Factsheet FS20

NHS Continuing Healthcare and NHS-funded nursing care

October 2020

About this factsheet

This factsheet explains what NHS Continuing Healthcare is; how the NHS decides whether you are eligible for it and what to do if unhappy with an eligibility decision. It explains the effect of Covid-19 pandemic on undertaking assessments, particularly when involving hospital discharge.

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 be of interest:

6 *Finding care at home*

10 *Paying for permanent residential care*

22 *Arranging for others to make decisions on your behalf*

37 *Hospital discharge*

38 Property and paying for residential care

39 *Paying for care in a care home if you have a partner*

41 *How to get care and support*

76 *Intermediate care and reablement*

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

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

Contents

1 Recent developments

- The NHS-funded nursing care single band rate for year starting 1 April 2021 is £187.60 a week. If you moved into a nursing home before 1 October 2007 and were on the high band, it is £258.08 a week.
- Impact of Covid-19 on NHS Continuing Healthcare assessments.

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 refers to a residential care home, **nursing home** to a care home registered to provide nursing care. **Care home** refers to both as appropriate.

NHS CHC refers to NHS Continuing Healthcare**, NHS-FNC** to NHS-funded nursing care, **DST** to Decision Support Tool, **CCG** to Clinical Commissioning Group, **LA** to local authority, **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 whereas those arranged by social services are means-tested.

3.1 What is NHS Continuing Healthcare?

NHS CHC is an ongoing package of care arranged, 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. 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.

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.

3.2 What is the National Framework?

The 2018 *National Framework for NHS Continuing Healthcare and NHS-funded nursing care* applies in England. It:

- sets out principles and processes staff must follow when deciding eligibility for NHS Continuing Healthcare. See sections 4, 5, 7 and 8.
- 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. The Framework and tools are at www.gov.uk/government/collections/nhs-continuing-healthcare-and-nhs-funded-nursing-care.

Due to the Covid-19 pandemic, from 19 March until 31 August 2020, CCGs were not required to carry out NHS CHC assessments or regular reviews, or reviews of eligibility decisions. In August, the Department of Health and Social Care issued guidance to apply from 1 September 2020 - *Hospital discharge service: policy and operating model*, and supporting guidance - *Reintroduction of NHS continuing healthcare (NHS CHC): guidance*.

The latter explains how, in line with National Framework, staff should manage reintroduction of the NHS CHC process, particularly new cases involving hospital discharge, and cases put on hold between 19 March and 31 August.

Understanding the decision-making process

Beacon can help you navigate and understand the decision-making and the appeals process and impact of Covid-19 on usual NHS CHC 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.

There is a 20 minute NHS video explaining the NHS CHC process at www.youtube.com/watch?v=9xE2oGVRqvY.

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.

The chart on page 7 outlines the overall process.

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 need 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*' arises out of a 1999 Court of Appeal case known as *Coughlan Judgment*. The judge found there to be a limit on nursing care assistance a LA could legally provide and explained this as, 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 a LA is, or would but for the person's means, be under a duty to provide (the '**quantity test'**), **and**
- not of a nature beyond which a LA, whose primary responsibility is to provide social services, could be expected to provide (the '**quality test'**).

When considering NHS CHC eligibility, staff look at **key characteristics of your needs** in the 12 areas featured in the Checklist and 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.

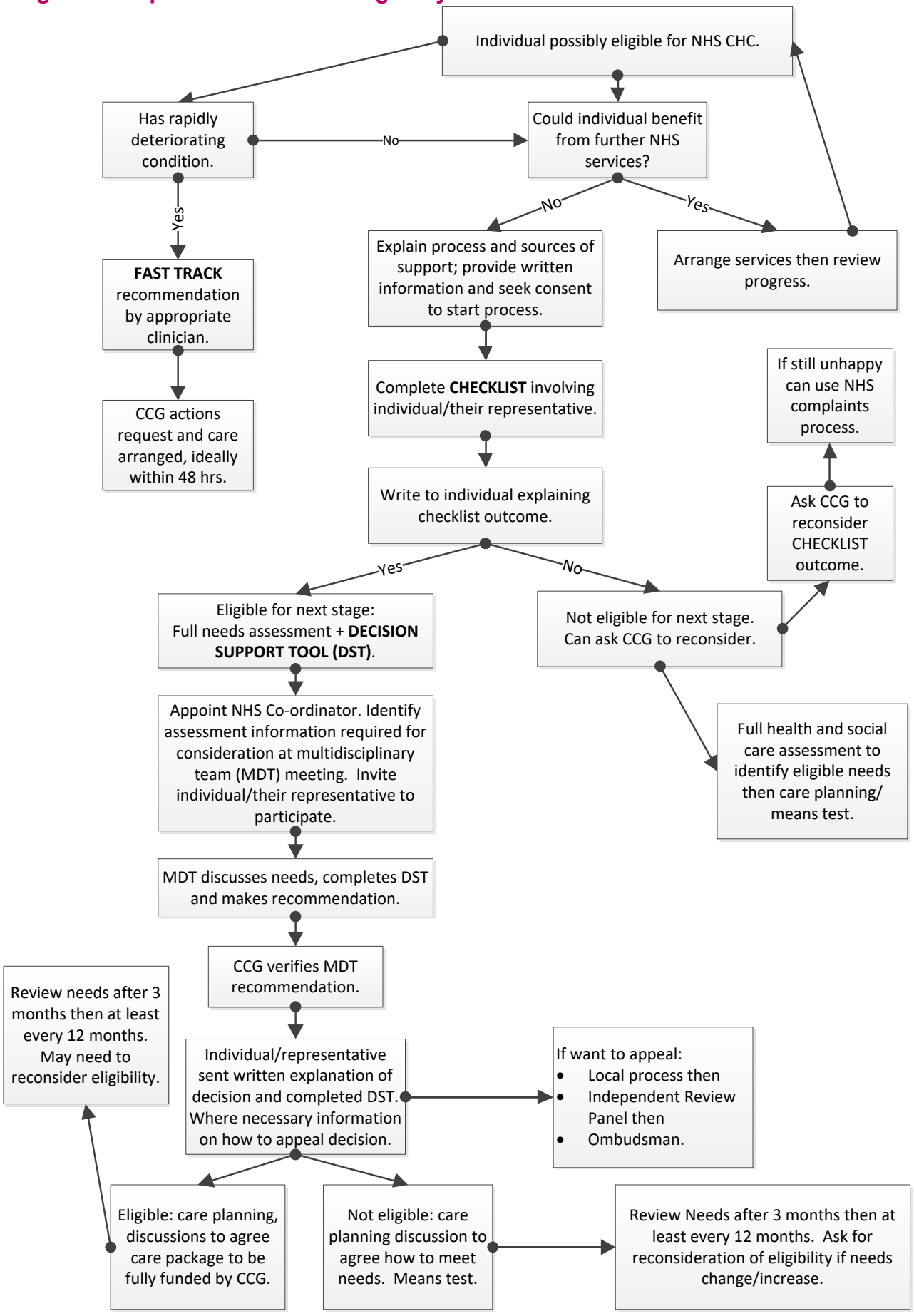
Intensity - relates to the severity of your needs, how frequently and to what extent they vary, and the resulting level of support required.

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 a LA's responsibilities.

Stages in the process to decide eligibility for NHS CHC



3.4 Who decides NHS CHC eligibility and funds your care?

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

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

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) uses assessment information to complete **DST** that informs their eligibility r*ecommendation* to the CCG.
- CCG makes the final eligibility *decision* but only in exceptional circumstances should it not follow the MDT recommendation.

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

3.6 Getting an assessment

CCGs, with their LA(s), should agree 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 need for NHS CHC at this time, there is no need to complete the Checklist. Staff should record their decision not to complete one, with reasons. (Framework para 91). If there is doubt between practitioners, they should complete the Checklist.

You can also approach the CCG NHS CHC co-ordinator explaining why you believe it appropriate to complete the Checklist. See PG14.

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 see your needs, how they affect you and how they might be managed. You can ask a family member or representative to support you or enquire about access to local advocacy services. You should have reasonable notice of key events, such as dates to complete the Checklist or DST, so your representative can arrange to 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 70 of the Framework states the term '*representative*' is intended to include any friend, unpaid carer or family member who is supporting you in the process as well as anyone acting in a more formal capacity (for example, a welfare deputy, an attorney or an organisation representing the individual).

4.2 Seeking consent to the assessment process

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

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

4.3 Consent and mental capacity

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

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

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

You are considered unable to make the decision if the answer to these questions is '*yes*' and you cannot do one or more of the following:

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

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

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

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

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

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

4.4 Confidentiality and sharing information

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

Sharing information in the absence of formal authority

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

- any decision to share information must be in your '*best interests*'
- only share information necessary for them to act in your '*best interests'*.

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

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

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

5 Process for reaching an eligibility decision

The Covid-19 epidemic affected the management of NHS CHC assessments. To help get through the backlog as rapidly as possible, CCGs and Local Authorities may align CHC and social care assessments, and share information as and when necessary.

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 of your 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?

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. Local CCGs and LAs identify who can complete it. Staff should seek your consent to complete it and normally offer you, and if you wish a representative, the opportunity to participate.

Applying the Checklist as part of hospital discharge

The onset of Covid-19 pandemic resulted in *new guidance on hospital discharge* and changes to the management of NHS CHC assessments. Guidance in place from 19 March meant staff were not required to carry out NHS CHC assessments in any setting until further notice.

Discharge between 19 March and 31 August 2020

During this time, if staff believed you may be eligible for NHS CHC, they made a local record of this decision, so they could contact you once NHS CHC assessments restarted. In some areas, they simply recorded you may be eligible; in others they completed a Checklist and recorded the positive decision.

Reintroduction of NHS Continuing Healthcare (CHC): guidance, issued 21 August, says NHS CHC assessments can resume from 1 September. Local staff should contact you to explain their programme for managing assessments, now restrictions are lifted. If you had a positive Checklist on discharge, staff can complete a new Checklist to assess your current needs, before agreeing to conduct a full assessment.

If your care on discharge was, and is still, funded by emergency Covid money, this should not be withdrawn until staff carry out NHS CHC or other assessments to establish your ongoing funding arrangements.

Discharge on or after 1 September 2020

From 1 September, NHS CHC guidance (21 August) and associated *Hospital discharge services: policy and operating model: guidance* apply if you are ready for discharge. If you need new care and support, including support to maximise your recovery, you should receive NHS funding in an appropriate community setting, and staff should aim to complete required assessments - including NHS CHC assessments and Care Act assessments - and decide how ongoing care will be paid for, within six weeks. If not completed within the six weeks, your care should be funded until it is.

Applying the Checklist if you live in a care home

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

Requests for assessment made from 1 September may be delayed as NHS staff manage the backlog of requests, on hold from 19 March, due to Covid-19 restrictions.

Applying the Checklist if you live in your own home

NHS or social care staff should contact their CCG 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.

Requests for assessment made from 1 September may be delayed as NHS staff manage the backlog of requests, on hold from 19 March, due to Covid-19 restrictions.

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 CCG on your behalf. Alternatively, contact the CCG CHC co-ordinator to explain why you think a Checklist is necessary.

Completing the Checklist Tool

The Checklist Tool and DST use the same **12 '*domains*' or '*areas of need*'** (see section 5.3).

The Checklist has three columns for each domain – 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 142-146 and PG23. The Checklist aims to be relatively straightforward and quick to complete but staff must have evidence to back up their choices.

Checklist outcome

You require a full assessment if the Checklist shows:

- two or more domains rated as **high,** or
- five or more domains rated as **moderate, or**
- one domain rated as **high** and four rated as **moderate,** or
- **high** in one of four DST domains with a priority level of need and any level of need in other domains.

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

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

A positive Checklist

A positive Checklist means you require a full assessment and should be referred to your CCG. **In most cases, it should take no more than 28 calendar days from the date the CCG receives a positive Checklist to reaching an eligibility decision**. CCG staff should tell you and your representative if it is likely to take longer. This timeline may be affected by Covid-19 pandemic-related effects on how NHS is able to operate.

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 found to be eligible and the CCG unnecessarily takes longer than 28 days to reach its decision, you can apply for reimbursement of services paid for beyond the 28 days. See *National Framework, Annex E* and in relation to effect of Covid-19 *2020 Reintroduction of NHS continuing healthcare: guidance.*

A negative Checklist

A negative Checklist indicates you do not need a full assessment and are not eligible for NHS CHC. The CCG should send you a written explanation of the decision, explaining your right to ask them to reconsider it. When reconsidering, the CCG must take account of additional information you or your representative provides. You should receive a written response explaining the right to use NHS complaints procedure, if dissatisfied with their final decision. See factsheet 66, *Resolving problems and making a complaint about NHS care*.

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

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

5.2 Undertake a full multi-disciplinary needs assessment

In line with changes to the NHS CHC process due to Covid-19, the CCG appoints a case co-ordinator or Trusted Assessor on receiving a positive Checklist. They ensure you and your representative understand the process, participate as much as you can and want to, and keep you informed until there is an eligibility decision.

They also gather up-to-date information about your physical, mental health and social care needs, inviting contributions from relevant health and social care professionals, including staff caring for you and those with direct knowledge of your needs but not currently caring for you. Each should consider your views, and prepare a report supporting their statements and observations, and findings from risk assessments.

Alzheimer's Society produces a guide to help NHS CHC assessors evaluate emotional and other needs of people in later stages of dementia.

5.3 Complete the Decision Support Tool (DST)

It is helpful to familiarise yourself with the DST. It has 12 '*domains*' or areas of need that 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.

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

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

The co-ordinator selects a multi-disciplinary team (MDT) and invites you or a representative to take part in a meeting. In the light of Covid-19 restrictions and if feasible for you, they may propose a video conference, during which they complete the DST. They should give reasonable notice of the date, so your representative can arrange to participate if they wish.

At the meeting, all parties have access to assessment reports and evidence you submit on the day. MDT use their professional judgement to complete the DST, which informs their *recommendation* to the CCG.

Your and your representative's role at MDT meeting

The co-ordinator should explain the meeting format and identify support you or your representative need to be fully involved. 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 125).

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

Multidisciplinary team (MDT)

The Framework defines an MDT as:

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

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

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

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

Completing the DST

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

When completing the DST, an MDT should:

- complete all domains
- use assessment evidence and professional judgement to select the level most closely describing your needs
- choose the higher level and record any evidence or disagreements if they cannot decide or agree the level
- consider interactions between needs and not marginalise needs because they are successfully managed. Well-managed needs are still needs, and should be recorded appropriately (DST para 27 - 28)
- 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 CCG is aware of your views when making its final decision.

5.4 Reaching a decision

MDT recommendation to the CCG

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 domain 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.

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

this may also, depending on the combination of needs and your overall needs, indicate a primary health need. 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.

The CCG's decision

A CCG is usually expected to respond to MDT's recommendation within two working days and only in exceptional circumstances go against it. There may be gaps in supporting evidence, or an obvious mismatch between evidence and recommendation, which CCG may want to pursue with MDT. (see PG 39).

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

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

Use of a panel

Panels are not a required part of the decision-making process. CCGs can use them to ensure consistency and quality of decision-making, but they should not play a financial gate-keeper role. If the CCG and LA disagree about your eligibility, they may use a panel as part of their local dispute resolution process.

If a person dies while waiting for an eligibility decision

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

5.5 Joint package of health and social care

The CCG may decide you are not eligible for NHS CHC but because some of your needs are beyond the powers of a LA to meet on its own, the CCG is responsible for some of your care. In this case, the LA and CCG must agree their respective responsibilities for a joint package of health and social care; tell you who will lead in agreeing, managing and reviewing your care plan and whether the CCG contribution affects how much you pay towards the social care element of the package, which is subject to a mean-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 ask about local advocacy services.

6.1 If you lack capacity to consent to a care plan

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

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

An IMCA aims find out your views, wishes and feelings by talking to you, people close to you and professionals who know you. Staff must use an IMCA report to help reach a best interests decision and an IMCA can challenge a decision if it appears not to be in your best interests. An IMCA must be involved in 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.*

6.2 Your care package and options

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

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

If the CCG 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 CCG.

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

Care home

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

- **CCG has block contracts with several care homes in an area**. There may be reasons, based on your assessed needs, why a CCG should consider more expensive homes or accommodation than it usually does. Examples include a recognised link between feeling confined in a small room and displaying behaviour that challenges those caring for you.
- **It may be appropriate to move to a home closer to relatives who live in a different CCG area**. You cannot assume reasons you give will be accepted. If the CCG agrees you can live in a care home in another CCG area, they remain responsible for your care home fees.
- **Your current care home cannot meet your assessed needs.** You need to discuss your options with the CCG.
- **Your current care home can meet your NHS CHC needs but is more expensive than the CCG normally pays to meet similar needs**. This can arise if you 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*', NHS legislation does not.

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

  Framework discusses paying for higher cost services in paras 279 – 290.

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 CCG must fund and, if asked, arrange a package to meet your identified health and personal care needs but 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 CCG should aim to arrange services to maintain a similar package of care and replicate as far as possible, the personalisation and control of Direct Payments.

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

Family member provides care as a part of your care package

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

In particular, the CCG may need to provide additional support to care for you whilst 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, 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*.

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

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

6.3 Personal Health Budgets and NHS CHC

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

What is a personal health budget?

A PHB is an amount of money you can spend to support your identified health and wellbeing needs and goals. It is not new money but can mean spending this money in a way that better suits you. It cannot be used simply to pay care home fees.

It is expected all who choose to have a care package at home will have a PHB. If you do not, contact your NHS CHC 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 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 CCG holds the money, but you are actively involved in choosing who delivers your care and support
- a third party arrangement - an organisation such as a trust, holds the money and, 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 nominee or representative acting on your behalf.

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

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

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

If you are refused a direct payment, are asked to pay back any money, or the CCG wants to bring the arrangement to an end, you are entitled to a review of the decision and if unsuccessful, you can use the NHS complaints procedure to try to resolve the problem.

Note
For more about PHBs see www.nhs.uk/using-the-nhs/help-with-health-costs/what-is-a-personal-health-budget/.

6.4 If unhappy with your NHS CHC care package

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

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

7 Using the Fast Track Tool

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

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

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

Staff caring for you in any setting who believe you have needs for which the fast track pathway may be appropriate should contact an '*appropriate clinician*' and ask them to consider completing the Fast Track tool.

An '*appropriate clinician*' is a doctor or nurse knowledgeable about your health needs, diagnosis, treatment or care and able to provide an assessment of why you meet fast track criteria.

The CCG should accept 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 CCG should not impose strict limits basing eligibility on a specified, expected length of life remaining.

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

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

Exceptionally, there may be circumstances where a CCG does not believe the form, as completed, meets '*fast track*' criteria. In this case CCG 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 this, there may be situations where it is appropriate to review your NHS CHC eligibility.

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

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

8 NHS Continuing Healthcare reviews

The Covid-19 pandemic related backlog may affect the review timelines described below, but always get in touch with your named contact if you believe your care plan no longer meets your needs.

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

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 being a reduction in their actual day-to-day care needs.

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

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

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

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

You 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 CCG decision

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

9.2 Review process

Covid-19 pandemic related issues may affect how the NHS manages this process. Video conference meetings may be an option for all parties.

There are two stages in the review process:

- a ***Local Review*** (***LR***) managed by the CCG, 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 only helps if you are dissatisfied with the CCG's '*primary health need*' decision or the procedure the CCG followed to reach the eligibility decision, including application of eligibility criteria.

Local Review stage

Each CCG should publish a local review process with timescales, that is fair and transparent, and takes 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 CCG 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 CCG representative with authority to decide what the next steps should be and allow you to explain why you are still dissatisfied. It should result in a written record of the meeting for both parties, including the agreed next steps.
- following this meeting and outcome of next steps, CCG 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 review to ask NHSE, in writing, for an independent review.

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

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

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

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

Independent Review Panel recommendation

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

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

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

10 Effect on benefits of NHS CHC funding

Disability benefits

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

If you receive NHS CHC in a *nursing* home, AA and both components of DLA and PIP are suspended after 28 days from when CCG 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 CCG 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.

State Pension and Pension Credit

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

11 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 will ask if you would like a *Care Act 2014* assessment, to identify your ongoing social care needs. Subject to meeting national 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.

12 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 CCG Continuing Healthcare manager. If seeking a review in respect of a deceased relative, the CCG may require evidence to prove you are entitled to any money that may be forthcoming. They could ask to see the Grant of Probate or Letters of Administration.

13 Refunds if NHS should have paid for your care

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

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

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

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

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

As a self-funder, the CCG should make an ex-gratia payment to restore your finances to the state they would be in, had the delay not occurred and to remedy any injustice arising from the delay.

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

if your assessment was put on hold due to Covid-19, and you are subsequently found eligible for NHS CHC, *2020 Reintroduction of NHS CHC* refers to 2018 *National Framework* Annex E.

Refunds following a revised decision

If a CCG revises its initial decision, it should reimburse to the LA, any care costs the LA incurred, starting from the date of CCG's initial decision (or earlier if unjustifiable delay occurred) until 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 CCG 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 reached correct decision at the outset.

Refunds following a retrospective review

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

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

14 NHS-funded nursing care

NHS-funded nursing care (NHS-FNC) is a fixed rate payment made directly to a nursing home by its local CCG, 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 CCG area to one in another CCG area, the new CCG 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 found 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 best 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 year starting 1 April 2021.

If you moved into a nursing home on or after 1 October 2007, you are on the single band of nursing care, the weekly rate is £187.60.

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 £258.08.

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 *2018 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 a CCG 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 53).

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 and publishes 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 may affect eligibility for disability benefits such as AA, DLA or PIP, seek advice if you are affected.

14.3 Review of NHS-funded nursing care needs

The Covid-19 related backlog of assessments may affect these review timelines but *2018 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, and 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 CCGs should consider paying a retainer to help safeguard residents' nursing home place while they are in hospital.

If you go into a nursing home on a temporary basis for a period of less than six weeks, you qualify for a NHS-funded nursing care payment.

There is no need for a nursing needs assessment if the stay is for less than six weeks and you have already been assessed for nursing care in the community. This may apply if you have a trial period in a home or are admitted for respite care or in an emergency because your carer is ill.

Useful organisations

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

Offers free and paid for services, including up to 90 minutes of 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

Provides advice or information about claims for Disability Living Allowance, Personal Independence Payment or Attendance Allowance

- **Attendance Allowance (AA)**
  Telephone 0800 731 0122
- **Disability Living Allowance (DLA)**

  If you were born on or before 8 April 1948
  Telephone 0800 731 0122

  If you were born after 8 April 1948
  Telephone 0800 121 4600
- **Personal Independence Payment helpline**
  Telephone 0800 121 4433

Local Healthwatch
www.healthwatch.co.uk
Telephone 03000 683 000

Can signpost to the local NHS independent advocacy service.

Office of the Public Guardian
www.gov.uk/government/organisations/office-of-the-public-guardian
Telephone 0300 456 0300

Supports and promotes decision-making for those who lack capacity or would like to plan for their future under the *Mental Capacity Act 2005*.

Parliamentary and Health Service Ombudsman
www.ombudsman.org.uk
Telephone 0345 015 4033

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

Age UK

Age UK provides advice and information for people in later life through our Age UK Advice line, publications and online. Call Age UK Advice 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 4498

In Northern Ireland contact

Age NI
www.ageni.org
0808 808 7575

In Scotland contact

Age Scotland
www.agescotland.org.uk
0800 124 4222

Support our work

We rely on donations from our supporters to provide our guides and factsheets for free. If you would like to help us continue to provide vital services, support, information and advice, please make a donation today by visiting www.ageuk.org.uk/donate or by calling 0800 169 87 87.

Our publications are available in large print and audio formats

Next update October 2021

The evidence sources used to create this factsheet are available on request. Contact *resources@ageuk.org.uk*