My Care Consultant

Your guide to NHS Continuing Health Care

Practical information and tips to help secure a fair outcome when seeking NHS CHC funding

PRODUCED IN ASSOCIATION WITH JUST.

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My Care Consultant (MCC) is an independent care navigation company that exists to help consumers navigate their way through the complex care system, understand their care options and the various ways to pay for it. We provide a range of information and advice services designed to help you understand and secure all available financial and practical help from the State, the Local Authority and the NHS, as well as help in sourcing suitable care services and clear explanations in respect of ways to fund them. Whether it's just a question needing an answer or a bespoke care planning service that's needed, we can help resolve your concerns and find solutions to your care needs.

We understand that arranging often urgent care for a loved one without much time or previous experience of care or the benefit system can be overwhelming. We hope this guide to NHS Continuing Health Care provides useful, clear and practical information and tips to help you understand eligibility and support you when trying to secure funding regarding this aspect of the care system.

To find out more about how MCC can help you, contact us on 020 3290 3110 or email us via: ask@mycareconsultant.co.uk

About Just

We are Just. We're here to help you achieve a better later life.

At Just we recognise that everyone's retirement needs are different. You may want a regular income with the security of knowing that it's guaranteed to be paid for life. Maybe you are looking for peace of mind and want to make arrangements for future care costs. Or perhaps you want to access the money tied up in your property to spend on home improvements or holidays. It could even be a combination of these things.

Here at Just, we're proud to be one of the UK's leading providers of retirement financial solutions. And that's why we believe we can help you.

We're pleased to support this guide to NHS Continuing Health Care from My Care Consultant, and hope it helps boost your understanding of this important topic.

Introduction

NHS Continuing Healthcare (NHS CHC) is a package of care for people aged 18 or over who are assessed as having a 'primary health need' that has arisen because of disability, accident, or illness.

Confusion often arises over the difference between health care and social care. Social care relates to help needed to carry out day-to-day activities, e.g. washing, dressing, mobility etc., and is usually paid for by the person receiving care, by their local authority, or by a combination of the two. However, if someone is assessed as having a 'primary health need', and is awarded NHS CHC funding, this funding will not only pay for their health care, but will also pay for their associated social care needs.

If someone receives NHS CHC in their own home, the NHS covers the cost of the care and support they need to meet their assessed health and associated care needs. If they receive NHS CHC in a care home the NHS will also pay their care home fees including food and accommodation.

NHS CHC is available in **England, Wales** and **Northern Ireland** and applies to any setting (for example, a care home or where care is being provided at home). In **Scotland** it is known as *Hospital Based Complex Clinical Care* and is only available in a hospital setting.

This guide principally relates to the current rules, regulations, and practices applicable to those living in **England**. A high level summary of those applicable to Wales, Northern Ireland and Scotland can be found in the Appendix along with sources of further, more detailed information applicable to each jurisdiction.

Background

The issue of unfair assessments for NHS CHC has unfortunately been going on for years. As far back as February 2003, the Parliamentary and Health Services Ombudsman produced a report on "NHS Funding for Long Term Care", in response to the conduct of the NHS, stretching back to 1996. When this wasn't acted on, the Ombudsman produced another report in March 2007 on "Retrospective Continuing Care Funding and Redress" which again criticised the NHS's approach to the funding assessment issues.

The NHS responded with the National Framework to guide Clinical Commissioning Groups (CCGs) on the provision of a consistent NHS CHC service, with the needs of the individual at its core. However, in November 2020, the Parliamentary and Health Services Ombudsman produced its latest report entitled 'Continuing Healthcare: getting it right first time' which found not only continuing failings in care and support planning relating to NHS CHC but also failings in reviews of previously unassessed periods of care.

At My Care Consultant we continue to see examples where the correct assessment procedures haven't been properly followed or implemented, so we hope this guide is a useful starting point for those in need of care, their loved ones or legal representatives, helping them understand what should happen and what to do if it doesn't.

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An Overview - 12 key facts you need to know before getting into the detail

1. NHS Continuing Health Care (NHS CHC) is a funding system that pays all of someone's care costs.

2. It is paid by the local NHS and is available for those who need support with long-term health needs. The decision as to whether someone is eligible for this funding or not should never be influenced by how tight the local NHS budget is.

3. An assessment for CHC Funding should always take place *before* any discussion of the person's finances, or any Local Authority (means-tested) assessment, if there is a possibility of health-related needs.

4. The process surrounding NHS CHC funding is set out by the government in a document called *The National Framework for NHS continuing healthcare assessments and NHS-funded nursing care (2018).*

5. You can apply for NHS CHC by visiting your GP, requesting an assessment from a social worker at your local authority or, if you are in hospital, by speaking with your ward consultant or discharge coordinator.

6. Nobody can be certain whether you will be eligible or not until an assessment has taken place.

7. Most people are assessed via a two-stage process: an initial 'Checklist' which if positive, is followed by a full assessment. If an individual is reaching the end of their life, they may instead have what is known as a Fast-Track Assessment.

8. If someone is assessed as eligible, be aware that it is not for life – NHS CHC is reviewed three months after the original decision and annually thereafter.

9. If someone is eligible for NHS CHC, some of their state benefits may be affected. For example Attendance Allowance (AA), the care component of Disability Living Allowance (DLA), and the daily living component of Personal Independence Payment (PIP), will normally stop 28 days after NHS CHC begins. For someone receiving care at home, AA, DLA and PIP should be unaffected by being awarded NHS CHC.

10. If the decision is made that an individual is not eligible for NHS CHC, but they feel that they *should* have been awarded the funding, they may be able to challenge the decision.

11. Someone who is judged to be not eligible for NHS CHC, might qualify for NHS Funded Nursing Care (FNC) instead. This is a contribution made by the NHS for residents of nursing homes to pay towards the cost of care delivered to them by a registered nurse.

12. This guide is designed to provide a useful overview of the process, what to look out for and how to ensure that the correct outcome is reached. Whilst it shouldn't be the case, making a successful claim for NHS CHC can often come down to having sufficient knowledge and expertise available to support you through the process.

What is NHS Continuing Health Care?

NHS Continuing Healthcare is a package of care for people aged 18 or over who are assessed as having a 'primary health need' that has arisen because of disability, accident, or illness. It is arranged and paid for by the NHS.

If an individual receives NHS CHC in their own home, the NHS covers the cost of the care and support they need in order to meet their assessed health and associated care needs. This includes personal care such as help with washing and getting dressed. If they receive NHS CHC in a residential or nursing care home, the NHS pays their care home fees.

What is a 'primary health need'?

It's important to appreciate what a primary health need is, as it is a "balancing judgement" that determines eligibility. In other words, if someone is assessed as *not* having a primary health need, then their application for NHS CHC funding will automatically be rejected. You will not often hear the phrase *"primary health need"* used within the NHS as it was created specifically to describe eligibility for NHS CHC funding.

The National Framework that contains the rules in respect of NHS CHC states:

'A primary health need is a concept developed by the Secretary of State for Health to assist in deciding when an individual's primary need is for healthcare (which is appropriate for the NHS to provide) rather than social care (which the Local Authority may provide under the Care Act 2014).'

This means that a person is deemed to have a 'primary health need' if the nature of the care they require is beyond that which a local authority can legally provide. A local authority is legally limited to providing nursing care which is merely incidental or ancillary to the provision of the accommodation (which a local authority is under a duty to provide), and which is of a nature that social services can be expected to provide. In practice, the nursing care that the local authority can be expected to provide covers issues such as dealing with minor injuries, giving prescribed medicine, and the provision of nursing care by a registered nurse if the local authority has obtained consent from the relevant Clinical Commissioning Group (CCG).

It's important to appreciate that having a particular diagnosis does not automatically entitle someone to NHS CHC funding. Being deemed to have a primary health care need has more to do with what their overall day-to-day care needs are when considered as a whole.

A person is deemed to have a 'primary health need' if the nature of the care they require is beyond that which a local authority can legally provide.

How is a 'primary health need' determined?

A primary health need is established with reference to four characteristics of need, namely: nature, intensity, complexity and unpredictability. Any one or a combination of these characteristics being present will determine whether an individual has a primary health care need or not.

- **Nature** - this looks at the type of needs, and the care interventions required to meet them.
- **Intensity** - this looks at the quantity, severity and continuity of needs.
- **Complexity** – this looks at the level of skill and knowledge required to meet the individual's needs.
- **Unpredictability** – this looks at the degree to which needs fluctuate and create challenges in managing the needs.

So, someone who has been diagnosed with Alzheimer's disease, Parkinson's disease or another degenerative condition will not necessarily be assessed as having a primary health need. Eligibility is determined by assessing their day-to-day care needs and how those needs should be met in terms of their prevention or treatment.

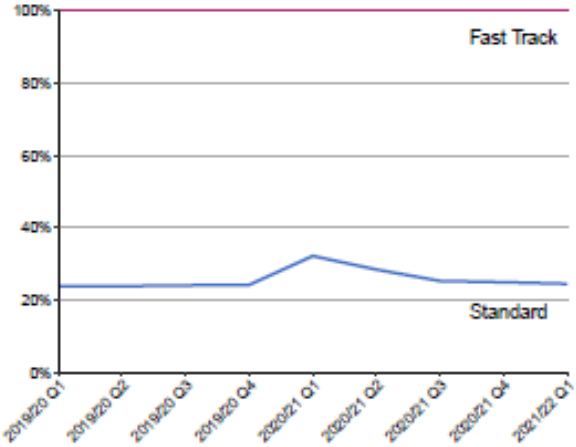
Someone who has been diagnosed with Alzheimer's disease, Parkinson's disease or another degenerative condition will not necessarily be assessed as having a primary health need.

Depending on the progression of an individual's illness or the nature of their disability, they are likely to present with a number of health and social care needs, some of which may well be intense, complex and/or unpredictable. If any one, or combination of, specific health needs are assessed as being of an intensity, complexity or level of unpredictability that means the person's primary need is for health care, then they should be eligible for continuing healthcare funding.

Where an individual qualifies for NHS CHC, the NHS is responsible for commissioning a care package that meets their health and associated social care needs.

How often are people found eligible for NHS CHC?

Due to the stringent eligibility criteria for receiving NHS CHC funding, coupled with a degree of erroneous assessments, only a minority of those referred for assessment end up being eligible for NHS CHC funding. As can be seen in the following diagram, the standard conversion rate from being assessed to being found eligible for NHS CHC during Q1 2021/22 was 100% for those where the Fast-Track process was used. But fewer than one in four of those who went through the standard NHS CHC assessment process were awarded NHS CHC funding.



NHS CHC referrals and activity were impacted by the emergency coronavirus legislation, so data for the Q1 2021/22 reporting period may therefore not be comparable to previous periods, nor entirely typical.

The total number of referrals into the assessment process submitted during Q1 2021/22 was 41,441. Of these, 17,562 were via the standard NHS CHC assessment route and 23,915 were via the Fast-Track assessment.

How long does it take?

It's expected that the overall assessment and eligibility decision-making process should in most cases not exceed 28 calendar days from the date that the local CCG receives a positive Checklist (see the next section, *The Assessment Process* for details of what the Checklist is and how it is carried out).

The overall assessment and eligibility decision-making process should in most cases not exceed 28 calendar days from the date that the local Clinical Commissioning Group receives a positive Checklist

However, on 30th June 2021, 3015 standard NHS CHC assessment referrals had exceeded the expected 28 days, some by a considerable period of time. Of those:

- **569** exceeded by up to 2 weeks;
- **475** exceeded by more than 2 weeks and up to 4 weeks;
- **920** exceeded by more than 4 weeks and up to 12 weeks;
- **680** exceeded by more than 12 weeks and up to 26 weeks;
- **371** exceeded by more than 26 weeks.

The total number of people in receipt of NHS CHC funding in England on 30th June 2021 was 53,563.

The Assessment Process

The process surrounding NHS Continuing Healthcare funding is set out by the government in a document called *The National Framework for NHS continuing healthcare assessments and NHS-funded nursing care.* You can find a link to this document in the 'Sources of Further Information' section of this guide on page 33.

Anyone is entitled to an eligibility assessment if they reasonably believe they have a primary health need. Indeed, the NHS is under a statutory obligation to undertake an assessment in all cases where it 'appears that there may be a need for such care'. Eligibility for NHS CHC is, however, a decision ultimately taken by the relevant Clinical Commissioning Group (CCG) that holds the contract with the GP practice responsible for an individuals' care at the time they apply. There are over 100 CCGs in England, each responsible for commissioning services for their local populations.

Stage 1 - The Checklist

The first stage in establishing eligibility for NHS CHC and determining whether an individual is entitled to free care involves the use of a screening tool called the Checklist. This should be used to identify people who should then have a full assessment to determine eligibility.

Completion of the Checklist should be triggered automatically in some circumstances, such as:

- When a person is ready for discharge from hospital, and before a local authority funding assessment takes place.
- When a person is going into a nursing home.
- When a person's physical or mental health appears to decline significantly.

However, anyone can ask for a Checklist assessment to be carried out and it can take place in a hospital or a community setting, such as a GP's surgery. It can be carried out by a variety of health & social care practitioners trained in its use – for example, a registered NHS nurse, the individual's GP, social workers or care managers.

Anyone is entitled to an eligibility assessment if they reasonably believe they have a primary health need.

The Checklist is based on 11 areas of care need, referred to as domains. These are:

1. Breathing*
2. Nutrition
3. Continence
4. Skin integrity
5. Mobility
6. Communication
7. Psychological/emotional
8. Cognition
9. Behaviour*
10. Drug therapies and medication: symptom control*
11. Altered states of consciousness

Each domain is broken down into three levels, A, B or C (where A indicates a high level of care need, and C a low level of care need). The outcome of the Checklist is dependent on the number of As, Bs and Cs identified for the individual being assessed.

A full assessment for NHS CHC should then be carried out where there are:

- Two or more domains at level A, or
- Five or more at level B, or
- One at level A and four at level B, or
- One at level A in a domain marked with an * - Behaviour, Breathing, Drug Therapies or Altered State of Consciousness.

By way of example, the following table illustrates the levels of need used within the checklist in respect of breathing:

Breathing*	Level C	Level B	Level A
	Normal breathing, no issues with shortness of breath. **OR** Shortness of breath or a condition, which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Shortness of breath or a condition, which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not consistently respond to management and limit some daily activities. **OR** Requires any of the following: - low level oxygen therapy (24%); - room air ventilators via a facial or nasal mask; - other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to therapeutic treatment and limits all daily living activities. **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (non-invasive positive airway pressure, or non-invasive ventilation).

There are some situations where it is not deemed necessary to complete the Checklist, for example where there has been a previous decision that the individual is ineligible and it is clear that there has been no change in their needs.

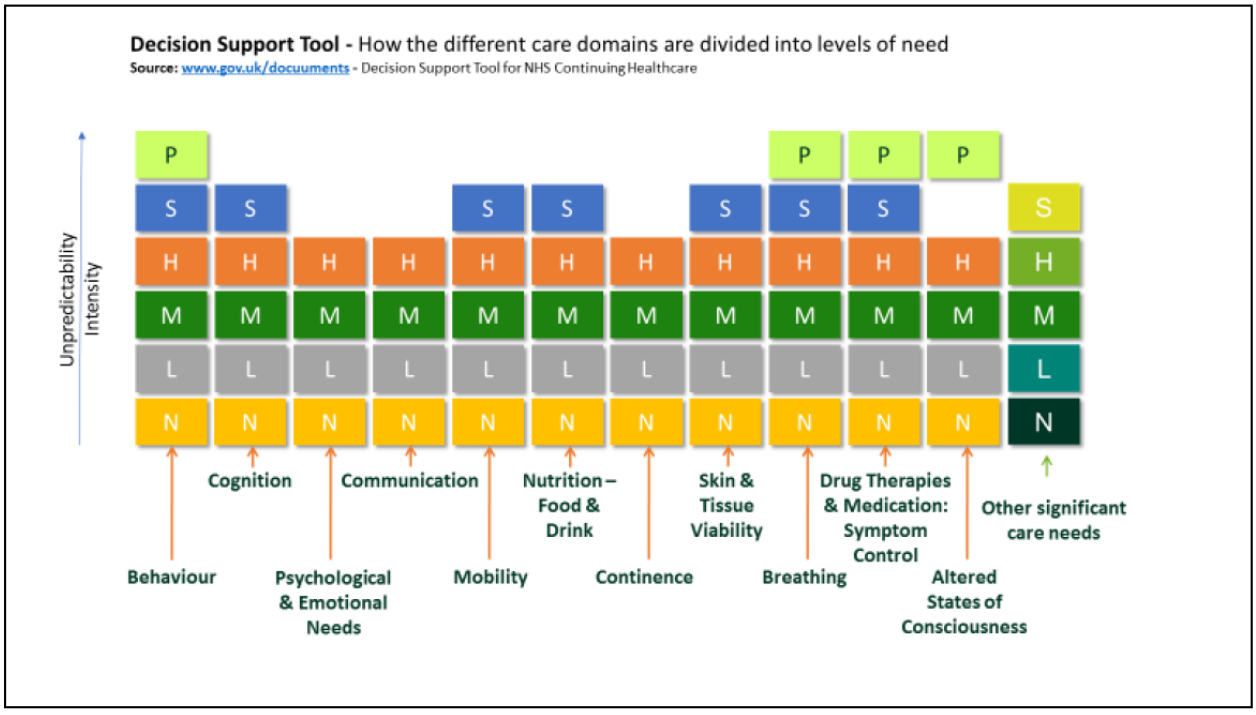
Stage 2 - The full assessment

The full assessment involves what is referred to as a Multi-Disciplinary Team (or MDT) and makes use of something called the Decision Support Tool (or DST). It is not an assessment in itself, but a way of bringing together and applying evidence and a summary of the person's needs, so that the MDT can make a recommendation to the CCG about eligibility or ineligibility.

Like the Checklist, the DST uses domains although in this case the individual is assessed on their needs in each of twelve domains, which are scored as reflecting low (L), moderate (M), high (H), severe (S) or priority (P) needs.

There is no specific combination of scores that will 'guarantee' eligibility, however, a clear recommendation of eligibility to NHS CHC would be expected where:

- the needs in any domain have been assessed as at "priority" level
- a total of two or more incidences of "severe" needs have been identified across all care domains
- a severe level need combined with needs in a number of other domains or
- a number of domains with high and/or moderate needs.



The following table illustrates the level of need used within the Decision Support Tool in respect of breathing:

BREATHING - Description	Level of need
Normal breathing, no issues with shortness of breath.	**No needs**
Shortness of breath or a condition which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	**Low**
Shortness of breath or a condition which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not consistently respond to management and limit some daily living activities. **OR** Requires any of the following: • low level oxygen therapy (24%). • room air ventilators via a facial or nasal mask. • other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	**Moderate**
Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to treatment and limits all daily living activities.	**High**
Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway. **OR** Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bi-level positive airway pressure, or non-invasive ventilation).	**Severe**
Unable to breathe independently, requires invasive mechanical ventilation.	**Priority**

The Fast-Track Tool

The Fast-Track pathway tool is used when a person has a rapidly deteriorating condition and may be entering a terminal phase. It can only be completed by an 'appropriate clinician' with sufficient evidence to establish eligibility. Where it is appropriate to use the Fast-Track Pathway Tool, this replaces the need for a Checklist and DST to be completed

The Fast-Track pathway tool is used when a person has a rapidly deteriorating condition and may be entering a terminal phase.

NHS Funded Nursing Care

NHS CHC must be considered, and a decision about it made *before* any consideration is given to eligibility for NHS-funded nursing care payment. This is a weekly payment of £187.60 per week 2021/22, which the NHS pays to homes providing nursing care, to support the provision of nursing care by a registered nurse.

A Joint package of care?

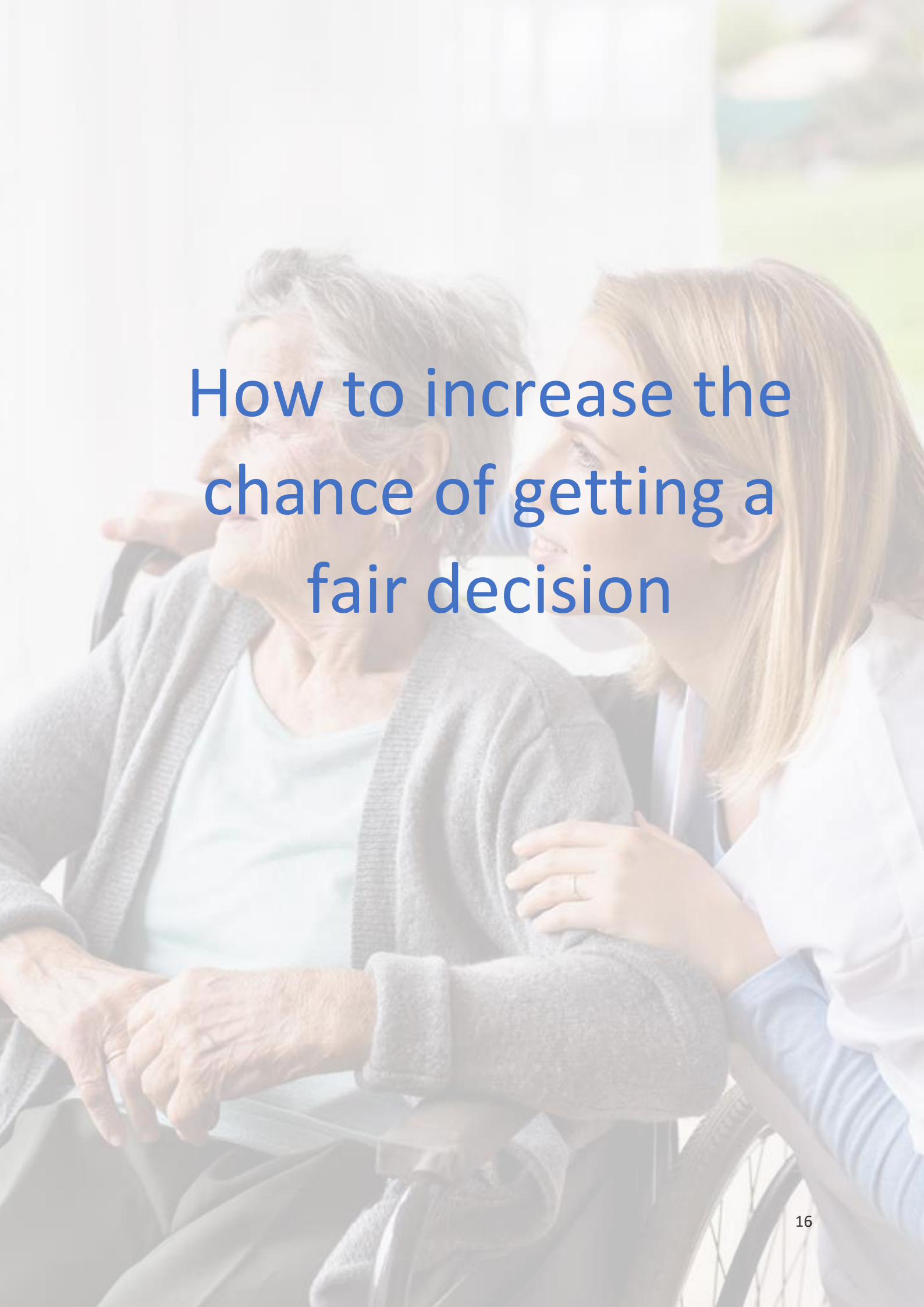
When someone doesn't meet the threshold for NHS CHC funding but still has complex health needs, an arrangement between the local CCG and local authority may be made whereby they work together to arrange, manage and review a person's support and share the cost of those services. This is known as a joint package of care.

What happens next?

If the person being assessed for NHS CHC is unsuccessful, they have the right of appeal (see the section of this guide entitled, 'How to challenge a decision' on page 26). If they are still unsuccessful, their needs will be deemed as social care needs (not health care needs) and their case will be passed to social services who will then assess their financial circumstances to determine whether they have to pay for none, some, or all, of their own social care costs, as a "self-funder".

If the person being assessed for NHS CHC is successful then a discussion should follow, typically allowing them a choice of care homes that offer an element of nursing due to their healthcare needs. Choosing the right care home, or even choosing care at home, is a whole subject in itself and not within the scope of this guide. In whatever environment NHS CHC is provided – whether in a care home or in the person's own home – it should always take account of their personal preferences where it is practical to do so.

It's worth noting that, from April 2014, the Government introduced Personal Health Budgets (PHBs). This was designed to give individuals more choice and control over how their own health and care needs are met.



How to increase the chance of getting a fair decision

So far, we have looked at the theory of how NHS CHC is delivered. The objective of the assessment process is to ensure that those who are eligible are identified as such. Unfortunately, both the pressures on the NHS and in some cases a lack of consistency in respect of applying the National Framework mean that some who should be eligible miss out. There is perhaps an inherent conflict of interest in operation too, given the cash-strapped NHS is itself responsible for deciding who is eligible for free NHS CHC funding. This section of our guide seeks to identify key areas to focus on to increase the chances of getting the right outcome from the assessment process.

TOP TIP

PREPARATION IS KEY. This means understanding all stages of the assessment process, becoming familiar with the language used and most importantly developing a full picture of the needs and circumstances of the person applying for support.

Consenting to the assessment process

The National Framework states that the 'individual's informed consent should be obtained before the start of the process to determine eligibility for NHS CHC' and that 'if there is a concern that the individual may not have the capacity to give consent, this should be determined in accordance with the Mental Capacity Act 2005'.

If the person being assessed lacks capacity this means a decision must be made in their best interests and a decision-maker identified, for example a registered Lasting Power of Attorney (LPA) or court-appointed deputy. In the absence of either of these, a continuing health care nurse may act as the decision maker.

Disclosure of medical and care records

The NHS CHC assessment process is complex and as already said, arguments in support of it need to be planned and properly presented to succeed. This often involves family securing health and social care records, scrutinising them and preparing reasoned arguments to support eligibility.

The rules governing information sharing are the same for NHS Continuing Healthcare as elsewhere and derive from several acts of Parliament, (including the Data Protection Act 1998, the Access to Health Records Act 1990 and the Mental Capacity Act 2005), the common law duty of confidence, and from a range of national guidance. As such, practical interpretation can vary.

Most NHS-related services will in our experience insist on a Health & Welfare LPA before liaising with family members on behalf of a patient and disclosing medical records. Some professionals point to the distinction between care cost decisions and care treatment decisions, maintaining that a Property and Finance LPA or an Enduring Power of Attorney (EPA) are both perfectly adequate when pursuing a claim for NHS CHC (as funding care costs fits the remit of this type of LPA and an EPA – for example, a person may have to sell their property and deplete

their own finances to pay for care otherwise).

However, page 104 of the National Framework (2018) states that what information can, and should, be shared depends on a number of factors, including:

'If alive but lacking capacity, whether someone else has legal authority to make welfare decisions on their behalf (e.g. under health and welfare lasting power of attorney or health and welfare court deputy arrangements). If so the person with legal authority can give consent to sharing information on their behalf.'

Page 107 goes on to say:

'Where a person has been appointed as attorney or deputy in relation to the person's property and financial affairs only, they do not have authority to make decisions about health and welfare.'

On 10th November 2021, the Office of the Public Guardian provided clarification in its 'Guidance for NHS regarding disclosure to individuals holding either a Lasting Power of Attorney or a deputyship' in respect of medical information to enable them to make best interest decisions on behalf of the donor. This guidance clearly states that:

*'An attorney holding a Lasting Power of Attorney (**either** Property and Affairs or Health and Welfare) (LPA) or a court-appointed deputy should be able to access relevant medical records of the vulnerable adult.'*

'When dealing with a request from an attorney, health professionals should satisfy themselves that the donor did not include an instruction in the instrument that specifies this type of data should not be disclosed to their attorney.'

Whilst this still leaves some scope for arguing about medical v care records, it does provide greater clarification and supports the general argument for information disclosure and consent relevant to NHS CHC to and from attorneys of a Property & Finance LPA and EPA.

In conclusion, we would recommend a pragmatic approach so that where capacity has not been lost both a Property & Finance LPA and a Health & Welfare LPA are established at the earliest opportunity and that consideration is given to instructions specifying that relevant medical and care records should be disclosed to the attorney in situations such as establishing eligibility for NHS CHC. Where matters are complex or a dispute with the NHS ongoing, we suggest seeking legal advice from a solicitor experienced in NHS CHC.

If the person being assessed lacks capacity this means a decision must be made in their best interests and a decision-maker identified…

Who can attend an assessment process?

The National Framework (2018, s307) states that 'Any person may choose to have a family member or other person (who should operate independently of local authorities and CCGs) to act as an advocate on their behalf'.

The Department of Health and Social Care also states in its document 'Decision Support Tool for NHS Continuing Health Care (November 2012)' that *'The individual should be given the opportunity to be supported or represented by a carer, family member, friend, or advocate if they so wish. The assessment process should draw on those who have direct knowledge of the individual and their needs'.*

At My Care Consultant we are aware of occasions where a family has been told that an advocate will not be allowed to attend an assessment. This is NOT correct, and reference should be made to both of the above mentioned documents and the importance of making sure the individual's views and wishes are represented and taken into account.

If professional carers are involved in the person's care, encourage them to keep full notes about the person's needs. These notes can then be used during the assessment along with information from other professionals, such as the person's GP.

Preparing for the assessment process

- Make sure the person being assessed, or their representative, is familiar with the various stages of the assessment process and the language/terminology used.
- **DO NOT sign anything before an assessment has taken place** – this includes any form of agreement with social services in relation to a Care Agreement or Financial Terms.
- There may be delays with CCGs processing requests for NHS CHC assessments due to the backlog created by the COVID emergency, so check that the person being assessed is officially on the waiting list by contacting their local CCG directly. Also make sure the CCG have logged the date on which the request was made.
- Poor record-keeping could be the difference between being assessed as eligible or not. If you are a legal representative or advocate for the person being assessed, you should, if possible, keep your own care diary of the circumstances and needs of the person requiring care whilst waiting for the assessment. This should include:
  a) how the person is feeling physically and emotionally each day, and what kind of support they need.
  b) how they appear – physically, mentally, and emotionally. Did they greet you? How did they look? Were they verbally aggressive? Did they seem agitated? Did they appear tearful or anxious? Did they communicate with you verbally or through gestures?
  c) Any recent changes or incidents such as falls or extreme changes in behaviour. What happened, were they admitted into hospital as a result? If someone was there to intervene, what might have happened if they weren't there? (In other words, if nobody had been there to intervene, would the

person probably have been admitted to hospital?)

d) The complexity, intensity and frequency of meeting a need, since these are key indicators of a primary health need.

- Keep all of the paperwork that is sent from the Clinical Commissioning Group relating to the continuing healthcare screening Checklist and full assessment.
- If someone is being discharged from hospital, the NHS are now obliged to put an interim package of care in place until a Checklist assessment is done to ensure there is no gap in healthcare provision.

Poor record-keeping could be the difference between being assessed as eligible or not.

The Checklist

Checklists aren't always completed accurately, and procedures are not always followed correctly which can result in people being unreasonably refused a full assessment.

- Reasonable notice should be given to the person being assessed that a Checklist is to be completed. They should be asked for their consent and that consent should be recorded.
- **Request a copy of the Checklist once it has been completed** - if the person being assessed is found to be eligible for (free) NHS CHC funding following a full assessment, funding should be backdated to the 29th day from when a positive Checklist was received by the CCG, in line with the National Framework.

What to do prior to the full assessment

If it is decided that a full assessment should be carried out, the following may

TOP TIP

Make notes and prepare beforehand regarding the 12 domains and the 4 key indicators - essentially complete a blank Decision Support Tool from your own point of view.
We would also suggest you get hold of and read through the Framework. You can find a link to the decision support tool, the Framework, and other documents on page 33 of this guide.

seem daunting and a lot of work, but it's worth taking the time to do, as it's easy to forget important points when in a meeting and feeling under pressure:

- Note that the multidisciplinary team (MTD) are required to review all relevant care notes and medical records (e.g. GP, hospital, treatment records etc.) in relation to an individual's care needs. The person being assessed, or their legal representative, should make sure they get hold of these records, too, and review them carefully in advance to make sure they accurately reflect the person's care needs in full.
- Make notes regarding any events that have taken place over the past few months such as falls, deterioration in condition, change in medical conditions or any new conditions.
- If there's an area of care that is particularly intense, complex or unpredictable such as challenging

behaviour or management of nutrition, it may be useful to ask any care home manager or care agency involved to keep a detailed one-week log of all events relating to that particular need in the lead up to the assessment. For example, if challenging behaviour is difficult for the care staff to manage, ask them to keep a *"Cohen-Mansfield Agitation Inventory",* an ABC chart, or similar.

- Contact the coordinating assessor to confirm the date, time and location of the assessment, how the meeting will take place and what information they will need from the person being assessed or their advocate at each stage. At the same time, make sure that any key member of the person's care team attends the meeting (such as a key nurse or care home or care agency representative).
- Ask what members of the multidisciplinary team will be present (social worker, GP etc). Remember, the MDT must consist of at least two people from different (healthcare) professions - one healthcare professional and one social services professional. If a social worker or representative of the local authority is not present, you should question how it can be stated or considered that a patient's needs are within the lawful power of the local authority to meet if no one from the local authority is able to give their opinion that this is the case?

Take the time to prepare well, as it's easy to forget important points when in a meeting and feeling under pressure

What to do during the full assessment

Some people find these full assessment meetings intimidating and feel that the MDT try to position what's being said to their own advantage. The person being assessed, or their representatives, must remain vigilant and resolute in terms of getting their points across. They should be given sufficient opportunity to talk about their care needs and to communicate their views as to why they feel they are eligible for NHS CHC funding.

Remember that a need shouldn't be discounted in the assessment process just because it is being successfully managed.

Well managed needs are still needs.

- We recommend the individual being assessed is accompanied by an advocate when the assessment is done.
- We recommend that the person's advocate makes notes during the assessment itself - particularly recording what is said and who said it. If there are any disagreements about levels of need, note who was in disagreement and why.
- Where there is a disagreement within the MDT in terms of the assessed levels within any domain, accepted practice is that the higher level should be chosen.
- Don't be hesitant to question if you are concerned that the assessors don't

seem properly trained in the NHS National Framework and the Assessment process. They should also be knowledgeable about the health and social needs of the individual being assessed, and where possible, should have recently been involved in their treatment or care.

- A useful tip is to describe the care needs of the person being assessed as if it were their 'worst day'. If you are representing someone and you feel that they are 'putting on a brave face', it may be appropriate to ask the coordinating assessor if you can speak to them privately after the meeting to give them what you feel is a more accurate description of the person's needs.
- Likewise, it's common for people's care needs to fluctuate from day to day. Some people will be more comfortable or settled on some days than others. It's important that the person being assessed tells the coordinating assessor about how they have been in recent weeks and months, not just how they are today. For example, a person with dementia who displays agitated or aggressive behaviour may only do so a couple of times each week and be perfectly calm and cooperative the rest of the time. A 'snapshot' of the person's needs on just one day would not provide an accurate or balanced view.
- If there is anything you don't understand or would like further clarification about, be sure to ask. It's important that those being assessed are given every opportunity to understand what is being said and how that may impact upon the assessment against each area of care, and when looking at the totality of their needs.
- Provide any written evidence you think may be useful. After the meeting has finished, the coordinating assessor should begin the process of gathering written documentation relating to the health and social care needs of the individual being assessed, for example previous continuing healthcare assessments, care plans, risk assessments, daily evaluation reports, medication, hospital and GP records, and specialist assessments relevant to the weeks and months directly preceding the assessment date. You can ask the coordinating assessor what information they will be gathering and ask them to consider anything else you feel may be relevant. You should also provide them with a copy of your care diary (mentioned previously under *"Preparing for the assessment process"*).

The decision

The Clinical Commissioning Group (CCG) should review the Decision Support Tool alongside the evidence that has been collated. In all but exceptional circumstances they should uphold the recommendation of the MDT. They should then write promptly to the person being assessed, informing them of their decision, and including a rationale for how the decision was made. If the decision is that the person is not eligible for NHS CHC, the CCG should include information on whether they qualify for NHS Funded Nursing Care, and about how to contact the CCG if they wish to challenge the eligibility decision.

In all but exceptional circumstances the CCG should uphold the recommendation of the multidisciplinary team.

We recommend that when this letter is received, a copy of the final, completed Decision Support Tool is requested and that the following are checked:

- Has the process of assessment been carried out correctly? For example, are your comments and views clearly contained in the Decision Support Tool, including where you have disagreed with a level of need assigned to a care domain?
- That supporting evidence has been included to ensure it is an accurate picture of the person's healthcare needs.
- Is a need defined as moderate when it should be high, severe or priority? Perhaps the assessor has given a lower score for a need because it is well managed by carers?
- Make sure there is a clear overall recommendation from the multidisciplinary team as to whether or not the person being assessed has a **primary health need** and is eligible for continuing healthcare. (Note: it is not acceptable for the multidisciplinary team to ask a CCG or decision panel to make the recommendation on their behalf).
- In any assessment where a joint package of care is recommended, it is important to ask the assessors why full NHS CHC is not being recommended instead.
- Make sure there is no evidence of budgetary or commissioner influences in the assessment or decision-making process. The local CCG's budgetary difficulties should have no bearing on the decision made.
- If the CCG takes longer than 28 days to make a decision, but the person does then qualify for NHS CHC funding, if the delay is not justifiable they should refund any care costs between day 29 and the date of their decision.
- If the CCG takes longer than 28 days to make a decision, and the person being assessed is receiving a fully funded interim package of care after hospital discharge (under current guidelines), their care package should continue to be paid for until the CCG makes a decision. If they are then found to be eligible for NHS CHC funding, then their care should continue to be paid for by the NHS. However, if they are *not* found eligible, they will be subject to local authority assessment to determine their eligibility for social care and how much of their own care they will be expected to pay for (including for the care they have already received between day 29 and the date of the CCG's decision).

NHS CHC Reviews

Once someone qualifies for NHS CHC funding, their eligibility should be reviewed after three months and annually thereafter. These reviews should be primarily about checking that the person's care needs are still being met appropriately. Full re-assessments of eligibility for NHS CHC should only be requested if there is clear evidence of significant changes to the person's care needs. In such a scenario, a full reassessment of eligibility for NHS CHC including the completion of a new DST by an MDT should be arranged and where appropriate, comparison should be made

to the information provided in the previous DST.

Following the reassessment, the MDT should make an eligibility recommendation to the CCG (using the concepts of nature, intensity, complexity and unpredictability) and a decision subsequently made by the CCG for the individual to either remain eligible for NHS CHC or for eligibility to be revoked.

Where eligibility is revoked, the CCG and local authority should consult one another and the individual about any proposed changes in arrangements and funding. Any alternative funding arrangements should be agreed and put into effect before any withdrawal of existing funding in order to ensure continuity of care. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change (usually the CCG).

In any assessment where a joint package of care is recommended, it is important to ask the assessors why full NHS CHC is not being recommended instead

Where NHC CHC is being withdrawn

If eligibility for continuing healthcare is being withdrawn, it's important to request a thorough explanation in writing from your Clinical Commissioning Group as to why they believe the person in question is no longer eligible. The decision to withdraw NHS CHC funding can be challenged if the person (or their representatives) disagree with the decision.

Previously unassessed period of care

It's crucial that the care provider is keeping good, accurate, and up-to-date records about the person's care needs. This is particularly important for anyone who is self-funding or partially funding their care while waiting for their assessment. Care records are important and may be needed to inform a retrospective assessment, so it's really important that such records are of good quality. The person in need of care or their legal representative can ask to see their care records at any time and can also ask to be involved in care plan reviews.

Where needs increase

If someone is not deemed eligible for NHS CHC at first, it doesn't mean they won't be eligible at some point down the line, as care needs can change. If their care needs increase, they can apply for a new assessment.

Retrospective claims

Retrospective claims can be made for a refund of the care costs that have previously been paid by someone who, it is now agreed, should have been receiving NHS CHC funding. This is often referred to as "restitution" or "redress". The period under consideration will need to be after 01/04/2012 as the opportunity to claim for periods before that date has now passed.

We appreciate that the NHS is having to make significant savings within its budgets, but that should not include evading proper reimbursement to families who have wrongly paid care fees.

We're aware of some anecdotal evidence of cases where we would argue the CCG

has crossed that particular line, for example:

1. A case where the CCG has agreed to refund fees for the full period in question with the exception of the last few weeks of 'end of life' care because this took place within a hospital. We understand the CCGs rationale was simply that the patient wasn't living in the care home but in hospital. But this ignores the fact that the patient was still contractually obliged to continue paying for their care at the care home during this time, even though they were not physically there. If a decision like this is challenged with the help of legal representation, we understand that the CCG is likely to apologise for the oversight and reimburse the difference.

2. A case where a particular CCG maintained a policy of repaying refunds directly to the care home and NOT to the family as it was more efficient for them to do so. If successful in a retrospective claim, we suggest you insist early on that the CCG pay you directly and if they refuse, consider lodging a formal complaint and report the matter to NHS England.

3. A case where a CCG recently tried to get away with not paying any interest on the restitution sum awarded following a family's successful retrospective review. The CCG agreed the patient was indeed eligible for reimbursement of past care fees paid, but deliberately chose to omit interest on the restitution sum.

   The NHS Refreshed Redress Guidance provides that where there has been 'maladministration' (i.e. incompetence) the CCG should pay interest on the restitution (currently at RPI rates). This is an automatic entitlement and is set out in the NHS Refreshed Redress Guidance which came into effect on 1st April 2015.

TOP TIP

When you are applying for, or challenging, a decision on NHS continuing healthcare, put your case in writing and keep a record of all correspondence. Even if you have been successful and the person has been found eligible for NHS continuing healthcare, make sure you receive a copy of all the relevant paperwork, including the completed Decision support tool. This can be helpful in the future, especially if NHS continuing healthcare is withdrawn at a later date.

We appreciate that the NHS is having to make significant savings within its budgets, but that should not include evading proper reimbursement to families who have wrongly paid care fees.

How to challenge a decision

Challenging a decision not to proceed to full assessment

If someone has been told that they will not be considered for full assessment following use of the Checklist, they can ask the CCG to reconsider its decision and can request another Checklist assessment. To do this, they should contact the NHS CHC team within the CCG and request a repeat of the Checklist. At the same time, they should provide their reasons as to why they disagree. It's always sensible to do both in writing.

Challenging a full assessment decision

When a full assessment results in a negative decision, there are three ways to challenge this:

1. **The local review process at CCG level**

Following a decision, the CCG (or a third party acting on their behalf) should issue a decision letter that explains the decision, why it was made and the person's right to request a review of the decision. Each CCG must have a local review process, including timescales, which should be made publicly available, and a copy should be sent to anybody who requests a review of a decision.

Where a full assessment has been undertaken using the Decision Support Tool (or using the Fast-Track Pathway Tool), and a decision has been reached, a review can be requested any time within six months from the date of the letter containing the decision. The CCG (or third party acting on their behalf) then have three months from the date of the request for a review, in which to complete a local review.

2. **A request to NHS England/ Independent Review Panel**

Once local procedures have been exhausted, if the person and/or their representatives still have reason to believe the wrong decision has been made, the case should be referred to an NHS England Independent Review Panel (IRP), which should consider the case and make a recommendation to the CCG. If using the local review process would cause undue delay, NHS England has discretion to agree that the matter should proceed directly to an IRP without completing the local process first. Although the role of the IRP is advisory, its recommendations should be accepted by the CCG in all but exceptional circumstances. The Framework sets out principles to be followed both locally and by IRPs (such as in the gathering of available evidence).

3. **A referral to the Parliamentary and Health Service Ombudsman.**

If the Independent Review Panel upholds the original decision and the individual or their representatives want to continue to challenge this, the next stage is to refer the case to the Health Service Ombudsman. Someone's rights under existing NHS complaints procedures and their right to refer a case to the Health Service Ombudsman is not affected by the IRP procedures or outcome.

TOP TIP

The Ombudsman has the final say if you have exhausted the local complaints system and review panel. So it's important to have good records so you can make an effective case to the Ombudsman.

The relevance of legal precedent

It is important to note that NHS CHC assessment is not in itself a 'legal process'. Appeals and challenges do not involve law tribunals. At each stage of the assessment and appeal process, the people making decisions regarding someone's eligibility for NHS CHC are health and social care professionals, whose job it is to interpret a set of health criteria. Therefore, it is neither required nor sensible to focus an appeal on the intricacies of case law when the remit of the panel is to understand the individual's personal health needs in detail and apply health criteria to them.

However, the law is the ultimate arbiter of whether someone is eligible for NHS CHC and overrides any Continuing Healthcare guidelines. So below you will find details of certain cases in law, and historical decisions made by the Ombudsman, that have been used to support successful claims for NHS CHC. They can and should be referred to, where relevant, in the event of disputed eligibility.

It is important to note that NHS CHC assessment is not in itself a 'legal process'.

Coughlan Case, 1999

Court of Appeal Judgment of R v North and East Devon Health Authority

In July 1999 the most important (and well known) legal case concerning NHS CHC was concluded - that of Pamela Coughlan. This ruling made it clear that if an individual has healthcare needs that are over and above what social services can be expected to provide and are therefore primarily health needs, the NHS has a responsibility to provide for those needs, and to fund the necessary care.

Only if the individual's need is not primarily for health care – i.e., not the responsibility of the NHS – may consideration be given as to whether local authority social services could purchase nursing care in very limited circumstances, and pass the cost to the individual whose healthcare needs are:
(i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide; and
(ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide.

So, the Coughlan case was fundamentally instrumental in clarifying the legal distinction between healthcare needs and social care needs and providing a clear boundary line as to which body has responsibility for providing (and paying for) the individual's care.

The judgment in Coughlan clearly establishes that when a person's primary need is for health care, and that is why they are placed in nursing home accommodation, the NHS is responsible for the full cost of the package

The Leeds Ombudsmen Case, 1994

A complaint to the Health Service Ombudsman against Leeds Royal Infirmary (Case Number: E.62/93-94) in January 1994.

This Ombudsman Report, whilst not legally binding, has provided clarification that it is unreasonable for a health authority to implement a policy that fails to make NHS CHC available where a need for substantial nursing care exists.

The Pointon Ombudsmen Case, 2003

A complaint to the Health Service Ombudsman against a local Primary Care Trust made on behalf of Mr. Pointon (Case Number E.22/02-03).

This ruling led to the principle that NHS CHC could be provided in any setting, not just care homes with nursing. It also provided confirmation that Alzheimer's Disease could result in a 'primary health need'.

The Grogan Case 2006

The case of Grogan vs Bexley Primary Care Trust (2006) 9 CCLR 188

This ruling ultimately established important principles such as the requirement of Primary Care Trusts (now known as CCGs) to assess all of the individual's relevant needs rather than only their nursing needs, as well as clarification in respect of the interaction between continuing healthcare and the registered nursing care contribution (Now more commonly referred to as funded nursing care contribution – FNC). In all cases decision makers should establish whether an individual is eligible for continuing healthcare before considering nursing care contributions.

The Pearce Ombudsman Case 2007

The case of Ruby Pearce v Torbay Care Trust (2007)

Mike Pearce (a former detective with Scotland Yard's Flying Squad) was forced to sell the family home to fund his mother's care fees after she was deemed not eligible for continuing healthcare. His mother suffered with Alzheimer's disease and required full assistance with all activities of daily living. After a 5-year battle with Torbay PCT resulting in one of the first continuing healthcare assessments using the new National Framework (at the time not finalised), the Ombudsman upheld his complaint and recommended Torbay PCT pay £50,000 in retrospective restitution.

Only if the individual's need is not primarily for health care – i.e. not the responsibility of the NHS – may consideration be given to whether local authority social services could purchase nursing care

UNDERSTANDING THE RELEVANT LEGISLATION

The ***National Framework*** and ***Decision Support Tool*** have been drafted to help health and social care commissioners comply with legislations when determining responsibility for the provision of health services in the community.

The ***National Framework*** sets out the recommended assessment and appeals process for CCGs to follow when making decisions about CHC funding.

The ***Decision Support Tool*** aids consistency and fairness of decision making when applying the primary health need test.

Whilst the National Framework is not legally binding, it is underpinned by the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, subsequently amended by The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013). Known more commonly as the Standing Rules they require CCGs to 'have regard to' the guidance in the National Framework when determining the responsible commissioner and resolving disputes. Failure to do so may result in authorities breaking one or more of these laws which underpin the National Framework.

Sources of further information

Key Department of Health and Social Care documents

The National Framework
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

The Checklist
https://www.gov.uk/government/publications/nhs-continuing-healthcare-checklist

The Decision Support Tool
https://www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool

The Fast Track Tool
https://www.gov.uk/government/publications/nhs-continuing-healthcare-fast-track-pathway-tool

NHS Funded Nursing Care
https://www.gov.uk/government/publications/nhs-funded-nursing-care-practice

Specialist Helplines and Advocacy

Beacon

https://www.beaconchc.co.uk/how-we-can-help/

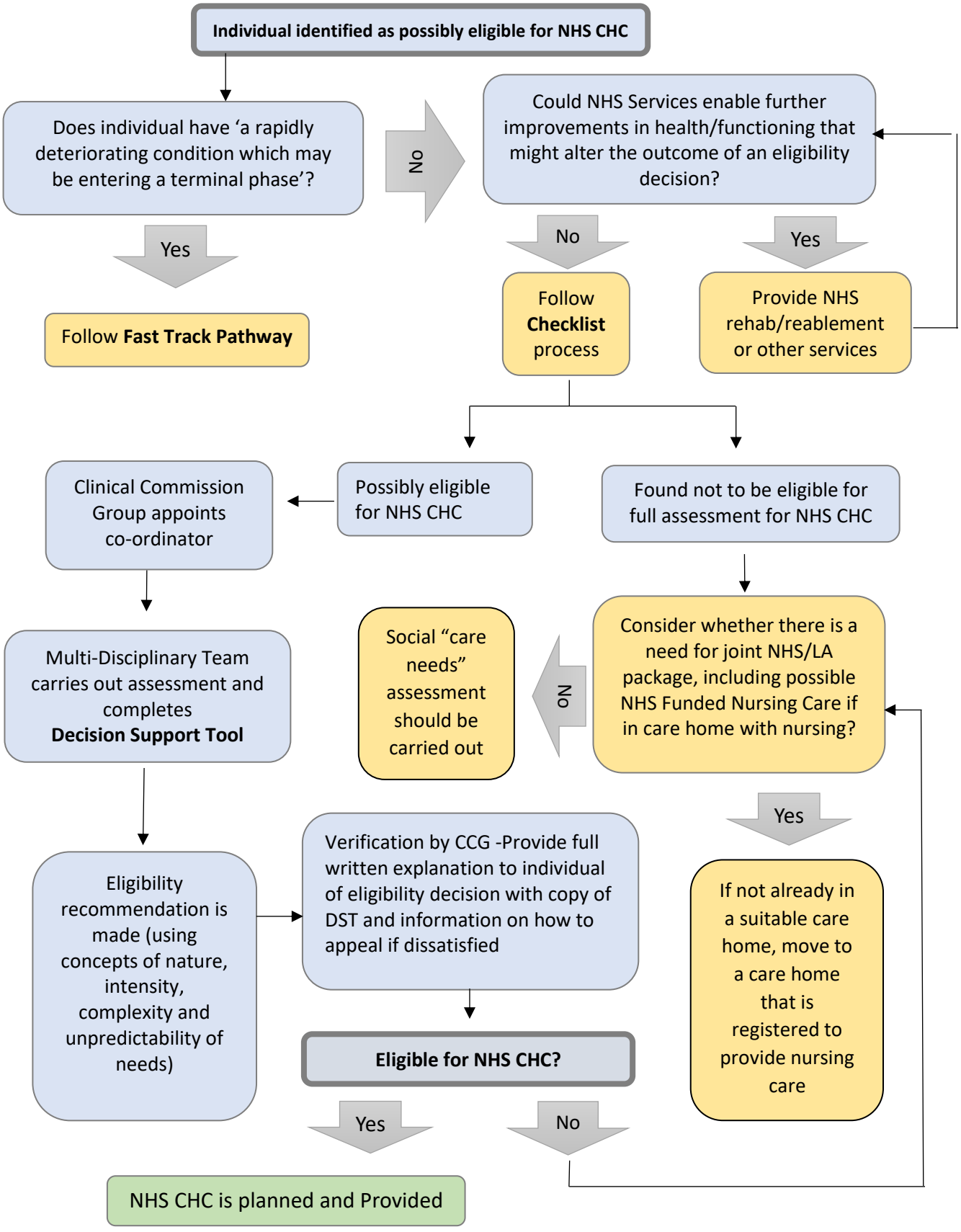
'Beacon' evolved from a service offered by Age UK Oxfordshire. In 2014 it became a UK-wide social enterprise offering independent NHS CHC support services, with profits donated to charity for older peoples' services. They are also the chosen supplier for England's first independent Information and Advice Service for CHC, commissioned by NHS England themselves. This funding means that they can provide free advice to hundreds of people every month as well as chargeable services for more detailed support and advocacy.

APPENDICES

A. Eligibility flowchart for NHS CHC in England
B. NHS CHC in Northern Ireland
C. Hospital based Complex Clinical Care (Scotland)
D. NHS CHC in Wales
E. Glossary of useful terms

Appendix A – Eligibility for NHS Continuing Health Care (England)

(Primary Source: Replication of flowchart within Care Box Online Resource, My Care Consultant)



Appendix B – NHS Continuing Health Care – Northern Ireland

The current system

NHS Continuing healthcare is available in Northern Ireland, although in a context where health and social care is fully integrated: the Health and Social Care board (HSCB) is responsible for commissioning health and social care services for the local population and Health and Social Care Trusts (HSCT) are required to deliver services. The basic principles for assessing eligibility for Continuing Healthcare are set out in the Northern Ireland Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance, which can be found here:

https://www.health-ni.gov.uk/publications/guidance-charging-residential-accommodation

HSC Trusts are responsible for ensuring that an assessment of need is carried out for individuals with a multi-disciplinary professional and with clinical input as required. The assessment process covers both health and social care needs and should focus on maximising opportunities for independent living. If the outcome of an assessment indicates a primary need for healthcare, then the HSC Trust is responsible for finding the complete package of care in any setting, which is referred to as continuing healthcare. If the outcome of an assessment indicates a primary need for social care, this need may be met in a residential or nursing home setting, where HSC Trusts are required to levy a means-tested charge.

Reforms and Consultations

Age NI conducted a study of the provision of Continuing Healthcare in Northern Ireland and presented their findings and recommendations in a report – *The Denial of NHS Continuing Healthcare in Northern Ireland* (May 2014). This argued that older people were being denied access to assessments for continuing healthcare, partly because of a lack of clear guidance. It recommended that the Northern Ireland Department of Health "draft and publish guidance on NHS Continuing Healthcare in NI to provide clarity and to require collation and monitoring of data in a standardised way."

In response to this, the Department carried out a comprehensive review before publishing a consultation document in 2017 but owing to there being no Northern Ireland Executive between January 2017 and January 2020, a response report was not published until 11th February 2021. The outcome of the consultation revealed that, by a small margin, respondents requested a Single Eligibility Criteria Question be implemented. The Department is now "engaging with the HSC Board, HSC Trusts and other stakeholders to ensure that any revision to the current Continuing Healthcare policy is underpinned by guidance that is fit for purpose."

Appendix C – Hospital Based Complex Clinical Care- Scotland

(Primary Source: House of Commons Briefing Paper Number CBP06128, 15 April 2020)

The Current Situation

In Scotland, NHS continuing healthcare was replaced by 'Hospital Based Complex Clinical Care' from 28 May 2015, which marked the Scottish Government's full acceptance of the Independent Review of NHS Continuing Healthcare. This change was part of the integration of health and social care in Scotland starting from April 2015.

Assessment for long-term complex clinical care is now be based around a single eligibility question: "Can the individual's care needs be properly met in any setting other than a hospital?" If, following a full assessment, the answer to this question is 'Yes', then the person will be discharged from NHS care to a suitable community setting – home with support, a care home or supported accommodation. At this point the local authority's charging policies will apply, and the individual may have to contribute towards the cost of their care.

Care Information Scotland has a webpage on Hospital Based Complex Clinical care and can be found here:
https://careinfoscotland.scot/topics/how-to-get-care-services/hospital-based-complex-clinical-care/

Appendix D – NHS Continuing Health Care – Wales

The current system

Continuing NHS Healthcare exists in Wales in a similar form to that in England. Instead of CCGs, however, Health Boards are responsible for ensuring that Continuing NHS Healthcare is provided to individuals. The National Framework for Continuing NHS Healthcare sets out a mandatory process for the NHS in Wales, working together with local authorities, to assess health needs and decisions on eligibility, and to provide appropriate care for adults.

The current version of the Welsh National Framework (as of September 2021) was completed on 29 June 2014. However, in 2019 there was a review of the 2014 CHC Framework and the Decision Support Tool (DST) that forms a part of the NHS CHC assessment process. This led to the publication in July 2021 of a revised NHS CHC Framework and DST which was scheduled to take effect in November 2021**.** However, in light of current pressures within the health sector, implementation has been deferred until the 1st April 2022 (at the earliest). When implemented, it will provide a consistent foundation for assessing, commissioning, and providing CHC for adults, over the age of 18, across Wales and is the definitive source of information on NHS CHC in Wales as it stands

Details of the 2021 revised Framework including a summary of the main changes between the 2014 and 2021 Framework is set out in the document entitled *'NHS Continuing Healthcare – The National Framework for Implementation in Wales'* which can be found here:

https://gov.wales/national-framework-nhs-continuing-healthcare

Reforms and consultations

Following the implementation of the 2021 Framework, the Welsh Government has given a commitment to review the NHS CHC Framework within five years of implementation and to issue additional or interim guidance where this is required.

The NHS Funded Nursing Care in Care Homes Guidance 2004 remains in effect. The Welsh government has stated however that this will be subject to review during the lifetime of the 2021 NHS CHC Framework. The current FNC guidance can be found here:

http://www.wales.nhs.uk/documents/whc-2004-024-e.pdf

Appendix E - GLOSSARY OF USEFUL TERMS

Checklist

A screening tool to help identify individuals who may need a referral for a full assessment of eligibility for NHS continuing healthcare.

Clinical Commissioning Group (CCG)

CCGs are responsible for commissioning healthcare services to meet the reasonable needs of the people within their local area, except for those services that NHS England or local authorities are responsible for commissioning.

Decision Support Tool (DST)

The purpose of the Decision Support Tool (DST) is to support the application of the National Framework and inform consistent decision making. The DST should be used in conjunction with the guidance in the National Framework.

Fast track assessment route

Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require 'fast tracking' for immediate provision of NHS Continuing Healthcare.

Fast Track tool

The Fast-Track Tool should be completed by an appropriate clinician, who should give the reasons why the person meets the criterion required for the fast-tracking decision.

Joint Funded

A package of care which is partly, but not wholly, funded by the NHS.

Local Resolution Request

A local resolution request is a request by the individual or their representative, to the CCG to review an eligibility decision following a full assessment undertaken using the Decision Support Tool (or the Fast-Track Pathway tool).

Multidisciplinary Team (MDT)

In the context of NHS Continuing Healthcare, a multidisciplinary team is a team of at least two professionals, usually from both the health and the social care disciplines.

National Framework

The revised 2018 National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care

NHS Continuing Healthcare

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident, or illness.

NHS-funded Nursing Care

NHS-funded Nursing Care (FNC) is the funding provided by the NHS to care homes with nursing, in order to support the provision of nursing care by a registered nurse. Since 2007 FNC has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS CHC before a decision is reached about the need for FNC.

Previously Unassessed Period of Care

Claims for Previously Unassessed Periods of Care (PUPoC) refer to a specific request to consider eligibility for a past period of care, where there is evidence that the individual should have been assessed for eligibility for NHS CHC funding. PUPoCs may relate to either deceased or ongoing eligible cases.

Primary Health Need

'Primary health need' is a concept developed by the Secretary of State to assist in deciding which treatment and other health services it is appropriate for the NHS to provide. Where a person has been assessed to have a 'primary health need', they are eligible for NHS Continuing Healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for providing all of that individual's assessed health and social care needs.

Standard NHS CHC (non-Fast Track)

NHS CHC cases which are not Fast Tracked. This includes those that have been agreed eligible via the standard NHS CHC assessment route (i.e., positive checklist, DST etc.) and those Fast-Track cases that have been reviewed and changed to Standard NHS CHC. It does not include Previously Unassessed Periods of Care (PUPoCs).

Standard NHS CHC assessment route

Assessment route for individuals who have not been referred for assessment via the Fast-Track assessment route.

NOTES

In association with