Factsheet FS20

NHS Continuing Healthcare and NHS-funded nursing care

July 2023

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 you are unhappy with an eligibility decision.

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

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 and recovery*

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 Northern Ireland, Scotland or Wales, please contact Age NI, Age Scotland or Age Cymru for advice in these countries. 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

- The NHS-funded nursing care single band rate for year starting 1 April 2023 is £219.71 a week. If you moved into a nursing home before 1 October 2007 and are on the high band, it is £302.25 a week.
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (and associated tools) was updated to align with the *Health and Care Act 2022*. A key change is that Clinical Commissioning Groups have been replaced by Integrated Care Boards.

2 Continuing care terminology

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

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

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

Terminology and abbreviations used in this factsheet
Residential home - a residential care home.
Nursing home - a care home registered to provide nursing care.

We use '*care home*' in this factsheet to refer to both, unless referring to a nursing home specifically.

NHS CHC - NHS Continuing Healthcare
NHS-FNC - NHS-funded nursing care
DST - Decision Support Tool
ICB - Integrated Care Board
LA - local authority
MDT - multidisciplinary team
PG - practice guidance

3 NHS Continuing Healthcare

If you have significant ongoing care needs, it is not always clear whether responsibility to meet your needs lies with the NHS or local authority.

The Department of Health and Social Care *National Framework for NHS Continuing Healthcare and NHS-funded nursing care* standardises the process staff in England must follow when deciding this.

NHS services are free at the point of delivery, whereas those arranged by a local authority social services department are subject to a financial assessment, meaning you must usually pay a contribution.

3.1 What is NHS Continuing Healthcare?

NHS CHC is an ongoing package of care that is funded solely by the NHS, if you are aged 18 or over, and found to have a *'primary health need'*. It is provided to meet needs arising because of disability, accident, or illness.

Your package must meet your assessed health and associated social care needs and include accommodation if that is part of your overall need. You can receive NHS CHC in any appropriate setting, but it is usually at home or in a residential setting such as a care home.

Sections 3.2 and 3.5 describe the process staff must follow to reach a decision. '*Primary health need*' is explained in section 3.3.

3.2 What is the National Framework?

The *National Framework for NHS Continuing Healthcare and NHS-funded nursing care* applies in England. It:

- sets out eligibility criteria and the principles and processes staff must follow when deciding eligibility for NHS Continuing Healthcare. See sections 4, 5, and 7
- provides tools staff must use and complete to support decision-making – the Checklist Tool, Decision Support Tool (DST) and Fast Track Tool. See sections 5.1, 5.3 and 7
- provides common paperwork – the tools above must be used for recording evidence that informs decision-making
- sets out the process for challenging eligibility decisions. See section 9
- clarifies the interaction between assessment for NHS CHC and NHS-FNC. For information on NHS-FNC, see section 14.

The Framework document also includes *numbered Practice Guidance (PG)* in Q&A format, to support staff who assess and deliver NHS CHC. Standing Rules Regulations and Directions underpin the Framework and carry the force of law. To view the updated guidance and associated tools, see www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Understanding the decision-making process

The organisation Beacon can help you navigate and understand the decision-making and appeals process. They offer up to 90 minutes free, independent advice funded by NHS England. It is helpful to be familiar with the Checklist and DST, especially if you or a family member is to be present when they are used.

The flowchart on page 7 outlines the overall process of the assessment for NHS CHC. A public guide to NHS CHC is available at www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet

3.3 How is NHS CHC eligibility decided?

An NHS CHC eligibility decision is based on your day-to-day needs. It rests on deciding whether the main aspects, or the majority part, of the care you need is focused 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. There is no requirement for specialist staff to be providing care. However, staff contributing to your assessment must have relevant skills, knowledge about and an understanding of your underlying condition(s).

The term '*primary health need*' is from a 1999 Court of Appeal case known as *Coughlan Judgment*. The judge found there was a limit on nursing care assistance an LA could legally provide. When taken as a whole, nursing or other health services you require are:

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

When considering NHS CHC eligibility, staff look at **key characteristics of your needs** in 12 areas in the DST, and their impact on the care you require. This is to help determine whether the care you require exceeds the limits of a local authority's responsibilities. The 12 areas are listed in section 5.3.

The **key characteristics** are:

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

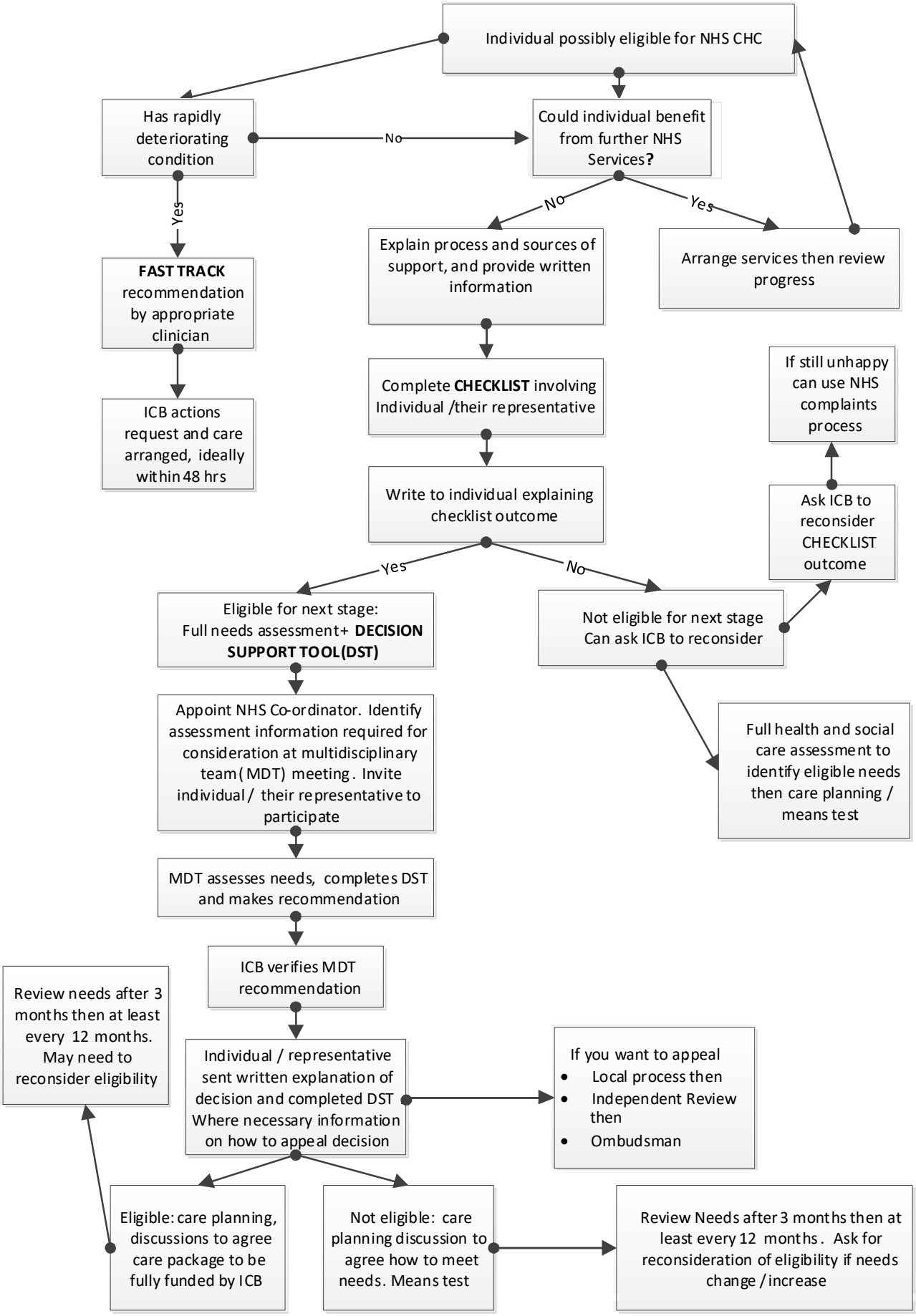
Intensity - relates to the severity of your needs, how frequently and to what extent they vary, and the resulting level of support required.

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. Staff also look at your response to your condition and how it affects your overall physical and mental health.

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.

Each of the characteristics may on their own, or in combination, demonstrate a '*primary health need*' because the quantity, the quality, or a combination of the quantity and quality of care required to meet your needs, exceeds the limits of an LA's responsibilities.

Stages in the process to decide eligibility for NHS CHC



3.4 Who decides NHS CHC eligibility and funds your care?

From 1 July 2022, the NHS structure changed. Integrated Care Systems (ICS) became statutory bodies. These are partnerships of NHS bodies and local authorities, working with other relevant organisations to deliver joined up health and care services. Each ICS has an Integrated Care Board (ICB) which is responsible for the commissioning of services including NHS CHC and NHS FNC. Clinical Commissioning Groups (CCG) previously responsible have been abolished.

3.5 Routes to reaching an NHS CHC decision

In most cases, once long-term needs are clear, staff follow these steps:

- They consider whether the type and level of your needs prompts them to apply the **Checklist,** which can lead to a *positive* or *negative* decision. In some cases, staff believe you should go straight to a full assessment.
- A **positive Checklist** triggers a full assessment of your needs.
- A multi-disciplinary team (MDT) conducts an assessment then uses that information to complete a **DST** that informs their eligibility r*ecommendation* to the ICB.
- The ICB makes the final eligibility *decision* but only in exceptional circumstances should it not follow the MDT recommendation.

You have a right to challenge the ICB 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 may be reaching the end of your life, staff can submit the '***Fast Track Tool***', see section 7.

3.6 Getting an assessment

ICBs should agree, with their LA(s), processes to identify who may be eligible. Not everyone with on-going health needs is likely to be eligible. If it is clear to health and care staff there is no current need for NHS CHC, there is no need to complete the Checklist. Staff should record their decision not to complete one, with reasons (Framework para 121). If there is doubt between practitioners, they should complete the Checklist.

Be sure to ask 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*'
- staff are considering your needs following a stay in hospital
- 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 already live in a nursing home, when they conduct your annual review of 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 ensure 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 language preferences and meeting *Accessible Information Standard* requirements, by for example addressing hearing or visual difficulties and supporting you to participate.

Staff should take account of how you view your needs, how they affect you and how they might be managed. You can ask a family member or representative to support you or ask 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 participate.

If you are eligible for NHS CHC, staff should take account of your wishes and ways you would prefer to be supported when deciding where and how to meet your needs, as well as the risks of different care packages and fairness of access to local NHS resources.

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

Note
A note to para 71 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 you).

4.2 Seeking consent to the assessment process

Staff must provide relevant information about the assessment so that you can make an informed decision regarding your participation in the process, including potential consequences of refusing to participate (para 75). The ICB can proceed with an assessment without consent.

However, valid consent must be obtained and recorded for any physical intervention or examination required as part of the assessment process, and for the sharing of personal information with third parties such as a family member, friend or advocate. They should record your consent prominently in your notes or using a consent form.

It is not necessary to seek consent to share personal data with other health and care professionals, but staff should explain with who and how your information might be shared as part of the assessment or to arrange appropriate care and support.

Refusing or withdrawing consent

At any stage, you can refuse to give or withdraw consent to participate in any physical examination or to the sharing of personal data with third parties other than health or care professionals. If you do, staff should try to find out why and address your concerns.

They must explain that refusing consent may affect the ability to meet your needs. If you later agree to an 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 to participate or to a physical examination or to the 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, see Stage 2.

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 as a court appointed personal welfare deputy.

To confirm a person has the authority to consent to a physical examination 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

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.

PG 8.7-8.9 provides the following examples 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:

- 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.

Any information shared must be in their *interests*, or to enable a third party to act in the person's *best interests.*

With this in mind and with regard to confidentiality, information should not be unreasonably withheld.

5 Process for reaching an eligibility decision

5.1 Apply the Checklist

As explained in section 3.6, there is no need to complete a Checklist if staff agree there is no evidence that you have a need for NHS CHC at that time. Once long-term needs are clear, the Checklist helps identify who needs a full assessment to determine eligibility, with the threshold set deliberately low, so anyone requiring a full assessment has the opportunity.

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?

Health and care professionals 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. Staff should give you reasonable notice of the intention to complete the Checklist, so that you or your representative have the opportunity to participate if you wish to. Your ICB is responsible for ensuring that the checklist is completed.

Applying the Checklist as part of hospital discharge

Staff are not required to complete a checklist or DST in an acute setting. In most cases, screening is likely to take place after a period of recovery following discharge.

To ensure timely discharge from hospital, consideration should be given to whether there is a need for further NHS funded services. This might include therapy, rehabilitation, intermediate care or an interim package of care, which should continue until an eligibility decision has been made.

ICBs should ensure there are processes in place to identify people who may require an NHS CHC assessment prior to their discharge, so that screening can take place at an appropriate time once discharged.

Applying the Checklist if you live in a care home

A care home manager should ensure they contact the ICB CHC team if they believe you may be eligible for NHS CHC. The ICB 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 their ICB CHC team to arrange a Checklist, if they think you may be eligible for NHS CHC. Community based staff 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. If NHS or social services staff are involved in your care, discuss with them your observations on, or changes to, your care needs, and request they contact the ICB on your behalf. Alternatively, contact the ICB CHC team to explain why you think a Checklist is necessary.

Completing the Checklist Tool

The Checklist Tool and the DST uses **11 '*domains*' or '*areas of need*'** (see section 5.3 for details of the domains).

The Checklist has three columns for each domain – A, B, C. The description in column A represents a **'*high*' level of needs;** in column B a **'*moderate*' level of needs**; and in column C **'*no and low*' needs**.

The assessor completes the Checklist by choosing the description most closely matching your needs and should take account of well-managed needs. The Framework discusses well-managed needs in paras 162-166 and PG 23.

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.

A positive Checklist

A positive Checklist means you require a full assessment and should be referred to your ICB but it does not indicate eligibility. **In most cases, it should take no more than 28 calendar days from the date the ICB receives a positive Checklist to reaching an eligibility decision**. ICB 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. 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 awaiting decision, are later found to be eligible and the ICB unnecessarily takes longer than 28 days to reach its decision, you can apply for reimbursement of services paid for beyond the 28 days. See Annex E of the *National Framework* for more details.

A negative Checklist

A negative Checklist indicates you do not need a full assessment and are not eligible for NHS CHC. The ICB should ensure that you are sent a written explanation of the decision, explaining your right to ask them to reconsider it.

When reconsidering, the ICB must take account of additional information you or your representative provides. You should receive a written response explaining the right to use the NHS complaints procedure, if dissatisfied with their final decision.

See factsheet 66, *Resolving problems and making a complaint about NHS care,* for more information about making a complaint.

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

You should have an assessment of your care needs to identify your eligibility for social care support and any care from NHS staff, see section 12 for more information.

5.2 The multidisciplinary assessment

On receiving a positive Checklist, the ICB appoints a case co-ordinator who is responsible until a decision on funding is made. They should ensure you and your representative understand the process, participate as much as you can and want to, and keep you informed at each stage. The case co-ordinator identifies and secures the involvement of the multidisciplinary team (MDT) who will complete the DST.

Multidisciplinary team (MDT)

The Framework defines an MDT as comprising of at least:

- 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. It 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 ICB consults the local authority, it should provide advice and assistance and not allow your 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 correct 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).*

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. If no one can attend, the co-ordinator should obtain your evidence and views. The Framework says, '*it is important the individual's view of their needs, including supporting evidence, is given appropriate weight alongside professional views*.' (para. 145).

ICBs may use a number of approaches to arrange an MDT assessment e.g. face to face or video conferencing. This decision should be made using person centred principles and to enable active participation of all MDT members. They should give reasonable notice of the date, so your representative can arrange to participate if they wish.

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

5.3 The Decision Support Tool (DST)

It is helpful to familiarise yourself with the DST. It has the same 11 '*domains*' as the Checklist, with an additional '*other*' domain or area of need that staff must consider when completing it:

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 also reflect changes in the nature, intensity, complexity, or unpredictability of the need. See section 3.3 for more information on how these levels should be assessed.

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

► indicates this domain goes up to **'severe'** level of need

Completing the DST

The DST is not an assessment in its own right. It is a tool for recording your needs in each of the 12 care domains.

When completing the DST, an MDT should:

- complete all domains with information about your care needs
- 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 (DST para 31-32)
- consider needs recorded in domain 12 - Other significant care needs.

The completed tool should give a comprehensive picture of your needs that captures their nature, complexity, intensity and unpredictability, and the quality and quantity of care required to manage them.

The DST has space to record your 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 ICB is aware of your views when making its final decision.

5.4 Reaching a decision

MDT recommendation to the ICB

The MDT must make a *recommendation* as to whether you have a primary health need and are therefore eligible for NHS CHC. They should take into account the range and level of your needs, including their nature, intensity, complexity and unpredictability; evidence from risk assessments; and if and how needs in one domain interrelate with another to create additional complexity, intensity or unpredictability.

The recommendation should refer to all key characteristics, but any characteristic can on its own, or in combination with others, be sufficient to indicate a primary health need.

Clear recommendation of eligibility is usually expected if you have:

- **priority** level of need in any domain with priority level (see page 15)
- **two or more instances of severe** needs across all care domains.

A primary health need may also be indicated 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 or** with **moderate** needs.

Whatever recommendation the MDT makes, it must be supported by clear, evidence-based reasons. It is not possible to equate incidences of one level of need with those of another level, for example two moderates do not equate to one high.

Dementia

The Alzheimer's society has a guide about approaching the NHS CHC assessment specifically for people with dementia. The guide provides tips and advice about how to prepare for the assessment.

For a copy of the guide, see www.alzheimers.org.uk/get-support/publications-and-factsheets/booklet-when-does-nhs-pay-care

The ICB's decision

An ICB is usually expected to respond to MDT's recommendation within two working days and only in exceptional circumstances go against it. In such circumstances, the ICB should refer back to the MDT to address any issues, for example there may be gaps in supporting evidence, or an obvious mismatch between evidence and recommendation (see PG 39).

The ICB 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 of the eligibility decision, if they decide you are not eligible. Someone appointed to act as your representative is entitled to receive a copy of the DST provided the correct basis for sharing such information has been established (see DST para 43).

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 a required part of the decision-making process. ICBs can use them to ensure consistency and quality of decision-making, but they should not play a financial gate-keeper role. If the ICB 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 ICB 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 ICB may decide you are not eligible for NHS CHC but because some of your needs are beyond the powers of an LA to meet on its own, the ICB is responsible for some of your care. In this case, the LA and ICB must agree their respective responsibilities for a joint package of health and social care.

They should tell you who will lead in agreeing, managing and reviewing your care plan. They must also explain whether the ICB contribution affects how much you pay towards the social care element of the package, which is subject to a means-test.

6 Care planning when eligible for NHS CHC

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

6.1 Your care package and options

The ICB that decides 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. These should be identified in your care plan. The funding must be sufficient, wherever it agrees you may live. Your ICB or care provider should not ask you to pay towards meeting your assessed needs.

The ICB should tell you who to contact with any concerns and who is responsible for monitoring your care and arranging regular reviews.

If the ICB agrees you can live outside its area, it remains responsible for care associated with meeting your NHS CHC needs. Once in your new area, you must register with a GP. Arranging NHS services unrelated to your NHS CHC, is the responsibility of your new GP practice and ICB.

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

Care home

Your ICB 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:

- **ICB has block contracts with several care homes in an area**. There may be reasons, based on your assessed needs, why an ICB 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.
- **Your current care home cannot meet your assessed needs.** You need to discuss your options with the ICB.

- **It may be appropriate to move to a home closer to relatives who live in a different ICB area**. You cannot assume reasons you give will be accepted. If the ICB agrees you can live in a care home in another ICB area, they remain responsible for your care home fees.
- **Your current care home can meet your NHS CHC needs but is more expensive than the ICB normally pays to meet similar needs**. This can arise if you were a self-funder 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. Social care legislation allows for '*top ups*', whereas NHS legislation does not.

  When reviewing your current accommodation, the ICB 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.

  The Framework discusses paying for higher cost services in paras 303-314.

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, the ICB must fund and, if asked, arrange a package to meet your identified health and personal care needs. Funding does not cover 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 ICB 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 ICB 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 ICB agrees to a home-based package and a family member or friend is an integral part of delivering your care plan, the ICB should identify and meet training needs to help them carry out this role.

In particular, the ICB may need to provide additional support to care for you whilst carers 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, in 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 another ICB area at a later date

If you receive NHS CHC at home and want to move to accommodation outside your ICB area, raise this with your funding ICB in plenty of time. It needs careful discussion between your current ICB and the ICB who would be responsible for providing NHS CHC services after you move. Both 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 ICB and the relevant health body in your chosen country.

6.2 If you lack capacity to consent to a care plan

An ICB 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 to 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 these 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.*

6.3 Personal Health Budgets and NHS CHC

Anyone receiving NHS CHC has the right to have a Personal Health Budget (PHB) with the expectation it 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 this money in a way that better suits you. It cannot be used simply to pay care home fees.

It is expected someone who chooses to have a care package at home will have a PHB. If you do not, contact your care manager to find out how it could work for you and about ways you could spend an allocated budget. You will never be asked to have more choice and control over your care or your money than you feel comfortable with.

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.

You can ask your NHS team to review and update your plan because your health or care needs have changed, or you feel the current plan is not working for you.

A care manager keeps your care plan and PHB management under review.

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

- a notional budget – the ICB 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 manages your care and budget in line with your care plan
- a direct payment – money is transferred to you or your nominee or representative, who contracts for necessary services or expenditure.

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.

For more information, see factsheet 24, *Personal budgets and direct payments in social care*.

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 the 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 the 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 ICB 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/using-the-nhs/help-with-health-costs/what-is-a-personal-health-budget/

6.4 If unhappy with your NHS CHC care package

If you are unhappy with issues such as the type, location or content of the care package being offered, the ICB should explain your right to complain using the NHS complaints process.

Making an effective complaint

Key points to consider:

- Be clear what your complaint is about – explain what you think is wrong with the current care package and how you are affected by it.
- Be clear about what you want to achieve by making a complaint – explain what changes you would like to see and why.
- State that you are making a formal complaint – this makes it clear that you expect them to respond in line with their complaints policies and procedures.
- Keep to the point- avoid giving details that distract from the main issues. Try to be polite and keep to relevant details.

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

7 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 that your needs are appropriate for the Fast Track pathway should contact an '*appropriate clinician*' and ask them to consider completing the Fast Track Tool.

An '*appropriate clinician*' is a doctor, nurse or specialist in end of life care knowledgeable about your health needs, diagnosis, treatment or care and able to provide an assessment of why you meet Fast Track criteria.

The ICB should accept a Fast Track recommendation and staff should promptly action it, so that a suitable care package is in place, preferably within 48 hours. The Tool should be supported by a prognosis, but the ICB 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 ICB does not believe the form, as completed, meets Fast Track criteria. In this case, the ICB should urgently ask the relevant clinician to clarify the nature of your needs and the reason for the use of the Fast Track Pathway Tool.

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 so, there may be situations where it is appropriate to review your NHS CHC eligibility (see paras 266-267 for when it may not be appropriate).

In such cases, a ICB should not remove Fast Track funding without reconsidering your eligibility. It should arrange for an MDT to complete a DST and make their eligibility recommendation.

If the ICB proposes a change in funding responsibility, it should tell you and give 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 a normal part of the NHS CHC process. They should be proportionate to the situation and primarily focus on whether the care plan arrangements remain appropriate to meet your needs. In most cases, it is expected there will not be a need to reassess for eligibility (para 203).

Reviews should take place within three months of the initial eligibility decision, but the timing may be affected by the MDT recommendation. After this, a review should take place at least annually.

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

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

Even if the ICB is responsible for all support, it should involve the LA in the MDT/DST process. The ICB 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 ICB should put any proposed changes in writing, with reasons, telling you from which date it proposes to implement the decision. Alternative funding arrangements must be put in place to ensure continuity of care before CHC funding is withdrawn. You have a right to request a review of the ICB decision, as described in section 9.

Staff 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 ICB for a review. It should acknowledge your request in writing within five working days and explain the appeal process.

Depending on the local appeals process there may be other steps with more limited deadlines to adhere to, so it is a good idea to ask about their processes prior to submitting your request. You can contact Beacon if considering whether to appeal.

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 ICB decision

The ICB'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 10).

9.2 Review process

There are two stages in the review process:

- a ***Local Resolution*** (***LR***) managed by the ICB, and
- an ***Independent Review*** managed by NHS England (NHSE) if unhappy with the local review outcome.

NHSE has discretion to put your case straight to independent review, if having LR would cause undue delay. The review process is only related to if you are dissatisfied with the ICB's '*primary health need*' decision, or the procedure the ICB followed to reach the eligibility decision, including application of eligibility criteria.

Local Resolution stage

The ICB should publish a local resolution process with timescales, that is fair and transparent. This must take account of the following guidelines:

- There should be an attempt to *informally* resolve any concerns through meaningful discussion between you or your representative and a ICB representative. You should be able to ask questions to help you understand the decision and provide information not already considered.
- If a *formal* meeting is required, it should involve a ICB 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 this meeting and outcome of next steps, the ICB either upholds or changes its decision. It should share its decision with you in writing and explain how, if still dissatisfied, to apply for an independent review.

Independent Review stage and timescales

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

NHSE is responsible for arranging an independent review panel (IRP). They can decide not to convene one on the advice of an independent individual who can chair a panel. It may decide to ask the ICB to attempt further local resolution prior to review. If NHSE decides not to convene an IRP, it should write 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 ICB to be legally represented at panel, although you may wish a family member, advocate, or advice worker to represent you. If you want advocacy support, your ICB should have details of local services.

The panel has a chair, independent of the NHS, and panel members, who are experienced health and social care professionals and who are independent of the ICB 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 National 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, 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 ICB should accept its recommendation. NHSE should tell you and the ICB of the decision in writing.

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

If the ICB 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 review.

10 Refunds if NHS should have paid for your care

You only become eligible for NHS CHC once the ICB has reached a decision informed by completion of the 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 ICB eligibility decision is:

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

You may be entitled to a refund if a retrospective review shows you should have been considered for NHS CHC, you are assessed and thus found eligible.

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

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

As a self-funder, the ICB 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 ICB's control; 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 the ICB revises its initial decision, it should reimburse to the LA any care costs the LA incurred, starting from the date of the ICB's initial decision (or earlier if unjustifiable delay occurred) until date the revised decision came into effect.

The LA should reimburse any contributions you made to the cost of your care. As a self-funder, the ICB should, in line with guidance in Managing Public Money, make an ex-gratia payment with aim of restoring your finances to state they would have been in, if a correct decision was reached at the outset.

11 Retrospective reviews of NHS CHC eligibility

If you think you should have been considered for NHS CHC but were not, you can raise this with social services, your care home manager or ICB CHC manager. If seeking a review in respect of a deceased relative, the ICB 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.

Refunds following a retrospective review

A retrospective review may show you were eligible for NHS CHC during the period under consideration. If so, the ICB 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 ICB decision on whether to provide redress or on the amount provided, you must use the NHS complaints procedure.

12 Care planning if you have a negative Checklist

If you do not progress beyond the Checklist stage, and staff did not ask at the outset to carry out CHC and social care assessments at the same time, they should ask if you would like a *Care Act 2014* assessment, to identify your ongoing social care needs. Subject to meeting specific eligibility criteria, your needs and views on how they can best be met form the basis of your care and support plan.

If you require 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 (see section 14)
- rehabilitation and recovery services such as physiotherapy
- assessment and support from community-based NHS staff such as district nurses, continence nurses, mental health nurses
- palliative care services (emotional support and control of symptoms, including pain management) if diagnosed with a terminal illness or nearing end of life.

13 Effect on benefits of NHS CHC funding

Disability benefits

You should notify the Disability Benefits Centre if you get a disability benefit - Attendance Allowance (AA), Disability Living Allowance (DLA) or Personal Independence Payment (PIP) and are awarded NHS CHC.

If you receive NHS CHC in a *nursing* home, AA and both components of DLA and PIP are suspended after 28 days from when ICB funding begins, or sooner if you were recently in hospital.

If you receive NHS CHC in a *residential* home, AA and the care components of DLA and PIP are suspended after 28 days from when ICB funding begins, but DLA or PIP mobility components continue.

If you 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.

The rules can be quite complex so seek advice if unsure about the effect of NHS CHC on these benefits.

State Pension and Pension Credit

State Pension is not affected by eligibility for NHS CHC.

However, if you receive Pension Credit, you lose the severe disability addition if payment of AA, DLA care component, or PIP daily living component stops.

14 NHS-funded nursing care

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

If you move from a nursing home in one ICB area to one in another ICB area, the new ICB is responsible for making NHS-FNC payment to the home.

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, these homes are not paid NHS-FNC.

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.

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

If staff propose your best option is to move into a nursing home, they must consider your eligibility for NHS CHC and agree that you are not eligible, before considering eligibility for NHS-FNC.

If you are found to be not eligible at the Checklist stage, and so did not have a full NHS CHC assessment, you must have a nursing needs assessment to identify your day-to-day nursing care and support needs.

You are eligible for NHS-FNC if you are assessed as having such a need, and it is decided your overall needs would most appropriately be met in a nursing home.

For information, see *NHS-funded nursing care practice guidance* www.gov.uk/government/publications/nhs-funded-nursing-care-practice

14.2 NHS-funded nursing care payments

NHS England reviews NHS-FNC weekly rates annually, usually in April. The following rates apply for the year starting 1 April 2023.

If you moved into a nursing home on or after 1 October 2007, you are on the single band of nursing care and the weekly rate is £219.71.

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 £302.25.

If placed on the high band in 2007, you stay on it until no longer resident in a nursing home; or become eligible for NHS CHC; or a review finds you no longer need nursing care; or 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 self-funding your nursing home place, ask them to explain how your fees take account of NHS-FNC payments. Check your contract for details of the fees you must pay, including if FNC rate changes. You may not be entitled to a refund of fees already paid if FNC payments rise.

The *NHS-funded nursing care practice guidance* 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. Where an ICB assesses that the resident's needs require the input of a registered nurse they will pay the NHS-funded Nursing Care payment (at the nationally agreed rate) direct to the care home, unless there is an agreement in place for this to be paid via a third party (e.g. a local authority). The balance of the fee will then be paid by the individual, their representative or the local authority unless other contracting arrangements have been agreed.'* (para. 59).

The Local Government and Social Care Ombudsman has guidance for nursing homes about NHS-FNC payments and ensuring contracts properly reference them, see www.lgo.org.uk/information-centre/news/2018/feb/ombudsman-offers-practical-guidance-on-contracts-for-social-care-providers

The Competition and Markets Authority addressed FNC payments in a recent study into care homes for older people. They publish a 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 can sometimes affect eligibility for disability benefits such as AA, DLA or PIP, if you are self-funding.

14.3 Review of NHS-funded nursing care needs

The *NHS FNC guidance* says you should have a review within three months of the original NHS-FNC eligibility decision being made, and usually at least annually after that.

When reviewing your need for NHS-FNC, staff must always consider your potential eligibility for NHS CHC. This may involve 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:

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

If staff reach this decision, they should record it in your notes, tell you of their decision and the reason for it.

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

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

If staff complete a new Checklist and it indicates a full assessment is required, an MDT should be appointed, the DST completed, and the normal decision-making process followed.

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-FNC guidance says ICBs 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 the 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.

15 Glossary

- **Checklist:** screening tool used to determine whether you need a full assessment for NHS CHC.
- **Decision Support Tool (DST):** assessment tool completed by the MDT to help determine an eligibility recommendation for NHS CHC.
- **Domains**: twelve areas of need or domains considered when assessing eligibility for NHS CHC, see section 5.3.
- **Fast Track Tool:** process to enable people who have a rapidly deteriorating condition that may be entering a terminal phase to access NHS CHC quickly, not requiring the completion of the DST, see section 7.
- **Funded Nursing Care (FNC):** a fixed payment made directly to nursing homes to support the provision of nursing care by the homes registered nurses, see section 14.
- **Integrated Care Boards (ICB):** Responsible for the commissioning of NHS services in their local area, responding to the needs of their populations.
- **Joint packages of care:** may be offered if you are not eligible for NHS CHC but the care you need is beyond the power of the LA to meet on its own. The LA and the ICB must agree their respective responsibilities.
- **Key characteristics:** are considered by staff completing an assessment for NHS CHC, includes nature, intensity, complexity and unpredictability, see section 3.3.
- **Local authority:** responsible for services in a particular area, includes social services.
- **Multidisciplinary Team (MDT):** team made up of different disciplines who complete the DST assessment tool, see section 5.2.
- **NHS Continuing Healthcare (CHC):** a complete package of on-going NHS and social care support arranged and funded by the NHS.
- **NHS CHC National framework (2022):** sets out the principles and processes staff must follow when deciding eligibility for NHS CHC, including the paperwork to be completed.

- **Nursing care home:** care home registered to provide nursing care.
- **Person centred**: placing the person at the centre of the assessment and planning processes by seeking their views throughout.
- **Practice Guidance (PG):** guidance to support staff in the delivery of NHS CHC, part of the national framework.
- **Primary health need:** the main aspects or the majority part of the care you need is focused on addressing and/or preventing health needs.
- **Residential care home:** a care home not registered to provide nursing care.
- **Top ups:** usually paid by a third party where you choose a more expensive care home out of preference not need. This is permissible under social care legislation but not under NHS legislation.

Useful organisations

Alzheimer's Society
www.alzheimers.org.uk
Telephone helpline 0333 150 3456

Provides information and offers support to people, their families and carers affected by any type of dementia.

Beacon
www.beaconchc.co.uk/
Telephone 0345 548 0300

Offers free and paid for services, including up to 90 minutes of independent advice about the NHS CHC assessment and appeals.

Competition and Markets Authority
www.gov.uk/government/organisations/competition-and-markets-authority
Telephone 020 3738 6000

Produces guidance for care homes on complying with consumer law.

Disability Service Centre
www.gov.uk/disability-benefits-helpline

- **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

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 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
0300 303 44 98

In Northern Ireland contact

Age NI
www.ageni.org
0808 808 75 75

In Scotland contact

Age Scotland
www.agescotland.org.uk
0800 124 42 22

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