, expected length of life remaining.

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

Staff should sensitively explain your needs may be subject to a review and as a result, the funding stream may change.

Exceptionally, there may be circumstances where a CCG does not believe the form, as completed, meets '*fast track*' criteria.

Review of fast track decision

If you are fast tracked, it is important to review your care package to make sure it continues to meet your needs. In doing this, there may be situations where it is appropriate to review your NHS CHC eligibility.

In such cases, a CCG should not remove fast track funding without reconsidering your eligibility, by arranging for an MDT to complete a DST and making their eligibility recommendation.

If the CCG proposes a change in funding responsibility it should tell you, giving reasons, in writing and explain your right to request a review of the decision. You may wish to contact Beacon for support in this situation.

8 NHS continuing healthcare reviews

Reviews are part of the NHS CHC process. They should be proportionate to the situation in question and primarily focus on whether the care plan or arrangements remain appropriate to meet your needs. It is expected that in the majority of cases there will be no need to reassess for eligibility (Framework para 183).

A flow diagram on page 54 of the National Framework illustrates the process for reviews which should take place within three months of the initial eligibility decision and at least annually after this. The MDT recommendation may specify a different timing for your first review.

When undertaking reviews, staff must ensure they do not misinterpret a situation where the individual's care needs are being well-managed, as being a reduction in their actual day-to-day care needs.

Eligibility should only be reviewed if the CCG can demonstrate there is clear evidence that needs have changed significantly since completing the previous DST. If CCG believes this, it should arrange for an MDT to complete a new DST and make their eligibility recommendation. During this time, the CCG must ensure your needs continue to be met.

You may want to contact Beacon for support in these circumstances.

Even if the CCG is responsible for all support, it can usefully involve the LA in the MDT/DST process. The CCG and LA should support a decision to remove eligibility and if they disagree, use their local disputes procedure to resolve it. If they agree you are no longer eligible, the CCG should put any proposed changes in writing, with their reasoning, telling you from what date it proposes to implement the decision. You can contact your LA to see if you are eligible for financial support. You have a right to request a review of the CCG decision, as described in section 9.

It should consider risks and benefits of a change in location or support (including funding) before any move or change is confirmed.

9 Challenging an eligibility decision

9.1 Submitting a request for a review of the decision

To challenge a decision following a full assessment and completion of DST, you or your representative have *six months*, from the date you received written notification of the decision, to ask the CCG for a review. It should acknowledge your request in writing within five working days and explain the appeal process.

The six 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.

You may want to contact Beacon if you are considering whether to appeal or to discuss your grounds for making one.

Composing your letter

Explain the reasons for your challenge, supporting it with as much evidence as you can. Where possible, relate it to DST domains. If you believe you should have been placed at a higher level for a particular domain, give examples from your experience or refer to a report you believe the DST did not capture. You can also highlight any gaps in evidence supporting the decision or failures to follow the Framework.

Funding your care once you challenge the CCG decision

The CCG's original decision remains valid and in place unless, or until, either stage of the review process recommends you should be eligible. You should receive appropriate care while awaiting the outcome of the review. You may have to contribute towards the cost of your care package during this time, with your financial circumstances affecting who is responsible for arranging and paying for it. If you are responsible for funding some, or all of it and your appeal is successful, you can claim costs incurred if you provide receipts (See section 13).

9.2 Review process

There are two stages in the review process:

- a **Local Review** managed by the CCG, and
- an **Independent Review** managed by NHS England (NHSE) if you are unhappy with the local review outcome. If going to local review would cause undue delay, NHSE has discretion to put your case straight to independent review.

The review process only helps if you are dissatisfied with the procedure the CCG followed to reach the eligibility decision, including how eligibility criteria were applied, or the CCG's '*primary health need*' decision.

Local Review stage

Each CCG should agree and publish a local review process that is fair and transparent, with agreed timescales that take account of the following guidelines:

- there should be an attempt to resolve any concerns informally through a meaningful discussion between you or your representative and a CCG representative. This should enable you to ask questions to help you understand their decision and provide further information.
- if a formal meeting is required, it should involve a CCG representative with authority to decide what the next steps should be and allow you to explain why you are still dissatisfied. It should result in a written record of the meeting for both parties, including the agreed next steps.
- following the formal meeting and outcome of next steps, the CCG either upholds or changes its decision. The CCG should share their decision with you in writing and explain how to apply for an independent review.

Independent Review stage and timescales

You have six months after hearing the final outcome of the local review to ask NHSE, in writing, for an independent review (IR).

NHSE is responsible for arranging an independent review panel (IRP) and can decide, on the advice of an independent individual who can chair a panel, not to convene one. It may decide to ask the CCG to attempt further local resolution prior to IR. If NHSE decides not to convene IRP, it should write to you explaining the reasons and your right to use the NHS complaints procedure if you disagree with their decision.

Role of the Independent Review Panel and your contribution

The IRP has a scrutiny and reviewing role. There is no need for you or the CCG to be legally represented when a 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.

The panel has a chair, independent of the NHS, and members, who are experienced health and social care professionals independent of the CCG making the eligibility decision.

At the meeting, you can explain why you are appealing, based on points raised in your letter, and answer the panel's questions. You can speak to Beacon to discuss how to prepare your case for the meeting.

The Framework, Annex D, explains IRP procedures.

Key elements of an Independent Review

The key elements of an Independent Review include:

- scrutiny of all available and appropriate oral or written evidence from relevant health and social care professionals and from you or your representative, and from the completed DST and MDT deliberations and audit of any attempts to gather records said not to be available
- involving you or your representative as far as possible, giving you an opportunity to contribute to, and comment on, information at all stages
- access to independent clinical advice to advise on clinical judgements.

Independent Review Panel recommendation

The IRP role is advisory and in all but exceptional circumstances, NHSE and subsequently the CCG should accept its recommendation. NHSE should tell you and the CCG of the decision in writing.

If the CCG decision is overturned, it should refund the cost of services you paid for since their '*not eligible*' decision.

If the CCG decision is upheld and you still disagree, their letter should explain how to refer your case to the Parliamentary and Health Service Ombudsman. You should do this within 12 months of receiving written notification of the outcome of the IR.

10 Effect on benefits of NHS CHC funding

Disability benefits

Notify the Disability Benefits Centre if you get a disability benefit - Attendance Allowance (AA), Disability Living Allowance (DLA) or Personal Independence Payment (PIP).

If you will receive NHS CHC in a *nursing home*, AA and both care and mobility elements of DLA and PIP and are suspended after 28 days from time CCG funding begins, or sooner if you were recently in hospital.

If you will receive NHS CHC in a *residential home*, the care component of disability benefits is suspended after 28 days from time CCG funding begins but DLA or PIP mobility components continue.

If you will live at home with an NHS CHC care package, you can continue to receive these disability benefits. Check you are receiving them at the appropriate level.

State Pension and Pension Credit

State Pension is not affected by eligibility for NHS CHC. If you receive Pension Credit, you lose the severe disability element of your AA, DLA care component, and PIP daily living component stops.

11 Care planning if you have a negative Checklist

If you are in hospital but do not progress beyond the Checklist, staff may issue an Assessment Notice to your LA, requesting an assessment to identify your ongoing needs. Subject to meeting national eligibility criteria, your needs and views on how they can best be met would form the basis of your care plan.

If you need services that are the responsibility of social services, these are means-tested. However, you should not be asked to pay for aids needed to assist with home nursing or daily living or for a minor adaptation that, with fitting charges, costs £1000 or less.

If you do not meet eligibility criteria, social services should provide information and advice on how you could meet your care needs.

NHS services are free and can be provided on a regular or ad-hoc basis.

They include:

- NHS-funded nursing care in a nursing home by a registered nurse
- rehabilitation and recovery services such as physiotherapy
- assessment and support from community-based NHS staff such as district nurses, continence nurses, specialist diabetic nurses
- palliative care services (emotional support and control of symptoms, including pain management) if diagnosed with a terminal illness.

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, your care home manager or 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. They could ask to see the Grant of Probate or Letters of Administration.

13 Refunds if NHS should have paid for your care

You only become eligible for NHS CHC once the CCG has reached a decision informed by completion of DST or Fast Track tool. Annex E of the Framework describes situations when you may be entitled to a refund and explains what happens if a CCG eligibility decision is:

- unjustifiably delayed beyond 28 calendar days, or
- revised after reconsideration using CCG local review process or IRP.

You may be entitled to a refund if a retrospective review indicates you should have been considered, you are then assessed and found eligible.

When you incur costs due to unjustifiable delay in decision-making

If CCG finds you eligible but '*unjustifiably*' takes longer than 28 calendar days from receiving the Checklist to reach its decision, it should refund to LA, costs of services provided from day 29 to date of the decision. The LA should reimburse contributions you made towards your care.

If you fully funded your care, the CCG should make an ex-gratia payment to restore your finances to the state they would be in, had the delay not occurred and to remedy any injustice arising from the delay.

Examples of '*justifiable*' delays include delay in receiving records or assessments from a third party; delays outside the CCG's control in convening a multi-disciplinary team; or delay in receiving a response from the individual or their representative asking for essential information or for participation in the process.

Refunds following a revised decision

If a CCG revises its initial decision, it should reimburse to the LA, any care costs the LA incurred, starting from the date of CCG's initial decision (or earlier if unjustifiable delay occurred) until the date the revised decision came into effect. If you contributed to the cost of your care, the LA should reimburse your contributions.

If you paid all your care costs, you should receive an ex-gratia payment directly from the CCG, in accordance with guidance in Managing Public Money. The aim is to restore your finances to the state they would have been in had they made the correct decision at the outset decision

Refunds following a retrospective review

A retrospective review may show you were eligible for NHS CHC during the period under consideration. If so, the CCG must decide a fair and reasonable amount to offer you or your estate, if you were funding your care during that time. In reaching their decision, they must consider the circumstances of your case and be able to justify their offer of redress.

Note

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

14 NHS-funded nursing care

NHS-funded nursing care (NHS-FNC) is a fixed rate payment made directly to nursing homes by the local CCG to support the provision of nursing care by the home's registered nurses to residents assessed as eligible for NHS-FNC.

Residential homes do not employ registered nurses, as residents receive necessary nursing care from NHS nurses based in the community, such as district nurses. Consequently, they are not paid NHS-FNC.

A Supreme Court judgment in 2017 found that registered nurse input includes time spent on stand-by, paid breaks, receiving supervision and time spent in circumstances ancillary to or closely connected with nursing care. You can find the Supreme Court definition of what registered nurse input covers in Framework para 248.

14.1 NHS-funded nursing care payments

NHS England reviews NHS-FNC rates annually, usually in April. The following rates apply for year starting 1 April 2019.

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 £165.56.

If you moved into a nursing home before 1 October 2007 and were on the high band in place at the time, the weekly rate is £227.77.

You remain on this high band until you are no longer resident in a nursing home; or become eligible for NHS continuing healthcare; or a review suggests you no longer need nursing care; or a review suggests your nursing needs no longer match high band criteria, in which case you transfer to the single band rate.

FNC and care home fees

If you self-fund your nursing home place, ask the home to explain how the amount you must pay takes account of NHS-FNC payments and check how they address this in your contract, including the effect of NHS-FNC rate changes.

The 2018 National Framework says The care home provider should set an overall fee level for provision of care and accommodation. This should include any registered nursing care provided by them. If resident eligible for FNC, the CCG will pay NHS-FNC direct to the home. The balance of the fee will then be paid by the individual, their representative or LA unless other contracting arrangements are agreed. (para 256).

The Local Government and Social Care Ombudsman offers guidance to nursing homes on how to approach NHS-FNC payments and ensure contracts properly reference them.

The Competition and Markets Authority addresses FNC payments in a 2017 market study into care homes for older people and publishes an online guide Care homes: consumer rights for residents and their families, see www.gov.uk/government/publications/care-homes-short-guide-to-consumer-rights-for-residents

Effect on disability benefits

NHS-funded nursing care payments do not affect eligibility for disability benefits such as AA, DLA or PIP.

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

If staff propose your best option is to move into a nursing home, they must agree you are not eligible for NHS CHC, before considering eligibility for NHS-FNC. If you have not have a full CHC assessment, you must have a nursing needs assessment to identify your day- to- day nursing care and support needs. For more information see 2018 NHS-funded nursing care best practice guidance, see www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

14.3 Review of NHS-funded nursing care needs

When staff review your need for NHS-funded nursing care, they must always consider your potential eligibility for NHS CHC. This usually involves completing the Checklist or where indicated, carrying out a full NHS CHC assessment, including completion of the DST.

However, it is not necessary to repeat the Checklist or DST:

- where staff reached their initial *not eligible* for NHS CHC decision following a Checklist and/or full assessment with completion of a DST, **and**
- it is clear there has been no material change in your needs.

Staff should record this in your notes, and tell you of their decision and reason for it.

To determine whether there has been a material change in need, staff should review the previously completed Checklist or DST and consider each domain and level of need, involving you or your representative or who someone who knows your care needs.

The assessor should annotate each domain according to their findings and provide a copy of the annotated tool and tell you how to request a review of the outcome, if you disagree with the finding that no material change in needs has occurred.

14.4 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' nursing home place 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 a 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 may apply if you have a trial period in a home or are admitted for respite care or in an emergency because your carer is ill.

Useful organisations

Beacon

www.beaconchc.co.uk/

Telephone 0345 548 0300

Offers free and paid for services, including up to 90 minutes of NHS England-funded independent advice about the NHS CHC assessment and appeals process and low cost advocacy services.

Disability Benefits Helpline

www.gov.uk/disability-benefits-helpline

Provides 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 0800 731 0122

Disability Living Allowance (DLA)

If you were born on or before 8 April 1948

Telephone 0800 731 0122

If you were born after 8 April 1948

Telephone 0800 121 4600

Personal Independence Payment helpline

Telephone 0800 121 4433

Local Healthwatch

www.healthwatch.co.uk

Telephone 03000 683 000

Each LA has one that may run or can signpost to the local NHS independent advocacy service.

Office of the Public Guardian

www.gov.uk/government/organisations/office-of-the-public-guardian

Telephone 0300 456 0300

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

Can look into your complaint if dissatisfied following an IRP decision about NHS CHC eligibility as well as complaints about NHS care.

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 or Age Cymru 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 Advice

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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