Department of Health & Social Care

Public Guidance: NHS Continuing Healthcare and NHS-funded Nursing Care

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Supporting the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

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Introduction

This guidance is for people who may be in need of ongoing care and support from health and social care professionals as a result of disability, accident or illness. It explains the process used to determine whether someone is eligible for NHS Continuing Healthcare (often referred to as NHS CHC, or just CHC).

We recognise that the funding arrangements for ongoing care can be complex and highly sensitive, and often affect people at a very uncertain stage of their lives. National guidance exists to ensure that everyone has fair and consistent access to NHS Continuing Healthcare, regardless of where they live in England. This guidance, which is called the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care (the National Framework), sets out how eligibility for NHS Continuing Healthcare is determined and how needs should be assessed and addressed.

The National Framework was first introduced in 2007 and most recently updated in 2018. None of the 2018 amendments and clarifications to the National Framework are intended to change the eligibility criteria for, or access to, NHS Continuing Healthcare. This guidance takes into consideration the changes made in the 2018 update of the National Framework.

Common Acronyms

CHC (or NHS CHC) = NHS Continuing Healthcare

DST = Decision Support Tool

FNC = NHS-funded Nursing Care

CCG = Clinical Commissioning Group

MDT = Multidisciplinary Team

NHS Continuing Healthcare

What is NHS Continuing Healthcare?

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) specifically for the relatively small number of individuals (with high levels of need) who are found to have a 'primary health need' (see more in Primary Health Need section below). 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 Continuing Healthcare is free, unlike support provided by local authorities, which may involve the individual making a financial contribution depending on income and savings. It is the responsibility of the Clinical Commissioning Group (CCG) to decide the appropriate package of support for someone who is eligible for NHS Continuing Healthcare.

Who is eligible for NHS Continuing Healthcare?

People over 18 years of age who have been assessed as having a 'primary health need' are entitled to NHS Continuing Healthcare. Eligibility for NHS Continuing Healthcare is not dependent on a particular disease, diagnosis or condition, nor on who provides the care or where that care is provided.

How do you become eligible for NHS Continuing Healthcare?

There is a screening process with a Checklist followed by a full assessment of eligibility which help determine whether or not someone is eligible for NHS Continuing Healthcare. More information on these processes can be found later on in this guidance.

Where can you receive NHS Continuing Healthcare?

You can receive NHS Continuing Healthcare in any setting (apart from acute hospitals) – including in your own home or in a care home. If you are found to be eligible for NHS Continuing Healthcare in your own home, the NHS will pay for your package of care and support to meet your assessed health and associated social care needs. If you are found to

be eligible for NHS Continuing Healthcare in a care home, the NHS will pay for your care home fees, including board and accommodation.

Will I have to pay for NHS Continuing Healthcare?

No. The NHS care package provided should meet your health and associated social care needs as identified in your care plan. The care plan should set out the services to be funded and/or provided by the NHS. In some circumstances you might wish to purchase additional private care services, but this decision must be voluntary. Any additional services that you choose to purchase should not be meeting the assessed needs for which CCG is responsible.

Does NHS Continuing Healthcare last forever?

Not necessarily. Once eligible for NHS Continuing Healthcare, your care will be funded by the NHS.

You should normally have a review of your care package after three months, and then every twelve months. The focus of these reviews should be on whether your care plan or arrangements remain appropriate to meet your needs.

If your needs have changed to such an extent that theymight impact on your eligibility for NHS Continuing Healthcare, then the CCG may arrange a full reassessment of eligibility. This may mean your funding arrangements change, as eligibility for NHS Continuing Healthcare is based on needs rather than on the condition and/or diagnosis (See more in ‘Reviews’ section below.)

Primary Health Need

The concept of a ‘primary health need’ helps determine which health services it is appropriate for the NHS to provide to meet your needs, and which services local authorities may provide. We recognise that this concept is not straightforward. However, in order to decide whether or not you have a primary health need, there will be an assessment of eligibility which looks at the totality of your relevant needs in relation to four key characteristics:

- **Nature:** This describes the characteristics and type of your needs and the overall effect these needs have on you, including the type of interventions required to manage them.

- **Intensity:** This is the extent and severity of your needs and the support required to meet them, including the need for sustained/ongoing care

- **Complexity:** This is about how your needs present and interact and the level of skill required to monitor the symptoms, treat the condition(s) and/or manage the care.

- **Unpredictability:** This is describes the degree to which your needs fluctuate and thereby create challenges in managing them, including the risks to your health if adequate and timely care is not provided.

If it is decided that you have a primary health need, you will be eligible for NHS Continuing Healthcare.

You can read more about primary health need in the National Framework (paragraphs 54 – 66).

Assessments

Making decisions about who is eligible for NHS Continuing Healthcare

The process of assessment of eligibility and decision-making should be person-centred. This means placing you at the heart of the assessment and care-planning process.

It also means making sure that you have the opportunity to play a full role in the assessment process and receive the support to do this where needed. You could do this by asking a friend or relative to act as your representative and help explain your views.

The full assessment process for NHS Continuing Healthcare usually involves two steps: screening using the Checklist Tool, and a full assessment of eligibility using the Decision Support Tool (see page 12 for information on the Fast Track process).

Screening using the Checklist Tool

The first step in the assessment process for most individuals is screening using the Checklist Tool. The Checklist can be used in a variety of settings to help practitioners identify people who may need a full assessment of eligibility for NHS Continuing Healthcare.

The Checklist does not indicate whether you are eligible for NHS Continuing Healthcare, only whether you require a full assessment of eligibility. It is important to be aware that the majority of people who ‘screen in’ (have a ‘positive Checklist’) are found not to be eligible once the full assessment has been done.

The Checklist threshold has deliberately been set low in order to ensure those who may need an assessment of eligibility for NHS Continuing Healthcare have this opportunity.

When should a Checklist be completed?

Screening for NHS Continuing Healthcare should be at the right time and location for you and when your ongoing needs are known. A Checklist can be completed when you are in hospital or in a community setting.

You should normally be given the opportunity to be present at the completion of the Checklist, together with any representative you may have.

Not everyone will need to have a Checklist completed. There are many situations where it is not necessary to complete a Checklist, particularly when there is no suggestion that you might need NHS Continuing Healthcare or where you are recovering from a short-term illness and your longer-term needs are not yet clear.

Checklist outcomes

There are two potential outcomes following completion of the Checklist:

• a **negative** Checklist, meaning you do not require a full assessment of eligibility, and you are not eligible for NHS Continuing Healthcare; or

• a **positive** Checklist meaning you now require a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean you are eligible for NHS Continuing Healthcare.

Next steps following a negative Checklist

A negative Checklist means you do not require a full assessment of eligibility and therefore you are not eligible for NHS Continuing Healthcare.

If you believe this Checklist outcome is inaccurate, then you can ask the CCG to reconsider the outcome.

Next steps following a positive Checklist

A positive Checklist means that you require a full assessment of eligibility for NHS Continuing Healthcare.

Your CCG will arrange for this full assessment to take place. Having a positive Checklist does not necessarily mean you will be found eligible for NHS Continuing Healthcare.

The full assessment of eligibility for NHS Continuing Healthcare

For the full assessment of eligibility, a multidisciplinary team of professionals (usually referred to as the MDT) will assess whether or not you have a primary health need using the Decision Support Tool, (often referred to as the DST).

An MDT is made up of two or more professionals, and will usually include both health and social care professionals who are knowledgeable about your health and social care needs, and, where possible, have recently been involved in your assessment, treatment or care

The CCG is responsible for identifying someone to co-ordinate the assessment process and this person should be your main point of contact.

The assessment will, with your permission, involve contributions from a range of professionals involved in your care to build an overall picture of your needs. This is known as an ‘assessment of needs’. Your own views should be given appropriate weight alongside professional views to help achieve an accurate picture of your needs. The multidisciplinary team will then use the information from your assessment of needs to complete a ‘Decision Support Tool’. Whilst the multidisciplinary team will normally meet ‘face to face’ it may sometimes involve contributions from people using technology if they cannot be there in person.

Assessment of Eligibility for NHS Continuing Healthcare using the Decision Support Tool

Eligibility for NHS CHC is based on your needs, not on your diagnosis or condition. The Decision Support Tool collates and presents the information from your assessment of needs in a way that assists consistent decision-making regarding NHS Continuing Healthcare eligibility. The Decision Support Tool brings together and records your various needs in 12 ‘care domains’, which are broken down into a number of levels.

The purpose of the tool is to help the multidisciplinary team assess the nature, complexity, intensity and unpredictability of your needs – and so recommend whether or not you have a ‘primary health need’.

The multidisciplinary team will then make a recommendation to the CCG as to whether or not you have a primary health need, which will determine your eligibility for NHS Continuing Healthcare. The CCG should usually accept this recommendation, except in exceptional circumstances and with clearly articulated reasons for their decision.

Notification of the eligibility decision for NHS Continuing Healthcare

The eligibility decision regarding NHS Continuing Healthcare should normally be made within 28 calendar days from the date the CCG received notification that you needed a full assessment of eligibility (normally through a positive Checklist), though in some situations it will take longer than 28 days for a decision to be made. The CCG should then inform you in writing as soon as they can, giving clear reasons for their decision on whether or not you are eligible. They should also explain your right to request a review of the decision.

Fast Track Pathway Tool

If you have a rapidly deteriorating condition which may be entering a terminal phase, then you may require ‘fast tracking’ to receive urgent access to NHS Continuing Healthcare.

In the Fast Track Pathway there is no requirement to complete a Checklist or the Decision Support Tool. Instead, an appropriate clinician will complete the Fast Track Pathway Tool to establish your eligibility for NHS Continuing Healthcare.

This clinician will send the completed Fast Track Pathway Tool directly to your CCG, which should arrange for a care package to be provided for you, normally within 48 hours from receipt of the completed Fast Track Pathway Tool.

Your CCG should review your care needs and the effectiveness of your care package. There may be some instances where it becomes appropriate to reassess your eligibility for NHS Continuing Healthcare using the Decision Support Tool. If this is necessary, your CCG will carefully explain the process, as detailed in the ‘Assessments’ section above (page 8).

Next Steps

What if you are not eligible for NHS Continuing Healthcare?

If you are not eligible for NHS Continuing Healthcare, the CCG can (with your permission) refer you to your local authority who can discuss with you whether you may be eligible for support from them. If you are not eligible for NHS Continuing Healthcare but still have some health needs, then the NHS may still pay for part of your package of support. This is known as a 'joint package of care'. One way in which this is provided is through NHS-funded Nursing Care (see 'NHS-Funded Nursing Care' section below). The NHS might also provide other funding or services to help meet your needs.

If the local authority is involved in funding some of your care package then, depending upon your income and savings, you may have to pay them a contribution towards the costs of that part of your care package. There is no charge for the NHS elements of a joint package of care.

Whether or not you are eligible for NHS continuing healthcare, you are still entitled to make use of all of the other services from the NHS in your area in the same way as any other NHS patient.

Please see the 'Individual Requests for a Review of an Eligibility Decision' section below for more information on your rights if you are dissatisfied with the outcome of your eligibility decision.

Services provided if you are entitled to NHS Continuing Healthcare

If you are eligible for NHS Continuing Healthcare, your CCG will be responsible for your care planning, commissioning services and your case management. The CCG will discuss options with you as to how your care and support needs will be best provided for and managed.

When deciding on how your needs will be met, your wishes and preferred outcomes should be given due regard. This should include discussions about your preferred setting in which

to receive care (e.g. at home or in a care home) as well as how your needs will be met and by who.

The NHS care package provided should meet your assessed health and associated social care needs, as identified in your care plan.

Reviews

You should normally have a review of your care package within three months of a positive eligibility decision being made. After this you should have further reviews on at least an annual basis.

The focus of these reviews should be on whether your care plan or arrangements remain appropriate to meet your needs. Any adjustment to your care plan will be made accordingly.

The most recently completed Decision Support Tool will normally be available at the review and is used as a point of reference to identify any potential change in needs.

If your needs have changed to such an extent that they may impact on your eligibility for NHS Continuing Healthcare, then the CCG may arrange a full reassessment of eligibility, in line with the process outlined in the Assessments section above.

Neither the NHS nor the local authority should withdraw from an existing care or funding arrangement without a joint reassessment of your needs, and without first consulting with one another, and with you, about any proposed change in arrangement, as well as ensuring that alternative funding or services are put into effect.

Individual Requests for a Review of an Eligibility Decision

If you disagree with a decision not to proceed to full assessment of eligibility for NHS Continuing Healthcare following screening using the Checklist, you can ask the CCG to reconsider the decision.

If you disagree with the eligibility decision made by the CCG (after a full assessment of eligibility including the completion of the Decision Support Tool), or if you have concerns about the procedure followed by the CCG to reach its eligibility decision, you can ask the CCG to review your case through its local resolution process.

Where it has not been possible to resolve the matter through the local resolution process, you can apply to NHS England for an independent review of the decision.
NHS England can consider asking the CCG to attempt further local resolution prior to the independent review.

Following an independent review, if the original decision is upheld but you remain dissatisfied, you have the right to make a complaint to the Parliamentary and Health Service Ombudsman.

Any individual has a right to complain about any aspect of the service they receive from the NHS, the local authority or any provider of care. The details of the complaints procedure are available from the relevant organisation.

NHS-funded Nursing Care

For individuals in care homes with nursing, registered nurses are usually employed by the care home itself. In order to fund the provision of such nursing care by a registered nurse, the NHS makes a payment direct to the care home. This is called 'NHS-funded Nursing Care' and is a standard rate contribution towards the cost of providing registered nursing care for those individuals who are eligible. Local authorities are not permitted to provide or fund registered nursing care (except in very limited circumstances).

Registered nursing care can involve many different aspects of care. It can include direct nursing tasks as well as the planning, supervision and monitoring of nursing and healthcare tasks to meet your needs.

Determining Eligibility for NHS-funded Nursing Care

Your eligibility for NHS Continuing Healthcare should always be considered before a decision is reached about your need for NHS-funded Nursing Care.

You are eligible for NHS-Funded Nursing Care if:

- you do not qualify for NHS Continuing Healthcare but have been assessed as requiring the services of a registered nurse and it is determined that your overall needs would be most appropriately met in a care home with nursing; and

- you are resident within a care home that is registered to provide nursing care.

Assessment for NHS-funded Nursing Care

You may not need to have a separate assessment for NHS-funded Nursing Care if you have already had a full multidisciplinary assessment of eligibility for NHS Continuing Healthcare, as in most cases this process will give sufficient information for the CCG to decide on the need for NHS-Funded Nursing Care.

If necessary, your CCG can arrange for an assessment to help determine whether you are eligible for NHS-funded Nursing Care. This decision could be based on a nursing needs assessment which specifies your day-to-day care and support needs. People who do not

require a full assessment of eligibility for NHS Continuing Healthcare can still be eligible for NHS-funded Nursing Care.

The NHS-funded Nursing Care rate

Since 2007, NHS-funded Nursing Care has been based on a single-band rate. This rate is the contribution provided by the NHS to support the provision of nursing care by a registered nurse, as set out above. If you are eligible for NHS-funded Nursing Care your CCG will arrange for a payment at the nationally agreed rate to be made directly to your care home. The balance of the care home fee will then be paid by yourself, your representative or your local authority (or a combination of these) unless other contracting arrangements have been made.

NHS-funded Nursing Care reviews

Reviews of your need for NHS-funded Nursing Care will usually be undertaken after 3 months, then at least annually. At these reviews consideration will also be given as to whether your needs have changed such that you are either no longer eligible for NHS-funded Nursing Care or that you might now be eligible for NHS Continuing Healthcare. In order to decide whether you might now be eligible for NHS Continuing Healthcare, a Checklist will normally be completed at the NHS-funded Nursing Care review. However, where a Checklist and/or Decision Support Tool have previously been completed and it is clear that there has been no material change in your needs then it should not be necessary to repeat the Checklist or the Decision Support Tool.

Dissatisfaction with the NHS-funded Nursing Care decision

If you are not happy with the decision regarding NHS-funded Nursing Care, you can ask the CCG for the decision to be reviewed and/or use the CCG complaints process.