NHS Continuing Healthcare and NHS-funded nursing care

July 2024

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The NHS-funded nursing care single band rate for the year starting 1 April 2024 is £235.88 a week. If you moved into a nursing home before 1 October 2007 and are on the high band, it is £324.50 a week.

December 2023 The Department of Health and Social Care published guidance:

. This looks at whether people should have received NHS CHC for past periods of care.

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

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

- ongoing care package involving free

3.1

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

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

Sections 3.2 and 3.5 describe the process staff must follow to reach a decision. ‘ ’ is explained in section 3.3.

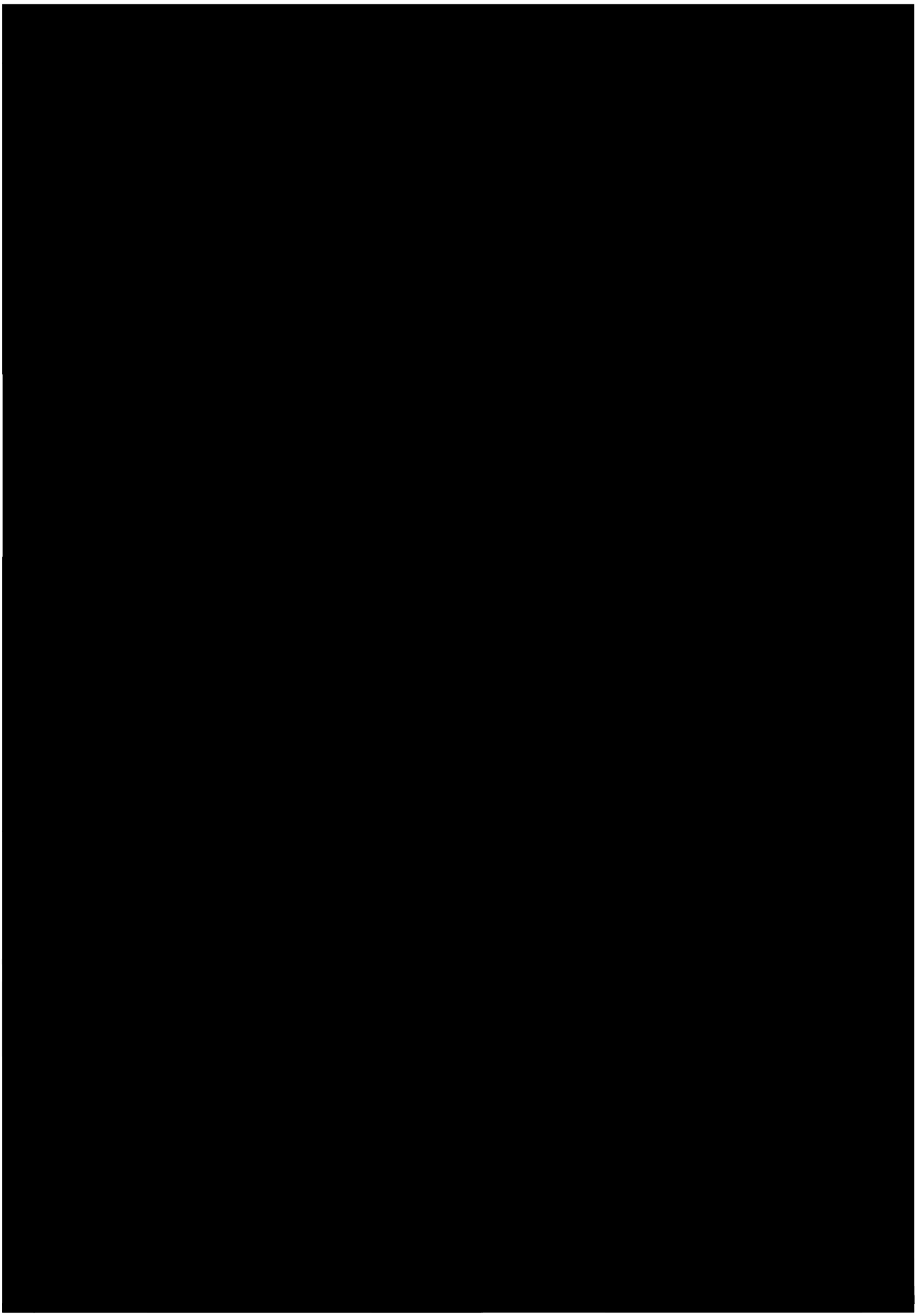
3.2

The - applies in England. It contains:

the eligibility criteria, principles and processes staff must follow when deciding eligibility for NHS Continuing Healthcare. See sections 4, 5, and 7

the tools staff must use and complete to support decision-making –

3.3



3.4

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

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

They must explain that refusing consent may affect the ability to meet your needs. If you later agree to an LA assessment, the LA cannot take responsibility for meeting needs found to be an NHS responsibility.

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4.3

From the outset, staff must take all practical steps to help you make decisions for yourself.

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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 for the purposes of NHS CHC assessment.

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5.1

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. As per section 3.6, there is no need to complete a Checklist if staff agree there is no evidence that you have a need for NHS CHC at that time.

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 t

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

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

See factsheet 66,
for more information about making a complaint.

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

5.2

On receiving a positive Checklist, the ICB appoints a case co-ordinator who is responsible until a decision on funding is made. They should ensure you and your representative understand the process, participate as much as you can and want to, and keep you informed at each stage.

The case co-ordinator identifies and secures the involvement of the multidisciplinary team (MDT) who will complete the DST.

The Framework defines an MDT as comprising of at least:

two professionals from different health professions, or

one professional from a healthcare profession and one responsible for assessing individuals for community care services.

As a minimum, it can be two professionals from different healthcare professions. It should usually include health and social care professionals, knowledgeable about your health and social care needs and where possible, recently involved in your assessment, treatment or care.

If the ICB consults the local authority, it should provide advice and assistance and not allow your financial circumstances to affect its participation.

The Framework does not exclude the case co-ordinator from being an MDT member, but they should be clear about their two different functions.

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, ‘

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

When completing the DST, an MDT should:

complete all domains with information about your care needs

use assessment evidence and professional judgement to select the level most closely describing your needs

choose the higher level and record any evidence or disagreements if they cannot decide or agree the level

consider interactions between needs and not marginalise needs because they are successfully managed. Well-managed needs are still needs, and should be recorded appropriately (DST para 31-32)

consider needs recorded in domain 12 - Other significant care needs.

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

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

5.4

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

The recommendation should refer to all key characteristics, but any characteristic can on its own, or in combination with others, be sufficient to indicate a primary health need.
is usually expected if you have either:

level of need in any domain with priority level (see page 15), or

needs across all care domains.

A primary health need may also be indicated if there is either:

one domain recorded as together with needs in a number of other domains, or

a number of domains with with needs.

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

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

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

and only in exceptional circumstances go against it. In such circumstances, the ICB should refer back to the MDT to address any issues, for example are there gaps in supporting evidence, or an obvious mismatch between evidence and recommendation (see PG 39).

The ICB may share its decision with you verbally but should always confirm in writing, giving clear reasons for the decision and a copy of the completed DST. It should tell you who to contact for clarification and how to request a review of the eligibility decision, if they decide you are not eligible. Someone appointed to act as your representative is entitled to receive a copy of the DST provided the correct basis for sharing such information has been established (see DST para 43).

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

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

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

5.5

The ICB may decide you are not eligible for NHS CHC but because some of your needs are beyond the powers of an LA to meet on its own, the ICB is responsible for some of your care. In this case, the LA and ICB

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

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

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

Your ICB is responsible for meeting the cost of your accommodation and care needs identified in your care plan. If a care home is the preferred or best option,

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.

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

If you want to receive care in Wales, Scotland, or Northern Ireland, regardless of setting, there needs to be discussion between your funding ICB and the relevant health body in your chosen country.

6.2

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

it must make a ‘ ’ 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.

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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,

may be entering a terminal phase

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

Staff caring for you in any setting who believe that your needs are appropriate for the Fast Track pathway should contact an ‘ ’ and ask them to consider completing the Fast Track Tool.

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

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

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

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

Exceptionally, there may be circumstances where a ICB does not believe the form, as completed, meets Fast Track criteria. In this case, the ICB should urgently ask the relevant clinician to clarify the nature of your needs and the reason for the use of the Fast Track Pathway Tool.

If you are fast tracked, it is important to review your care package to make sure it continues to meet your needs. In doing so, there may be situations where it is appropriate to review your NHS CHC eligibility (see paras 266-267 for when it may not be appropriate).

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

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

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Reviews are a normal part of the NHS CHC process. They should be proportionate to the situation and primarily focus on whether the care plan arrangements remain appropriate to meet your needs. In most cases, it is expected there will not be a need to reassess for eligibility (para 203).

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

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

Eligibility should only be reviewed if the ICB can demonstrate there is clear evidence that needs have changed significantly since completing the previous DST. If the ICB believes this, it should arrange for an MDT to complete a u ae

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.

The ICB's original decision remains valid and in place unless, or until, either stage of the review process recommends you should be eligible. You should receive appropriate care while awaiting the outcome of the review.

You may have to contribute towards the cost of your care package during this time, with your financial circumstances affecting who is responsible for arranging and paying for it. If you are responsible for funding some, or all, of it and your appeal is successful, you can claim costs incurred if you provide receipts (See section 10).

9.2

There are two stages in the review process:

a ( ) managed by the ICB, and

an managed by NHS England (NHSE) if unhappy with the local review outcome.

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

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

There should be an attempt to resolve any concerns through meaningful discussion between you or your representative and a ICB representative. You should be able to ask questions to help you understand the decision and provide information not already considered.

If a meeting is required, it should involve a ICB representative with authority to decide what the next steps should be and allow you to explain why you are n h

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

NHSE is responsible for arranging an independent review panel (IRP). They can decide not to convene one on the advice of an independent individual who can chair a panel. It may decide to ask the ICB to attempt further local resolution prior to review. If NHSE decides not to convene an IRP, it should write expl

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

AA and both components of DLA and PIP are suspended after 28 days from when ICB funding begins, or sooner if you were

14.1 -

If staff propose your best option is to move into a nursing home, they must consider your eligibility for NHS CHC and agree that you are not eligible, before considering eligibility for NHS-FNC. If you are found to be not eligible at the Checklist stage, and so did not have a full NHS CHC assessment, you must have a nursing needs assessment to identify your day-to-day nursing care and support needs.

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

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

14.2 -

NHS England reviews NHS-FNC weekly rates annually, usually in April. The following rates apply for the year starting 1 April 2024.

If you moved into a nursing home on or after 1 October 2007, you are on the single band of nursing care and the weekly rate is £235.88. 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 £324.50.

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.

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 - says:

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(para. 59).

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

The Competition and Markets Authority looked at FNC payments in a study into care homes for older people. They publish a guide , see www.gov.uk/government/publications/care-homes-short-guide-to-consumer-rights-for-residents

NHS-funded nursing care payments do not affect eligibility for AA or DLA, if you are self-funding. However, it may affect your PIP award, and you may need to seek further advice if in this situation.

14.3 -

The 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 for NHS CHC decision following a Checklist or full assessment with completion of a DST, and

it is clear there has been no material change in your needs.

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

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

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

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

sets out the principles and processes staff must follow when deciding eligibility for NHS CHC, including the paperwork to be completed.

care home registered to provide nursing care.

: placing the person at the centre of the assessment and planning processes by seeking their views throughout.

guidance to support staff in the delivery of NHS CHC, part of the national framework.

the main aspects or the majority part of the care you need is focused on addressing and/or preventing health needs.

a care home not registered to provide nursing care.

usually paid by a third party where you choose a more expensive care home out of preference not need. This is permissible under social care legislation but not under NHS legislation.

The evidence sources used to create this factsheet are available on request. Contact

This factsheet