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

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Incorporating the NHS Continuing Healthcare Practice Guidance

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October 2018 (revised), published March 2018

The 2018 National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

The revised 2018 National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care. This guidance replaces the previous version of the National Framework, published in November 2012, and will be implemented on 1 October 2018. It includes Practice Guidance to support staff delivering NHS Continuing Healthcare. This revised 2018 National Framework follows an extensive period of external engagement with stakeholders, across the NHS, Local Authorities, and patient representative groups. The 2018 National Framework has been collaboratively written by the Department, NHS-England and Local Authorities.

In addition to the 2018 revision of the National Framework, there is also an update to the Practice Guidance and the annexes which accompany the Framework. The user notes for the Checklist, Decision Support Tool and Fast Track Pathway Tool have been updated, alongside some minor clarifications to the domain wordings and descriptors. The updated National Tools should be used from 1st October 2018 alongside the updated National Framework.

The 2018 National Framework is intended to:

- 1) provide greater clarity to individuals and staff, through a new structure and style
- 2) reflect legislative changes since the 2012 National Framework was published, primarily to reflect the implementation of the Care Act 2014,
- 3) clarify a number of policy areas, including:
 - a) Setting out that the majority of NHS Continuing Healthcare assessments should take place outside of acute hospital settings. This will support accurate assessments of need and reduce unnecessary stays in hospital.
 - b) Providing additional advice for staff on when individuals do and do not need to be screened for NHS Continuing Healthcare in order to reduce unnecessary assessment processes and respond to a call for greater clarity on this.
 - c) Clarifying that the main purpose of three and 12 month reviews is to review the appropriateness of the care package, rather than reassess eligibility. This should reduce unnecessary re-assessments.
 - d) Introducing new principles for CCGs regarding the local resolution process for situations where individuals request a review of an eligibility decision. The aim is to resolve such situations earlier and more consistently.
 - e) Providing clearer guidance, including dedicated sections, on: the roles of CCGs and local authorities, NHS-funded Nursing Care, inter-agency disputes, well-managed needs, and the Fast Track Pathway Tool.

Importantly, none of the 2018 amendments and clarifications to the National Framework, Practice Guidance, annexes or National Tools are intended to change the eligibility criteria for NHS Continuing Healthcare.

All those involved in the delivery of NHS Continuing Healthcare should become familiar with the whole National Framework, Practice Guidance, annexes and National Tools and should align their practice accordingly.

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Executive summary

1. This revised National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care.
2. This guidance replaces the previous version of the National Framework, published in November 2012 and will be implemented on 1 October 2018. It includes Practice Guidance to support staff delivering NHS Continuing Healthcare.
3. At the heart of the National Framework is the process for determining whether an individual is eligible for NHS Continuing Healthcare or NHS-funded Nursing Care.
4. An individual is eligible for NHS Continuing Healthcare if they have a 'primary health need'. This is a concept developed by the Secretary of State to assist in determining when the NHS is responsible for providing for all of the individual's assessed health and associated social care needs.
5. In order to determine whether an individual has a primary health need, a detailed assessment and decision-making process must be followed, as set out in this National Framework. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for commissioning a care package that meets the individual's health and associated social care needs.
6. This National Framework is underpinned by Standing Rules Regulations¹, issued under the National Health Service Act 2006². These regulations, referred to henceforth as the Standing Rules, require Clinical Commissioning Groups (CCGs) to have regard to the National Framework.
7. This revised National Framework takes account of legislative changes brought about by the Care Act 2014³, which preserves the existing boundary and limits of local authority responsibility in relation to the provision of nursing and/or healthcare.
8. The individual, the effect their needs have on them, and the ways in which they would prefer to be supported should be kept at the heart of the process. Access to assessment, care provision and support should be fair, consistent and free from discrimination.

¹ [*The National Health Service Commissioning Board and Clinical Groups \(Responsibilities and Standing Rules\) Regulations 2012*](#)

² [*National Health Service Act 2006*](#)

³ [*Section 22 of the Care Act 2014*](#)

9. CCGs, the National Health Service Commissioning Board (referred to throughout this National Framework as NHS England) and local authorities have legal duties and responsibilities in relation to NHS Continuing Healthcare.
10. Those eligible for NHS Continuing Healthcare continue to be entitled to access the full range of primary, community, secondary and other health services.

Key Definitions

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a 'primary health need' as set out in this National Framework. 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. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS Continuing Healthcare is not determined by the setting in which the package of support can be offered or by the type of service delivery.

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

Primary Health Need is a concept developed by the Secretary of State for Health to assist in deciding when an individual's primary need is for healthcare (which it is appropriate for the NHS to provide under the 2006 Act) rather than social care (which the Local Authority may provide under the Care Act 2014). To determine whether an individual has a primary health need, there is an assessment process, which is detailed in this National Framework. Where an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for providing for all of that individual's assessed health and associated social care needs, including accommodation, if that is part of the overall need.

Clinical Commissioning Group (CCG) is intended to include any person or body authorised by the CCG to exercise any of its functions on its behalf in relation to NHS Continuing Healthcare. Where a CCG delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework. The CCG cannot delegate its final decision-making function in relation to eligibility decisions, and remains legally responsible for all eligibility decisions made (in accordance with Standing Rules).

Introduction

11. This guidance is based on statutory responsibilities, case law, input from the Parliamentary and Health Service Ombudsman, and comments received from stakeholders. It sets out the process for the National Health Service (NHS), working together with its local authority partners wherever practicable, to assess health needs and to decide on eligibility for NHS Continuing Healthcare. It is to be read in conjunction with the national tools to support decision making: the Checklist tool, the Decision Support Tool (DST) and the Fast Track Pathway Tool. Separate notes are attached to the tools themselves to explain how they should be applied.
12. The audience for this National Framework is wide ranging. The primary purpose of this National Framework is to support practitioners across health and social care to undertake assessments and deliver NHS Continuing Healthcare and NHS-funded Nursing Care. The National Framework is also of interest to individuals and their representatives involved in the Continuing Healthcare process. A public information leaflet, entitled 'NHS Continuing Healthcare and NHS-funded Nursing Care' is available from the Gov.uk website⁴.
13. NHS England, CCGs and local authorities must comply with their responsibilities, as set out in the Standing Rules and Care Act legislation⁵, as appropriate, in relation to NHS Continuing Healthcare.
14. **CCGs** should consider how the principles and processes in this guidance relate to what is currently in place, and should align their processes accordingly. They should consider where their responsibilities under the National Framework require clearer arrangements to be made with provider and other relevant organisations, and should ensure that these are built into commissioning processes. NHS England should help facilitate these processes.
15. In addition there is a requirement for **NHS England** to have processes in place to respond to requests for independent reviews of NHS Continuing Healthcare eligibility decisions. Guidance on the operation of these review processes is set out in this National Framework.
16. **Local authorities** should consider this National Framework and review whether their current practice and processes fit with their responsibilities outlined within this National Framework. CCGs and local authorities should work together collaboratively when they review existing processes.

⁴ [NHS Continuing Healthcare website](#)

⁵ [Department of Health and Social Care, The Care and Support \(Provision of Health Services\) Regulations 2014](#)

17. **Provider organisations** should consider this National Framework and review whether their current practice and processes fit with any delegated responsibilities outlined within this National Framework.
18. **Individuals** who need ongoing care or support may require services arranged by CCGs and/or local authorities. CCGs and local authorities should ensure that the assessment of eligibility for care or support and its provision take place in a timely and consistent manner, in accordance with their respective statutory responsibilities.
19. If a person does not qualify for NHS Continuing Healthcare, the NHS may still have a responsibility to contribute to that individual's health needs – either by directly commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both a local authority and a CCG, this is known as a 'joint package of care'.

Leadership and governance

20. The roles and responsibilities of the different bodies involved in NHS Continuing Healthcare are set out below. However, NHS Continuing Healthcare is fundamentally a 'whole system' issue requiring leadership across and within statutory agencies in order to ensure that the needs of individuals who might have a primary health need are properly assessed and addressed. These individuals are, by definition, some of the most vulnerable in our society and it is vital that systems deliver a person-centred approach to the wide variety of situations that NHS Continuing Healthcare encompasses. Strong system leadership is therefore critical to the successful implementation of this National Framework.

Roles and responsibilities of CCGs

21. CCGs are responsible and accountable for system leadership for NHS Continuing Healthcare within their local health and social care economy (refer to paragraphs 40-41), including:
- a) ensuring delivery of, and compliance with, the National Framework for NHS Continuing Healthcare;
 - b) promoting awareness of NHS Continuing Healthcare;
 - c) establishing and maintaining governance arrangements for NHS Continuing Healthcare eligibility processes and commissioning NHS Continuing Healthcare packages.
 - d) ensuring that assessment mechanisms are in place for NHS Continuing Healthcare across relevant care pathways, in partnership with the local authority as appropriate. The Standing Rules require CCGs to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for NHS Continuing Healthcare (the Care and support statutory guidance⁶ should be used to identify the relevant social services authority).
 - e) making decisions on eligibility for NHS Continuing Healthcare;
 - f) identifying and acting on issues arising in the provision of NHS Continuing Healthcare;
 - g) commissioning arrangements, both on a strategic and an individual basis;

⁶ [Department of Health and Social Care, Care and support statutory guidance](#)

- h) having a system in place to record assessments undertaken and their outcomes, and the costs of NHS Continuing Healthcare packages. It is important that any such system should clearly identify those receiving NHS Continuing Healthcare as a distinct group from those being supported via joint packages or any other funding routes;
- i) implementing and maintaining good practice;
- j) ensuring that quality standards are met and sustained;
- k) nominating and making available suitably skilled professionals to be members of Independent review panels (in accordance with Standing Rules¹);
- l) ensuring training and development opportunities are available for practitioners, in partnership with the local authority; and
- m) having clear arrangements in place with other NHS organisations (e.g. Foundation Trusts) and independent or voluntary sector partners to ensure effective operation of the National Framework.

Roles and responsibilities of NHS England

- 22. NHS England's functions include providing strategic leadership and organisational and workforce development, and ensuring that local systems operate effectively and deliver improved performance. NHS England holds CCGs accountable and therefore engages with them to ensure that they discharge their functions. In carrying out this role, NHS England should be aware of the range of responsibilities that CCGs hold in relation to NHS Continuing Healthcare, as detailed in paragraph 21 above.
- 23. NHS England is also responsible for appointing persons to act as chairs of independent review panels (IRPs) and establishing a list of IRP members drawn from local authorities and CCGs, in accordance with Standing Rules.
- 24. In some limited circumstances, NHS England may also have commissioning responsibility for some individuals who are either prisoners, or serving military personnel and their families. Where NHS England does have such responsibility, this National Framework will apply. Where a CCG is referred to throughout the National Framework, the responsibilities will also apply to NHS England in these limited circumstances.

Roles and responsibilities of the local authority

- 25. Where it appears that a person may be eligible for NHS Continuing Healthcare, the local authority must refer the individual to the relevant CCG.
- 26. There are specific requirements for local authorities to cooperate and work in partnership with CCGs in a number of key areas.

27. Local authorities must, as far as is reasonably practicable, provide advice and assistance when consulted by the CCG in relation to an assessment of eligibility for NHS Continuing Healthcare. This duty applies regardless of whether an assessment of needs for care and support under section 9 of the Care Act 2014 is required (refer to paragraphs 124-130). Where the local authority has carried out such an assessment of needs it must (as far as it is relevant) use information from this assessment to assist the CCG in carrying out its responsibilities (refer to paragraph 21).
28. A local authority must, when requested to do so by the CCG, co-operate with the CCG in arranging for a person or persons to participate in a multidisciplinary team. Local authorities should:
 - respond within a reasonable timeframe when consulted by a CCG prior to an eligibility decision being made (refer to paragraph 21)
 - respond within a reasonable timeframe to requests for information when the CCG has received a referral for NHS Continuing Healthcare.
29. It is also good practice for local authorities to work jointly with CCGs in the planning and commissioning of care or support for individuals found eligible for NHS Continuing Healthcare wherever appropriate, sharing expertise and local knowledge (whilst recognising that CCGs retain formal commissioning and care planning responsibility for those eligible for NHS Continuing Healthcare).
30. Regulations⁷ state that local authorities must nominate individuals to be appointed as local authority members of independent review panels where requested to do so by NHS England. This duty includes both nominating such individuals as soon as is reasonably practicable and ensuring that they are, so far as is reasonably practicable, available to participate in independent review panels.

Involvement of provider organisations

31. Provider organisations should consider their general duty of care to individuals, any Care Quality Commission requirements, and any contractual obligations in relation to NHS Continuing Healthcare. In particular they should ensure that individuals who may require a full assessment of eligibility are referred to the CCG, and that accurate records regarding the needs of individuals are made available, as appropriate, in the assessment and review process.

⁷ [Department of Health and Social Care, Regulation 3\(5\) of the Care and Support \(Provision of Health Services\) Regulations 2014](#)

Information available for members of the public about NHS Continuing Healthcare

32. Further information for the public on NHS Continuing Healthcare is available on the Gov.uk website. CCGs should make the Public Information leaflet available to members of the public, for example through local NHS websites, hard copies on hospital wards, through primary care outlets, local care homes and local voluntary sector organisations. Any individual being considered for NHS Continuing Healthcare at the screening or referral stage should be given a copy of the leaflet along with any relevant local information about processes and contact details and arrangements.

Legal context

33. Many people have ongoing care needs as a result of disability, accident or illness. Individuals requiring ongoing support to meet such needs might receive this from a range of sources including from friends and family, from their local authority or from the NHS.
34. Where adults receive care and support from local authorities they normally do so under the provisions of the Care Act 2014, subject to them meeting national eligibility criteria for care and support and usually subject to means testing, which may require them to make a financial contribution towards the cost or to meet the full cost themselves.
35. Where individuals receive care, treatment or support from the NHS this is normally under the provisions of the National Health Service Act 2006, referred to from this point onwards as the NHS Act. This support is provided free at the point of delivery to the individual.
36. These two distinct but overlapping legislative schemes work in parallel to create a system for care, support and treatment for adults in need.
37. Some individuals' nursing or healthcare needs are such that the local authority is not permitted to meet their ongoing care and support needs, and instead they become fully the responsibility of the NHS. These are individuals who have been assessed as having a 'primary health need' through the processes set out in this National Framework and who are eligible for NHS Continuing Healthcare. The limits of local authority provision and the concept of 'primary health need' arise from the interaction between duties and limitations placed on local authorities under the Care Act 2014 and the duties placed on CCGs and NHS England under the NHS Act.

Key legislation

38. Section 1 of the NHS Act requires the Secretary of State to continue the promotion in England of a comprehensive health service, designed to secure improvement in:
 - a) the physical and mental health of the people of England; and
 - b) the prevention, diagnosis and treatment of illness.
39. Section 1H of the NHS Act established the NHS Commissioning Board, known as NHS England, which is also subject to the duty outlined above to promote a comprehensive health service. Under the NHS Act, NHS England is responsible for ensuring that the NHS delivers better outcomes for patients within its available resources by supporting, developing and performance-managing an effective system of CCGs. In addition, NHS England has responsibility for commissioning

services that can only be provided efficiently and effectively at a national or a regional level.

40. Section 3 of the NHS Act requires CCGs to arrange for the provision of the following to the extent that they consider necessary to meet the reasonable requirements of the persons for whom it has responsibility:
- (a) hospital accommodation,
 - (b) other accommodation for the purpose of any service provided under this Act,
 - (c) medical, dental, ophthalmic, nursing and ambulance services,
 - (d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the group considers are appropriate as part of the health service,
 - (e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service,
 - (f) such other services or facilities as are required for the diagnosis and treatment of illness.
41. CCGs must exercise these functions consistently with the duty to promote a comprehensive health service. NHS Continuing Healthcare is provided as part of these functions, and the majority of the CCG's legal responsibilities in this regard are set out in the Standing Rules, in particular in regulations 21 and 22. Regulation 21(12) of the Standing Rules requires CCGs to have regard to this National Framework.
42. Under section 9 of the Care Act 2014, each local authority is under a duty to assess any person who it appears may be in need of care and support. Where a local authority is satisfied, on the basis of their assessment, that the adult has needs for care and support, it must then determine whether any of these needs meet the Care Act 2014 national eligibility criteria⁸. If not, the local authority may still have the power to meet them. If the local authority is required to meet needs or decides to meet them, the local authority must consider how it will do so. The Care Act 2014 replaces previous local authority duties to provide particular services with a duty to meet eligible needs.
43. Section 22 of the Care Act 2014 places a limit on the care and support that can lawfully be provided to individuals by local authorities. That limit is set out in section 22(1) and is as follows:
- 'A local authority may not meet needs under sections 18 to 20 by providing or arranging for the provision of a service or facility that is required to be provided under the National Health Service Act 2006 unless-*

⁸ [Department of Health and Social Care, Regulation 2 and 3 of the Care and Support \(Eligibility Criteria\) Regulations 2015](#)

(a) doing so would be merely incidental or ancillary to doing something else to meet needs under those sections, and

(b) the service or facility in question would be of a nature that the local authority could be expected to provide’.

44. The limit on social care pre-existed the Care Act 2014 and was considered and clarified in 1999 by the Court of Appeal in the Coughlan judgment (refer to Annex B). This judgment considered the responsibilities of health authorities and local authorities for social service provision, in particular the limits on the provision of nursing care (in a broad sense, i.e. not just registered nursing care) by local authorities. The principles from this judgment therefore inform section 22 of the Care Act 2014.
45. Section 22(3) of the Care Act 2014 provides a further limit of the care and support that can be provided by a local authority. This section prohibits local authorities from providing, or arranging for the provision of, nursing care by a registered nurse.
46. When carrying out a needs assessment under section 9 of the Care Act 2014, where it appears that a person may be eligible for NHS Continuing Healthcare the local authority must refer the individual to the relevant CCG (regulation 7 of the Care and Support (Assessment) Regulations 2014). The CCG then has a duty to take reasonable steps to ensure an assessment of eligibility is carried out where it appears there may be a need for such care (regulation 21(2) of the Standing Rules¹).
47. Also, if in the course of undertaking a needs assessment (under the Care Act 2014) the local authority identifies needs which might be met by other agencies (e.g. Housing or the NHS) it should make the necessary referrals to these other agencies.
48. If an NHS body is assessing a person’s needs (whether or not potential eligibility for NHS Continuing Healthcare has been identified) and the assessment indicates a potential need for care and support that may fall within a local authority’s responsibilities, it should notify the local authority of this in order for the local authority to then fulfil its responsibilities.

Health need and social care need

49. Some needs are clearly health needs and some needs are clearly social care needs; and some needs may be either or both. The difference between health needs and social care needs emerging from the legal principles outlined above are set out below.
50. Whilst there is not a legal definition of a health need (in the context of NHS Continuing Healthcare), in general terms it can be said that such a need is one related to the treatment, control, management or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).
51. Similarly, there is not a legal definition of the term 'social care need' in the context of NHS Continuing Healthcare. However, the Care Act 2014 introduced National Eligibility Criteria for care and support to determine when an individual or their carer has eligible needs which the local authority must address, subject to means where appropriate. These criteria set out that an individual has eligible needs under the Care Act 2014 where these needs arise from (or relate to) a physical or mental impairment or illness which results in them being unable to achieve two or more of the following outcomes which is, or is likely to have, a significant impact on their wellbeing:
 - managing and maintaining nutrition;
 - maintaining personal hygiene;
 - managing toilet needs;
 - being appropriately clothed;
 - being able to make use of the home safely;
 - maintaining a habitable home environment;
 - developing and maintaining family or other personal relationships;
 - accessing and engaging in work, training, education or volunteering;
 - making use of necessary facilities or services in the local community, including public transport and recreational facilities or services; and
 - carrying out any caring responsibilities the adult has for a child.
52. In the context of NHS Continuing Healthcare, therefore, a 'social care need' can be taken to relate to the Care Act 2014 eligibility criteria outlined above.

Other legislation

53. There is a range of other legislation which may well be relevant to individuals who are being assessed in relation to NHS Continuing Healthcare, such as the Mental Health Act 1983⁹ and the Mental Capacity Act 2005¹⁰. References are made to other key legislation at appropriate points within this National Framework and statutory bodies will need to consider the broader legislative context when assessing and addressing needs relating to NHS Continuing Healthcare.

⁹ [Mental Health Act 1983](#)

¹⁰ [Mental Capacity Act 2005](#)

Primary health need

54. To assist in determining which health services it is appropriate for the NHS to provide under the NHS Act, and to distinguish between those and the services that local authorities may provide under the Care Act 2014, the Secretary of State has developed the concept of a 'primary health need'. Where a person has been assessed to have a primary health need, they are eligible for NHS Continuing Healthcare and the NHS will be responsible for providing for all of that individual's assessed health and associated social care needs, including accommodation, if that is part of the overall need. Determining whether an individual has a primary health need involves looking at the totality of the relevant needs. In order to determine whether an individual has a primary health need, an assessment of eligibility process must be undertaken by a multidisciplinary team (MDT) (refer to paragraphs 119-123) which must use the national Decision Support Tool (DST) (refer to paragraphs 131-141).
55. An individual has a primary health need if, having taken account of all their needs (following completion of the Decision Support Tool), it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs. Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality.
56. Each individual case has to be considered on its own facts in accordance with the principles outlined in this National Framework.
57. There should be no gap in the provision of care. People should not find themselves in a situation where neither the NHS nor the relevant local authority (subject to the person's means and the person having needs that fall within the eligibility criteria for care and support⁸) will fund care, either separately or together.
58. Therefore, the 'primary health need' test should be applied, so that a decision of ineligibility for NHS Continuing Healthcare is only possible where, taken as a whole, the nursing or other health services required by the individual:
 - a) are no more than incidental or ancillary to the provision of accommodation which local authority social services are, or would be but for a person's means, under a duty to provide; and
 - b) are not of a nature beyond which a local authority whose primary responsibility it is to provide social services could be expected to provide.
59. In applying the primary health need test as set out above CCGs should take into account that section 22(1) of the Care Act 2014, in setting out the limits of Local Authority responsibilities, applies the 'incidental and ancillary' test in all situations, including where care is being provided in the person's own home. As there should

be no gap in the provision of care, CCGs should consider this test when determining eligibility. Eligibility is the same for all individuals, whether their needs are being met in their own home or in care home accommodation. Certain characteristics of need – and their impact on the care required to manage them – may help determine whether the ‘quality’ or ‘quantity’ of care required is more than the limits of a local authority’s responsibilities, as set out in section 22(1) of the Care Act 2014:

- **Nature:** This describes the particular characteristics of an individual’s needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type (‘quality’) of interventions required to manage them.
- **Intensity:** This relates both to the extent (‘quantity’) and severity (‘degree’) of the needs and to the support required to meet them, including the need for sustained/ongoing care (‘continuity’).
- **Complexity:** This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual’s response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.
- **Unpredictability:** This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person’s health if adequate and timely care is not provided. An individual with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

60. Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual’s needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered when completing the DST (refer to paragraphs 131-141).
61. It may be helpful for practitioners to think about these characteristics in terms of the sorts of questions that each generates. Examples of the type of question that might be relevant are given in Practice Guidance note 3 in this National Framework. Answering such questions may help practitioners describe and understand how each characteristic relates to the needs of the individual in question.
62. Eligibility for NHS Continuing Healthcare is a decision to be taken by the relevant CCG, based on an individual’s assessed needs. The diagnosis of a particular disease or condition is not in itself a determinant of eligibility for NHS Continuing Healthcare.

63. NHS Continuing Healthcare may be provided in any setting (including, but not limited to, a care home, hospice or the person's own home). Eligibility for NHS Continuing Healthcare is, therefore, not determined or influenced either by the setting where the care is provided or by the characteristics of the person who delivers the care. The decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs (refer to paragraphs 142-146). Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on NHS Continuing Healthcare eligibility.
64. Financial issues should not be considered as part of the decision on an individual's eligibility for NHS Continuing Healthcare.
65. In summary, the reasons given for a decision on eligibility should not be based on the:
- individual's diagnosis;
 - setting of care;
 - ability of the care provider to manage care;
 - use (or not) of NHS-employed staff to provide care;
 - need for/presence of 'specialist staff' in care delivery;
 - the fact that a need is well-managed;
 - the existence of other NHS-funded care; or
 - any other input-related (rather than needs-related) rationale.
66. Eligibility for NHS Continuing Healthcare is not indefinite, as needs could change. This should be made clear to the individual and/or their representatives.

Core values and principles

67. Individuals being assessed for NHS Continuing Healthcare are frequently facing significant changes in their life and therefore a positive experience of the assessment process is crucial. The process of assessment of eligibility and decision-making should be person-centred. This means placing the individual at the heart of the assessment and care-planning process.
68. There are many elements to a person-centred approach, including:
- a) ensuring that the individual and/or their representative is fully and directly involved in the assessment process;
 - b) taking full account of the individual's own views and wishes, ensuring that their perspective is incorporated in the assessment process;
 - c) addressing communication and language needs;
 - d) obtaining consent to assessment and sharing of records (where the individual has mental capacity to give this);
 - e) dealing openly with issues of risk; and
 - f) keeping the individual (and/or their representative) fully informed.

These are explained in the Practice Guidance note 4.

69. Access to assessment, decision-making and provision should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, or type of health need (for example, whether the need is physical, mental or psychological). CCGs and partner organisations are responsible for ensuring that discrimination does not occur and should use effective auditing to monitor this.
70. Assessments of eligibility for NHS Continuing Healthcare and NHS-funded Nursing Care should be organised so that the individual being assessed and their representative¹¹ understand the process and receive advice and information that will maximise their ability to participate in the process in an informed way. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike (refer to paragraphs 100, 159-161).
71. When commissioning the care package, the individual's wishes and expectations of how and where the care is delivered should be documented and taken into

¹¹In this National Framework the term **representative** is intended to include any friend, unpaid carer or family member who is supporting the individual in the process as well as anyone acting in a more formal capacity (e.g. welfare deputy or power of attorney, or an organisation representing the individual).

account, along with the risks of different types of provision and fairness of access to resources. This may include the option of a Personal Health Budget (PHB). More information on commissioning and PHBs can be found in paragraphs 296-300.

Consent

72. Where the individual concerned has capacity, their informed consent should be obtained before the start of the process to determine eligibility for NHS Continuing Healthcare. This consent will need to encompass permission to undertake the NHS Continuing Healthcare assessment process and also to the 'sharing and processing of data' (i.e. sharing relevant personal information between professionals in order to undertake the eligibility assessment for NHS Continuing Healthcare and, where appropriate, for audit and monitoring of decisions). For consent to be valid for these purposes it must be:

- **Explicit.** Consent must be expressly confirmed and recorded in writing, in a very clear and specific statement of consent, which is prominent and kept separate from other information.
- **Specific.** It should be made clear to the individual what they are being asked to consent to (e.g. just to having a Checklist completed or to the full assessment of eligibility process as well, if their Checklist is positive) and whether their information will be obtained and shared-for a specific aspect of the eligibility consideration process or for the full process. Also it needs to be explained that, subject to their consent, their personal information will be shared between different organisations involved in their care in order to complete the assessment of eligibility for NHS Continuing Healthcare.
- **Informed.** The individual should be informed about what the NHS Continuing Healthcare eligibility assessment process involves, what information will be obtained, and who it will be shared with before the start of the process to determine eligibility for NHS Continuing Healthcare.
- **Freely given.** This means consent must be given voluntarily by an appropriately informed person who has both the capacity and authority to consent to the intervention in question. It also means giving people genuine ongoing choice and control over how their personal information is used and shared. In the context of NHS Continuing Healthcare this means that the individual must have the capacity to consent freely and voluntarily to the NHS Continuing Healthcare eligibility assessment process as set out in this Framework. The individual should have a choice about whether or not to consent, and consent must not be conditional on the individual agreeing to something that is not related to the NHS Continuing Healthcare eligibility assessment process.
- **Can be withdrawn.** The individual must be made aware that they can withdraw their consent at any time, and made aware of the process for doing so, and that this includes withdrawing consent to share information.

It should be explained that, depending on the information in question, the decision to withdraw or withhold consent to share information might affect whether it is possible to complete the NHS Continuing Healthcare eligibility assessment.

73. If an individual with capacity does not consent to being assessed for NHS Continuing Healthcare or to sharing information which is essential for carrying out this assessment, the potential consequences of this should be carefully explained. This might affect the ability of the NHS and the local authority to provide appropriate services to them. The fact that an individual declines to be assessed for NHS Continuing Healthcare does not, in itself, mean that a local authority has an additional responsibility to meet their needs, over and above the responsibility it would have had if they had been assessed for NHS Continuing Healthcare. Where there are concerns that an individual may have significant ongoing needs, and that the level of appropriate support could be affected by their decision to decline the assessment, or to withhold consent to sharing essential information, the appropriate way forward should be considered jointly by the CCG and the local authority, taking account of each organisation's legal powers and duties. It may be appropriate for the organisations involved to seek legal advice (refer to Practice Guidance note 5 and 6 for more information).

Capacity

74. If there is a concern that the individual may not have capacity to give consent to the assessment process or the sharing of information, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice¹². CCGs should be particularly aware of the five principles of the Act:
- A person individual must be assumed to have capacity unless it is established that he lacks capacity.
 - A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
 - A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
 - An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
 - Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
75. It is important to be aware that just because an individual may have difficulty in expressing their views or understanding some information, this does not in itself mean that they lack capacity to make the decision in question. Appropriate support and adjustments, for example, using alternative methods of communication, should be made available to the person in compliance with the Mental Capacity Act 2005¹³, and with disability discrimination legislation¹⁴.
76. CCGs and local authorities should ensure that all staff involved in NHS Continuing Healthcare assessments are appropriately trained in Mental Capacity Act 2005 principles and responsibilities. Where the assessor is not familiar with Mental Capacity Act principles and the person appears to lack capacity the assessor should consult their employing organisation and ensure that appropriate actions are identified (refer to Practice Guidance note 7-10 for more information).

¹² [Capacity Act Code of Practice](#)

¹³ [Section 1\(3\) and Section 3\(2\) Mental Capacity Act 2005](#)

¹⁴ [Equality Act 2010](#)

Best interest decisions

77. If the person lacks the mental capacity to either give or refuse consent to the assessment process or the sharing of information, a decision must be made in the person's 'best interests' as to whether to proceed with the assessment and sharing of information. The best interests decision should be recorded. The person leading the assessment is responsible for making this decision and should bear in mind the expectation that everyone who is potentially eligible for NHS Continuing Healthcare should have the opportunity to be considered for eligibility. A third party cannot give or refuse consent for an assessment of eligibility for NHS Continuing Healthcare, or for sharing information, on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (Health and Welfare)¹⁵ or they have been appointed as a Deputy (Health and Welfare) by the Court of Protection.
78. If someone states that they have such authority the assessor should request sight of a certified copy of the original Deputyship Order or registered Lasting Power of Attorney and check the wording of the order to confirm that the person does have the relevant authority stated.
79. Where a 'best interests' decision needs to be made, the 'decision-maker' must take into account¹⁶ the views of any relevant third party who has a genuine interest in the individual's welfare (if it is reasonable and practicable to consult them). This will normally include family and friends. The decision-maker should be mindful of the need to respect confidentiality and should not share personal information with third parties unless it is considered in the best interests of the individual for the purposes of the NHS Continuing Healthcare assessment of eligibility. Where the individual has made an 'advanced statement' to the effect that they do not want personal information shared with specific individuals, this should be taken into account in assessing the individual's best interests.
80. Although the decision-maker must take account of the views of relevant third parties, those consulted (including family members) do not have the authority to consent to or refuse consent to the actions proposed as a result of the best interests process. The responsibility for the decision rests with the decision maker, not with those consulted. Where there is a difference of opinion between the decision-maker and those consulted, every effort should be made to resolve this informally. However, this process should not unduly delay timely decisions being made in the person's best interests.
81. An individual's capacity to make decisions may fluctuate, and there may be circumstances where an individual presents with a temporary loss of decision-making capacity. In these circumstances a decision needs to be made as to

¹⁵ [Lasting power of attorney: acting as an attorney](#)

¹⁶ [Section 4\(7\) Mental Capacity Act 2005](#)

whether it would be in the person's best interests to delay seeking consent until capacity is regained. If this is the case, the best interests decision to be made may also include whether to provide an interim care or support package.

Screening for NHS Continuing Healthcare using the Checklist tool

What is the Checklist tool and why is it used?

82. The Checklist is the NHS Continuing Healthcare screening tool which can be used in a variety of settings to help practitioners identify individuals who may need a full assessment of eligibility for NHS Continuing Healthcare. It is essential that the appropriate consent is sought prior to commencing this process (refer to paragraphs 72-73).
83. The Standing Rules¹⁷ require a CCG to take reasonable steps to ensure that individuals are assessed for NHS Continuing Healthcare in all cases where it appears that there may be a need for such care. These regulations also state that if an initial screening process is used to identify where there may be a need for such care, then the Checklist is the only screening tool that can be used for this purpose¹⁸. The purpose of the Checklist is to encourage proportionate assessments of eligibility so that resources are directed towards those people who are most likely to be eligible for NHS Continuing Healthcare, and to ensure that a rationale is provided for all decisions regarding eligibility.
84. The Checklist has 11 care domains broken down into three levels: A, B or C (where A represents a high level of care need, and C is a low level of care need). The outcome of the Checklist depends on the number of As, Bs, and Cs identified.
85. The Checklist threshold at this stage of the process has intentionally been set low, in order to ensure that all those who require a full assessment of eligibility have this opportunity. There may, very occasionally, be exceptional circumstances where a full assessment of eligibility for NHS Continuing Healthcare is appropriate even though the individual does not apparently meet the indicated threshold.
86. Completion of the Checklist is intended to be relatively quick and straightforward. It is not necessary to provide detailed evidence along with the completed Checklist (refer to paragraphs 97-99).

¹⁷ [*Section 21\(2\), The National Health Service Commissioning Board and Clinical Groups \(Responsibilities and Standing Rules\) Regulations 2012*](#)

¹⁸ [*Section 21\(4\), The National Health Service Commissioning Board and Clinical Groups \(Responsibilities and Standing Rules\) Regulations 2012*](#)

87. There are two potential outcomes following completion of the Checklist:
- a **negative** Checklist, meaning the individual does not require a full assessment of eligibility, and they are not eligible for NHS Continuing Healthcare; or
 - a **positive** Checklist meaning an individual now requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean the individual is eligible for NHS Continuing Healthcare.

When should a Checklist be completed?

88. Where there may be a need for NHS Continuing Healthcare, a Checklist should normally be completed.
89. Screening for NHS Continuing Healthcare should be at the right time and location for the individual and when the individual's ongoing needs are known. This will help practitioners to correctly identify individuals who require a full assessment of eligibility for NHS Continuing Healthcare.
90. Local health and social care joint processes should be in place to identify individuals for whom it may be appropriate to complete a Checklist, including for individuals in community settings. Wherever an individual requires a long-term care home placement with nursing or has significant support needs, a Checklist would be expected to be completed (unless the decision is made to go straight to the completion of a Decision Support Tool).
91. There will be many situations where it is not necessary to complete a Checklist. These include where:
- It is clear to practitioners working in the health and care system that there is no need for NHS Continuing Healthcare at this point in time. Where appropriate/relevant this decision and its reasons should be recorded. If there is doubt between practitioners a Checklist should be undertaken.
 - The individual has short-term health care needs or is recovering from a temporary condition and has not yet reached their optimum potential (if there is doubt between practitioners about the short-term nature of the needs it may be necessary to complete a Checklist). See paragraphs 109-117 for how NHS Continuing Healthcare may interact with hospital discharge.
 - It has been agreed by the CCG that the individual should be referred directly for full assessment of eligibility for NHS Continuing Healthcare.
 - The individual has a rapidly deteriorating condition and may be entering a terminal phase – in these situations the Fast Track Pathway Tool should be used instead of the Checklist.
 - An individual is receiving services under Section 117 of the Mental Health Act that are meeting all of their assessed needs.

- It has previously been decided that the individual is not eligible for NHS Continuing Healthcare and it is clear that there has been no change in needs.

Who can complete the Checklist Tool?

92. The Checklist can be completed by a variety of health and social care practitioners, who have been trained in its use. This could include, for example: registered nurses employed by the NHS, GPs, other clinicians or local authority staff such as social workers, care managers or social care assistants (refer to Practice Guidance note 13).
93. It is for each CCG and local authority to identify and agree who can complete the tool but it is expected that it should, as far as possible, include staff involved in assessing or reviewing individuals' needs as part of their day-to-day work.

The role of the individual in the screening process

94. The individual should be given reasonable notice of the intention to undertake the Checklist, and should normally be given the opportunity to be present at the completion of the Checklist, together with any representative they may have.
95. Before the Checklist is completed, it is necessary to ensure that the individual and (where appropriate) their representative understand that the Checklist does not indicate that the individual will be eligible for NHS Continuing Healthcare – only that they are entitled to be assessed for eligibility.
96. An individual cannot self-refer for NHS Continuing Healthcare by completing a Checklist themselves. The individual can request a Checklist from their CCG, for further details see Practice Guidance note 14.

How should the Checklist be completed?

97. The Checklist requires practitioners to record a brief description of the need and source of evidence used to support the statements selected in each domain. This could, for example, be by indicating that specific evidence for a given domain was contained within the inpatient nursing notes on a stated date. This will enable evidence to be readily obtained for the purposes of the MDT if the person requires a full assessment of eligibility for NHS Continuing Healthcare.
98. The principles in relation to 'well-managed need' (outlined in the Assessment of Eligibility section of this National Framework) apply equally to the completion of the Checklist as they do to the Decision Support Tool.

99. A link to the Checklist tool can be found on the [NHS Continuing Healthcare website](#). Practitioners should refer to the Checklist User Notes for more detail on how it should be completed.

What happens after the Checklist?

100. Whatever the outcome of the Checklist – whether or not a referral for a full assessment of eligibility for NHS Continuing Healthcare is considered necessary – the outcome must be communicated clearly and in writing to the individual or their representative, as soon as is reasonably practicable. This should include the reasons why the Checklist outcome was reached. Normally this will be achieved by providing a copy of the Checklist.

What happens following a negative Checklist?

101. A negative Checklist means the individual does not require a full assessment of eligibility and they are not eligible for NHS Continuing Healthcare.
102. If an individual has been screened out following completion of the Checklist, they may ask the CCG to reconsider the Checklist outcome. The CCG should give this request due consideration, taking account of all the information available, and/or including additional information from the individual or carer, though there is no obligation for the CCG to undertake a further Checklist.
103. A clear and written response should be given including the individual's (and, where appropriate, their representative's) rights under the NHS complaints procedure if they remain dissatisfied with the position.

What happens following a positive Checklist?

104. A positive Checklist means that the individual requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean the individual is eligible for NHS Continuing Healthcare.
105. An individual should not be left without appropriate support while they await the outcome of the assessment and decision-making process. A person only becomes eligible for NHS Continuing Healthcare once a decision on eligibility has been made by the CCG. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment. If, at the time of referral for an NHS Continuing Healthcare assessment, the individual is already receiving an ongoing care package (however funded) then those arrangements should continue until the

CCG makes its decision on eligibility for NHS Continuing Healthcare, subject to any urgent adjustments needed to meet the changed needs of the individual. In considering such adjustments, local authorities and CCGs should have regard to the limitations of their statutory powers. For details on how refunding arrangements might apply in such situations please refer to annex E.

106. Where the Checklist has been used as part of the process of discharge from an acute hospital and has indicated a need for full assessment of eligibility, a decision may be made at this stage first to provide other services and then to carry out a full assessment of eligibility at a later stage. This should be recorded. The relevant CCG should ensure that full assessment of eligibility is carried out once it is possible to make a reasonable judgement about the individual's ongoing needs. This should be completed in the most appropriate setting – whether another NHS setting, the individual's home or some other care setting. In the interim, the relevant CCG retains responsibility for funding appropriate care. For further information on how NHS Continuing Healthcare interacts with hospital discharge please see paragraphs 109-117.
107. Once an individual has been referred for a full assessment of eligibility for NHS Continuing Healthcare then, irrespective of the individual's setting, the CCG has responsibility for coordinating the process until the decision on funding has been made. The CCG should identify an individual (or individuals) to carry out this coordination role, which is pivotal to the effective management of the assessment and decision-making process. By mutual agreement, the coordinator may either be a CCG member of staff or be from an external organisation.

When and where to screen and assess eligibility for NHS Continuing Healthcare

108. Screening and assessment of eligibility for NHS Continuing Healthcare should be at the right time and location for the individual and when the individual's ongoing needs are known. The full assessment of eligibility should normally take place when the individual is in a community setting. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and ongoing needs.

Understanding how NHS Continuing Healthcare interacts with Hospital Discharge

109. In the majority of cases, it is preferable for eligibility for NHS Continuing Healthcare to be considered after discharge from hospital when the person's ongoing needs should be clearer. The aim in most cases will be for the individual to return to the place from which they were admitted to hospital, preferably their own home. It should always be borne in mind that an assessment of eligibility for NHS Continuing Healthcare that takes place in an acute hospital might not accurately reflect an individual's longer-term needs. This could be because, with appropriate support, the individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment.
110. CCGs should ensure that local protocols are developed between themselves, other NHS bodies, local authorities and other relevant partners. These should set out each organisation's role and how responsibilities are to be exercised in relation to hospital discharge, including intermediate or interim arrangements for step down or sub-acute care. In particular, CCGs should ensure (i.e. through contractual arrangements) that discharge policies with providers who are not NHS Trusts are clear. Where appropriate, the CCG may wish to make provisions in its contract with the provider. There should be processes in place to identify those individuals for whom it is appropriate to undertake a screening for NHS Continuing Healthcare using the Checklist and, where the Checklist is positive, for full assessment of eligibility to be undertaken at the appropriate time and place.
111. Where an individual is ready to be safely discharged from acute hospital it is very important that this should happen without delay. Therefore the assessment process for NHS Continuing Healthcare should not be allowed to delay hospital discharge.
112. In order to ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is

appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few weeks or months. It might also include intermediate care or an interim package of support, preferably in an individual's own home. In such situations, assessment of eligibility for NHS Continuing Healthcare, if still required, should be undertaken when an accurate assessment of ongoing needs can be made. The interim services should continue until it has been decided whether or not the individual has a need for NHS Continuing Healthcare (refer to paragraph 114). There must be no gap in the provision of appropriate support to meet the individual's needs.

113. Where an NHS body is considering issuing an Assessment Notice to a local authority under the provisions of the Care & Support (Discharge of Hospital Patients) Regulations 2014¹⁹, the responsible NHS body is required to consider whether or not to provide the individual with NHS Continuing Healthcare before issuing such a notice. This does not necessarily mean a Checklist needs to be completed if it is clear to the professionals involved that there is no need for NHS Continuing Healthcare (refer to paragraph 91).
114. CCGs and their partner organisations should ensure appropriate processes and pathways exist for individuals who may have a need for NHS Continuing Healthcare, for example:
 - a) rather than completing a Checklist in hospital a decision is made to provide interim NHS-funded services to support the individual after discharge. In such a case, before the interim NHS-funded services come to an end, screening, if required, for NHS Continuing Healthcare should take place through use of the Checklist and, where appropriate, the full MDT process using the DST (i.e. an assessment of eligibility); or
 - b) a 'negative' Checklist is completed in an acute hospital (i.e. the person does not have a need for NHS Continuing Healthcare) in which case, where appropriate, an Assessment Notice may be issued to the local authority; or
 - c) a 'positive' Checklist is completed in an acute hospital and interim NHS-funded services are put in place to support the individual after discharge until it is either determined that they no longer require a full assessment (because a further Checklist has been completed which is now negative) or a full assessment of eligibility for NHS Continuing Healthcare is completed; or
 - d) a 'positive' Checklist is completed in acute hospital and (exceptionally and for clear reasons) a full assessment of eligibility for NHS Continuing Healthcare takes place before discharge. In a small number of circumstances it may be decided to go directly to a full assessment within the acute hospital, without the need for a Checklist. If the full assessment

¹⁹ [Department of Health and Social Care, *The Care & Support \(Discharge of Hospital Patients\) Regulations 2014*](#)

does not result in eligibility for NHS Continuing Healthcare then, where appropriate, an Assessment Notice may be issued to the local authority; or,

- e) where the individual has an existing package or placement which all relevant parties agree can still safely and appropriately meet their needs without any changes, then they should be discharged back to this placement and/or package under existing funding arrangements. In such circumstances any screening for NHS Continuing Healthcare, if required, should take place within six weeks of the individual returning to the place from which they were admitted to hospital. If this screening results in a full assessment of eligibility and the individual is found eligible for NHS Continuing Healthcare through this particular assessment, then re-imbursement will apply back to the date of discharge.

115. CCGs are reminded that if an individual's needs reduce in a short time frame between a positive Checklist and a full assessment of eligibility taking place, it is legitimate to undertake a second Checklist, rather than necessarily proceeding to full assessment of eligibility for NHS Continuing Healthcare. The individual should be kept fully informed of the changed position.

Intermediate care and NHS Continuing Healthcare

116. Intermediate care is a programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live independently. Intermediate care is aimed at individuals who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute or longer-term in-patient care or long-term residential care. It should form part of a pathway of support. For example, intermediate care may be appropriately used where an individual has received other residential rehabilitation support following a hospital admission and, although having improved, continues to need support for a period prior to returning to their own home. It should also be used where an individual is at risk of entering a care home and requires their needs to be assessed in a non-acute setting with rehabilitation support provided where needed. This is irrespective of current or potential future funding streams.
117. Individuals should not be transferred directly to a long-term residential care setting from an acute hospital ward unless it is clearly appropriate under the circumstances. These circumstances might include:
- a) where the individual has an existing placement that can continue to meet their needs;
 - b) where the individual has already completed a period of specialist rehabilitation, such as in a stroke unit, and where long-term residential care is their preferred option;

- c) where the individual has had previous failed attempts at being supported at home (with or without intermediate care support); or
- d) those for whom the professional judgement is that a period in residential intermediate care followed by another move is likely to be unduly distressing for that individual.

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

118. Once an individual has been referred for a full assessment of eligibility for NHS Continuing Healthcare (following use of the Checklist or, if a Checklist is not used in an individual case, following direct referral for full consideration), then, a multidisciplinary team must assess whether the individual has a primary health need using the Decision Support Tool.

The Multidisciplinary Team (MDT)

119. The core purpose of the MDT is to make a recommendation on eligibility for NHS Continuing Healthcare drawing on the multidisciplinary assessment of needs and following the processes set out in this National Framework.
120. In accordance with regulations an MDT in this context means a team consisting of at least:
- two professionals who are from different healthcare professions, or
 - one professional who is from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014.
121. Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs and, where possible, have recently been involved in the assessment, treatment or care of the individual. Standing Rules¹ require that, as far as is reasonably practicable, the CCG must consult with the relevant local authority before making any decision about an individual's eligibility for NHS Continuing Healthcare and in doing so cooperate with that local authority in arranging for such persons to participate in an MDT for that purpose. CCGs may use a number of approaches (e.g. face-to-face, video/tele conferencing etc.) to arranging these MDT assessments in order to ensure active participation of all members as far as is possible.
122. If a local authority is consulted, there is a requirement for it to provide advice and assistance to the CCG, as far as is reasonably practicable. A local authority must, when requested to do so by a CCG, co-operate with the CCG in arranging for persons to participate in an MDT. The involvement of local authority colleagues as well as health professionals in the assessment process should streamline the

process of care planning and will make decision-making more effective and consistent. As with any assessments that they carry out, local authorities should not allow an individual's financial circumstances to affect its participation in a joint assessment.

123. The MDT works together to collate and review the relevant information on the individual's health and social care needs. The MDT uses this information to help clarify individual needs through the completion of the DST, and then works collectively to make a professional judgement about eligibility for NHS Continuing Healthcare, which will be reflected in its recommendation. This process is known as a multidisciplinary assessment of eligibility for NHS Continuing Healthcare.

Identifying an individual's needs

124. Establishing whether an individual has a primary health need requires a clear, reasoned decision, based on evidence of needs from a comprehensive range of assessments relating to the individual. A good-quality multidisciplinary assessment of needs that looks at all of the individual's needs 'in the round' – including the ways in which they interact with one another – is crucial both to addressing these needs and to determining eligibility for NHS Continuing Healthcare. The individual and (where appropriate) their representative should be enabled to play a central role in the assessment process.
125. It is important that the individual's own view of their needs, including any supporting evidence, is given appropriate weight alongside professional views. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion naturally progresses, rather than working through an assessment document in a linear fashion.
126. It is important that those contributing to this process have the relevant skills and knowledge. It is best practice that where the individual concerned has, for example a learning disability, or a brain injury, someone with specialist knowledge of this client group is involved in the assessment process.
127. The multidisciplinary assessment of an individual's needs informs the process for determining whether or not they are eligible for NHS Continuing Healthcare. However, regardless of whether the individual is determined to be eligible for NHS Continuing Healthcare, CCGs and local authorities should always consider whether the multidisciplinary assessment of needs has identified issues that require action to be taken. For example, if a multidisciplinary assessment of needs indicates that the individual has significant communication difficulties, referral to a speech and language service should be considered.

128. If a needs assessment under the Care Act 2014 has already been carried out by the local authority and is still relevant to an individual's current needs then, in accordance with the relevant regulations⁵, the local authority must use this assessment to provide advice and assistance to the CCG. This should be done in a timely way and according to locally agreed arrangements. For clarity, the local authority's duty to provide advice and assistance does not, in itself, trigger a duty to assess under section 9 of the Care Act 2014. The local authority should provide any other relevant information relating to the individual's up-to-date needs, where appropriate.
129. However, once an individual has been brought to the attention of the local authority, in addition to giving advice and assistance it should, having regard to the facts of the case, also consider whether a needs assessment under the Care Act 2014 is required. The absence of a needs assessment under the Care Act 2014 should not delay an assessment of eligibility for NHS Continuing Healthcare.
130. This National Framework encourages a joint approach to the assessment of eligibility for NHS Continuing Healthcare and it is important that all agencies respond in a timely manner. Local protocols should set how this is achieved, including in the absence of an existing local authority needs assessment under the Care Act 2014.

Using the Decision Support Tool

131. The Decision Support Tool (DST) has been developed to aid consistent decision making. The DST supports practitioners in identifying the individual's needs. This, combined with the practitioners' skills, knowledge and professional judgement, should enable them to apply the primary health need test in practice.
132. The DST is not an assessment of needs in itself. Rather, it is a way of bringing together and applying evidence in a single practical format, to facilitate consistent, evidence-based assessment regarding recommendations for NHS Continuing Healthcare eligibility. The evidence and rationale for the recommendation should be accurately and fully recorded.
133. The DST should not be completed without a multidisciplinary assessment of needs (meaning a comprehensive collection and evaluation of an individual's needs, refer to paragraphs 124-130). If any assessments relating to the individual's health and wellbeing (such as a needs assessment under the Care Act 2014) have recently been completed by practitioners, they may be used to complete the DST. However, care should be taken to ensure that such assessments provide an accurate reflection of current need.
134. The purpose of the DST is to help identify eligibility for NHS Continuing Healthcare. It is designed to collate and present the information from the

assessments of need in a way that assists consistent decision making regarding NHS Continuing Healthcare eligibility. The DST is a national tool and should not be altered.

135. The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. The tool provides practitioners with a method of bringing together and recording the various needs in 12 'care domains', or generic areas of need. Each domain is broken down into a number of levels. The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided.
136. The care domains are:
 1. Breathing
 2. Nutrition
 3. Continence
 4. Skin Integrity
 5. Mobility
 6. Communication
 7. Psychological & Emotional needs
 8. Cognition
 9. Behaviour
 10. Drug therapies and medication
 11. Altered states of consciousness
 12. Other significant care needs.
137. Completion of the tool should result in a comprehensive picture of the individual's needs that captures their nature, and their complexity, intensity and/or unpredictability – and thus the quality and/or quantity (including continuity) of care required to meet the individual's needs. Figure 1 indicates how the domains in the Decision Support Tool can illustrate (both individually and through their interaction) the complexity, intensity and/or unpredictability of needs. The overall picture, and the descriptors within the domains themselves, also relate to the nature of needs.

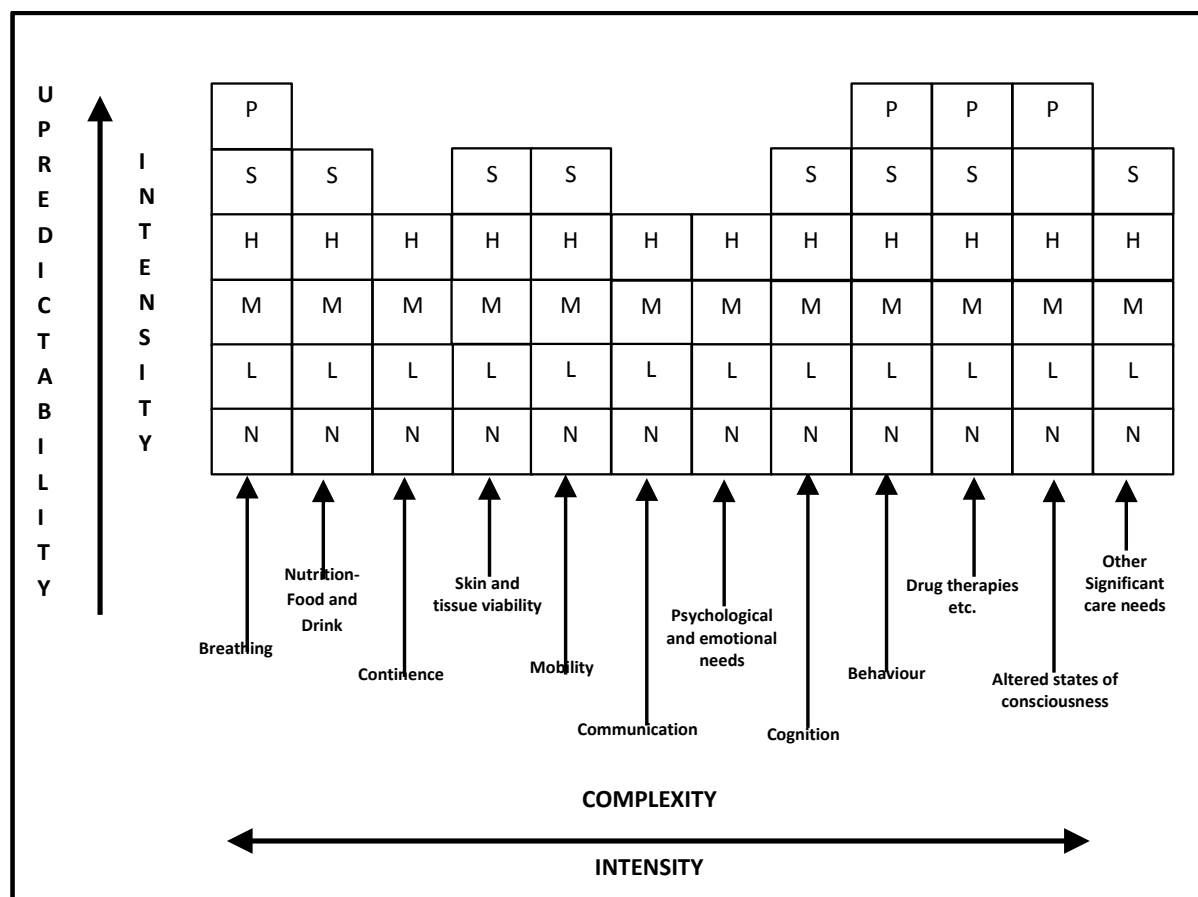


Figure 1 How the different care domains are divided into levels of need.

138. In certain cases, an individual may have particular needs that are not easily categorised by the care domains described here. In such circumstances, it is the responsibility of the MDT to determine the extent and type of the need and to take that need into account (and record it in the 12th care domain) when recommending whether a person has a primary health need.
139. Where deterioration can be reasonably anticipated to take place in the near future, this should also be taken into account, in order to avoid the need for unnecessary or repeat assessments.
140. When considering what evidence is needed to support completion of the DST, a proportionate approach should always be taken. This is further explained in Practice Guidance note 35.
141. Although the tool supports the process of determining eligibility, and ensures consistent and comprehensive consideration of an individual's needs, it cannot directly determine eligibility. Indicative guidelines as to threshold are set out in the tool (for example, if one area of need is at Priority level, then this demonstrates a primary health need), but these are not to be viewed prescriptively. Professional judgement should be exercised in all cases to ensure that the individual's overall level of need is correctly determined. The tool is to aid decision-making in terms of whether the nature, complexity, intensity or unpredictability of a person's needs are

such that the individual has a primary health need (refer to Practice Guidance note 35).

Well-managed needs

142. The decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on NHS Continuing Healthcare eligibility.
143. An example of the application of the well-managed needs principle might occur in the context of the behaviour domain where an individual's support plan includes support/interventions to manage challenging behaviour, which is successful in that there are no recorded incidents which indicate a risk to themselves, others or property. In this situation, the individual may have needs that are well-managed and if so, these should be recorded and taken into account in the eligibility decision.
144. In applying the principle of well-managed need, consideration should be given to the fact that specialist care providers may not routinely produce detailed recording of the extent to which a need is managed. It may be necessary to ask the provider to complete a detailed diary over a suitable period of time to demonstrate the nature and frequency of the needs and interventions, and their effectiveness.
145. Care should be taken when applying this principle. Sometimes needs may appear to be exacerbated because the individual is currently in an inappropriate environment rather than because they require a particular type or level of support – if they move to a different environment and their needs reduce this does not necessarily mean that the need is now 'well-managed', the need may actually be reduced or no longer exist.
146. It is not intended that this principle should be applied in such a way that well-controlled conditions should be recorded as if medication or other routine care or support was not present (refer to Practice Guidance note 23 for how the well-managed needs principle should be applied). The multi-disciplinary team should give due regard to well-controlled conditions when considering the four characteristics of need and making an eligibility recommendation on primary health need (refer to paragraph 59).

Making the recommendation of eligibility to the CCG

147. The MDT is required to make a recommendation to the CCG as to whether or not the individual has a primary health need, bearing in mind that where the CCG decides that the individual has a primary health need they are eligible for NHS

Continuing Healthcare (refer to Practice Guidance note 35). In coming to this recommendation the MDT should work collectively using professional judgement.

148. The written recommendation needs to be clear and concise whilst providing sufficient detail to enable the CCG and the individual to understand the underlying rationale for the recommendation.
149. The recommendation regarding eligibility for NHS Continuing Healthcare should:
 - provide a summary of the individual's needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs.
 - provide statements about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these characteristics provided in paragraphs 54-66 of the National Framework.
 - give an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability.
 - in the light of the above, give a recommendation as to whether or not the individual has a primary health need (with reference to paragraphs 54-66 of this National Framework). It should be remembered that, whilst the recommendation should make reference to all four characteristics of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.
150. Where an MDT recommends an individual is not eligible for NHS Continuing Healthcare, a clear rationale that considers the four key characteristics must still be provided. This must be based on the primary health need test, as set out in paragraph 58. Care planning for those individuals with ongoing needs, including the consideration of need for NHS-funded Nursing Care, will still be necessary.
151. If an MDT is unable to reach agreement on the recommendation this should be clearly recorded. Please refer to Practice Guidance note 21 and 28 for further information on the process to be followed by the MDT and Practice Guidance note 33 on what to do if MDT members disagree on domain levels. Please also see paragraphs 208-215 on interagency disagreements and disputes.
152. Where an individual and/or their representative expresses concern about any aspect of the MDT or DST process, the CCG coordinator should discuss this matter with them and seek to resolve their concerns. Where the concerns remain unresolved, these should be noted within the DST so that they can be brought to the attention of the CCG making the final decision.

Decision-making on eligibility for NHS Continuing Healthcare by the CCG

153. CCGs are responsible for decision making regarding NHS Continuing Healthcare eligibility, based on the recommendation made by the multidisciplinary team in accordance with the process set out in this National Framework. Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed.
154. CCGs should ensure consistency and quality of decision making. The CCG may ask a multidisciplinary team to carry out further work on a Decision Support Tool (DST) if it is not completed fully or if there is a significant lack of consistency between the evidence recorded in the DST and the recommendation made. However, the CCG should not refer a case back, or decide not to accept a recommendation, simply because the multidisciplinary team has made a recommendation that differs from the one that those who are involved in making the final decision would have made, based on the same evidence.
155. CCGs should not make decisions in the absence of recommendations on eligibility from the multidisciplinary team, except where exceptional circumstances require an urgent decision to be made (refer to Practice Guidance note 39).
156. CCGs may choose to verify multidisciplinary team's recommendation in a number of different ways and it is expected that CCGs will normally respond to MDT recommendations within 48 hours (two working days), and that the overall assessment and eligibility decision-making process should, in most cases, not exceed 28 calendar days from the date that the CCG receives the positive Checklist (or, where a Checklist is not used, other notice of potential eligibility) to the eligibility decision being made. It is expected that whether the verification is done by an individual or by a panel, this process should not be used as a gate-keeping function or for financial control. A decision not to accept the multidisciplinary team's recommendation should never be made by one person acting unilaterally. The final eligibility decision should be independent of budgetary constraints, and finance officers should not be part of a decision-making process.
157. CCGs should be aware of cases that have indicated circumstances in which eligibility for NHS Continuing Healthcare should have been determined, and where such an outcome would be expected if the same facts were considered in an assessment for NHS Continuing Healthcare under the National Framework (e.g. Coughlan (refer to Annex B) or those cases in the Health Service Ombudsman's report²⁰ on NHS funding for the long-term care of older and disabled people). However, they should be wary of trying to draw generalisations about eligibility for

²⁰ [The Parliamentary and Health Service Ombudsman, NHS funding for long term care 2002 -2003](#)

NHS Continuing Healthcare from the limited information they may have about those cases. There is no substitute for a careful and detailed assessment of the needs of the individual whose eligibility is in question.

158. As part of their responsibility to ensure consistent application of the National Framework, a CCG may review the pattern of recommendations made by multidisciplinary teams, in order to improve practice. However, this should be carried out separately from taking the decision on eligibility in individual cases. Care must be taken to ensure that any review of the pattern of recommendations supports compliance with the 'primary health need' test set out in this National Framework.

Communicating the eligibility decision to the individual

159. Once the eligibility decision is made by the CCG, the individual should be informed in writing as soon as possible (although this could be preceded by verbal confirmation where appropriate). This written confirmation should include:
- the decision on primary health need, and therefore whether or not the individual is eligible for NHS Continuing Healthcare;
 - the reasons for the decision;
 - a copy of the completed DST;
 - details of who to contact if they wish to seek further clarification; and
 - how to request a review of the eligibility decision.
160. Where an individual is not eligible for NHS Continuing Healthcare, the outcome letter may also include, where applicable and appropriate, information regarding NHS-funded Nursing Care or a joint package of care.
161. Where an individual is eligible for NHS Continuing Healthcare, an indication of the proposed care package, if known, could be included within this communication, or if not known at that stage, information on what the next steps are. Eligibility for NHS Continuing Healthcare is not indefinite, as needs could change. This should be made clear to the individual and/or their representative.

Timeframe for decision making

162. It is expected that CCGs will normally respond to MDT recommendations within 48 hours (two working days), and that the overall assessment and eligibility decision-making process should, in most cases, not exceed 28 calendar days from the date

that the CCG receives the positive Checklist (or, where a Checklist is not used, other notice of potential eligibility) to the eligibility decision being made.

163. In the minority of cases where an assessment of eligibility is being carried out in an acute hospital setting, the process should take far fewer than 28 calendar days if an individual is otherwise ready for discharge.
164. When there are valid and unavoidable reasons for the process taking longer, timescales should be clearly communicated to the person and (where appropriate) their representative(s). An example of this might occur where additional work is required to ensure that the DST and supporting evidence submitted to the CCG accurately reflect the full extent of an individual's needs. It should also be noted that the 28 calendar day timescale does not apply to children and young people in transition to adult services (refer to paragraph 342).

Care planning and delivery

165. Where an individual is eligible for NHS Continuing Healthcare, the CCG is responsible for care planning, commissioning services, and for case management. It is the responsibility of the CCG to plan strategically, specify outcomes and procure services, to manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare. The services commissioned must include ongoing case management for all those eligible for NHS Continuing Healthcare, including review and/or reassessment of the individual's needs.
166. CCGs should operate a person-centred approach to all aspects of NHS Continuing Healthcare, using models that maximise personalisation and individual control and that reflect the individual's preferences, as far as possible, including when delivering NHS Continuing Healthcare through a Personal Health Budget, where this is appropriate (refer to paragraphs 296-300).

Case management

167. Once an individual has been found eligible for NHS Continuing Healthcare, the CCG is responsible for their case management, including monitoring the care they receive and arranging regular reviews. CCGs should ensure arrangements are in place for an ongoing case management role for all those eligible for NHS Continuing Healthcare, as well as for the NHS elements of joint packages. This could be through joint arrangements with the local authority, subject to local agreement. Best practice would be for CCGs to assign a named case manager or named point of contact for anyone in receipt of NHS Continuing Healthcare.
168. The individual should be encouraged to have an active role in their care, be provided with information or signposting to enable informed choices, and supported to make their own decisions.
169. In the context of NHS Continuing Healthcare case management necessarily entails management of the whole package, not just the healthcare aspects. The key elements of case management, which in any given case might be undertaken by more than one professional, include:
 - a) ensuring that a suitable personalised care plan has been drawn up for, and with, the individual;
 - b) ensuring that the agreed care and support package continues to meet the individual's assessed health and associated care and support needs and agreed outcomes;

- c) where the care plan includes access to non-NHS services, ensuring that the arrangements for these are in place and are working effectively;
 - d) monitoring the quality of the individual's care and support arrangements and responding to any difficulties/concerns about these in a timely manner;
 - e) acting as a link person to coordinate services for the individual;
 - f) ensuring that any changes in the person's needs are addressed;
 - g) initiating/undertaking reviews as described in paragraphs 181-191.
170. Where an individual who is in receipt of NHS Continuing Healthcare becomes the subject of a safeguarding concern, this must be addressed by the responsible CCG using the local safeguarding procedures (i.e. where the individual is currently living). CCGs are reminded of their duties under the Care Act 2014 to co-operate with the local authority and local authorities are reminded of their responsibilities to make enquiries and also their responsibility to ensure, where appropriate, that an individual subject to a safeguarding enquiry has access to independent advocacy.

Care planning

171. The care planning process is central to the commissioning and provision of care to meet an individual's needs. Responsibility for care planning lies with the CCG.
172. Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health and associated care and support needs. The CCG has responsibility for ensuring this is the case, and determining what the appropriate package should be. In doing so, the CCG should have due regard to the individual's wishes and preferred outcomes. Although the CCG is not bound by the views of the local authority on what services the individual requires, any local authority assessment under the Care Act 2014 will be important in identifying the individual's needs and in some cases the options for meeting them. Whichever mechanism is used for meeting an individual's assessed needs, the approach taken should be in line with the principles of personalisation (refer to paragraphs 296-300).
173. Care planning for needs to be met under NHS Continuing Healthcare should not be carried out in isolation from care planning to meet other needs, and, wherever possible, a single, integrated and personalised care plan should be developed.

Commissioning and provision

174. CCGs should take a strategic as well as an individual approach to fulfilling their NHS Continuing Healthcare commissioning responsibilities. CCGs may wish to commission NHS-funded care from a wide range of providers, in order to secure high-quality services that meet the individual's assessed needs and offer value for money. To help inform this approach, CCGs should have an understanding of the market costs for care and support within the relevant local area. As part of any joint commissioning strategy that may be in place CCGs and local authorities should work in partnership, and share information (where appropriate) to enable them to commission better, innovative and cost-effective outcomes that promote the wellbeing of their populations.
175. As with all service contracts, commissioners are responsible for monitoring quality, access and patient experience within the context of provider performance. This is particularly important in this instance, as ultimate responsibility for arranging and monitoring the services required to meet the assessed needs of those who qualify for NHS Continuing Healthcare rests with the CCG. They should take into account the role and areas of focus of the Care Quality Commission and, where relevant, local authority commissioners, of the relevant provider's services to avoid duplication and to support the mutual development of an overall picture of each provider's performance.
176. CCGs should ensure clarity regarding the services being commissioned from providers, bearing in mind that those in receipt of NHS Continuing Healthcare continue to be entitled to access the full range of primary, community, secondary and other health services. The services that a provider of NHS Continuing Healthcare-funded services is expected to supply should be clearly set out in the service specification or contract between the provider and the CCG.
177. The starting point for agreeing the package and the setting where NHS Continuing Healthcare services are to be provided should be the individual's preferences. In some situations a model of support preferred by individuals will be more expensive than other options. CCGs can take comparative costs and value for money into account when determining the model of support to be provided, but should consider the following factors when doing so:
 - a) The cost comparison has to be on the basis of the genuine costs of alternative models. A comparison with the cost of supporting an individual in a care home should be based on the actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care home cost.
 - b) Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual's assessed needs and agreed desired outcomes. For example, individuals can

sometimes be described as needing 24-hour care when what is meant is that they need ready access to support and/or supervision. CCGs should consider whether models such as assistive technology could meet some of these needs. Where individuals are assessed as requiring nursing care, CCGs should identify whether their needs require the actual presence of a nurse at all times or whether the needs are for qualified nursing staff or specific tasks or to provide overall supervision. The willingness of family members to supplement support should also be taken into account, although no pressure should be put on them to offer such support. CCGs should not make assumptions about any individual, group or community being available to care for family members.

- c) Cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment (see the Gunter case in Practice Guidance note 46).

- 178. Unnecessary changes of provider or of care package should not take place purely because the responsible commissioner has changed from a CCG to a local authority (or vice versa).
- 179. To support a personalised approach to commissioning, CCGs should take into account relevant national policy and guidance, referring to the NHS-England website²¹.
- 180. NHS care is free at the point of delivery. The funding provided by CCGs in NHS Continuing Healthcare packages should be sufficient to meet the needs identified in the care plan. Therefore it is not permissible for individuals to be asked to make any payments towards meeting their assessed needs.

²¹ [NHS England website: personalisation](#)

NHS Continuing Healthcare Reviews (at three and 12 months)

Purpose and frequency of reviews

181. Where an individual has been found eligible for NHS Continuing Healthcare, a review should be undertaken within three months of the eligibility decision being made. After this, further reviews should be undertaken on at least an annual basis, although some individuals will require more frequent review in line with clinical judgement and changing needs.
182. Bearing in mind the minimum standards set out above, a guiding principle is that the frequency, format and attendance at reviews should be proportionate to the situation in question in order to ensure that time and resources are used effectively.
183. These reviews should primarily focus on whether the care plan or arrangements remain appropriate to meet the individual's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility.
184. It is expected that the most recently completed Decision Support Tool (DST) will normally be available at the review and should be used as a point of reference to identify any potential change in needs. Where there is clear evidence of a change in needs to such an extent that it may impact on the individual's eligibility for NHS Continuing Healthcare, then the CCG should arrange a full reassessment of eligibility for NHS Continuing Healthcare.
185. Where reassessment of eligibility for NHS Continuing Healthcare is required, a new DST must be completed by a properly constituted multidisciplinary team (MDT), as set out in this National Framework. Where appropriate, comparison should be made to the information provided in the previous DST. CCGs are reminded that they must (in so far as is reasonably practicable) consult with the local authority before making an NHS Continuing Healthcare eligibility decision, including any re-assessment of eligibility. This duty is normally discharged by the involvement of the local authority in the MDT process, as set out in the Assessment of Eligibility section of this National Framework. CCGs should ensure an individual's needs continue to be met during this reassessment of eligibility process.

Role of the local authority in reviews

186. If the local authority is responsible for any part of the care, both the CCG and the local authority will have a requirement to review needs and the service provided.

In such circumstances, it would be beneficial for them to conduct a joint review where practicable.

187. Even if all the services are currently the responsibility of the NHS, it may sometimes be beneficial for the review to be held jointly by the NHS and the local authority where there is an indication of a possible need for a care and support assessment as part of the review process.

Well-managed needs and reviews

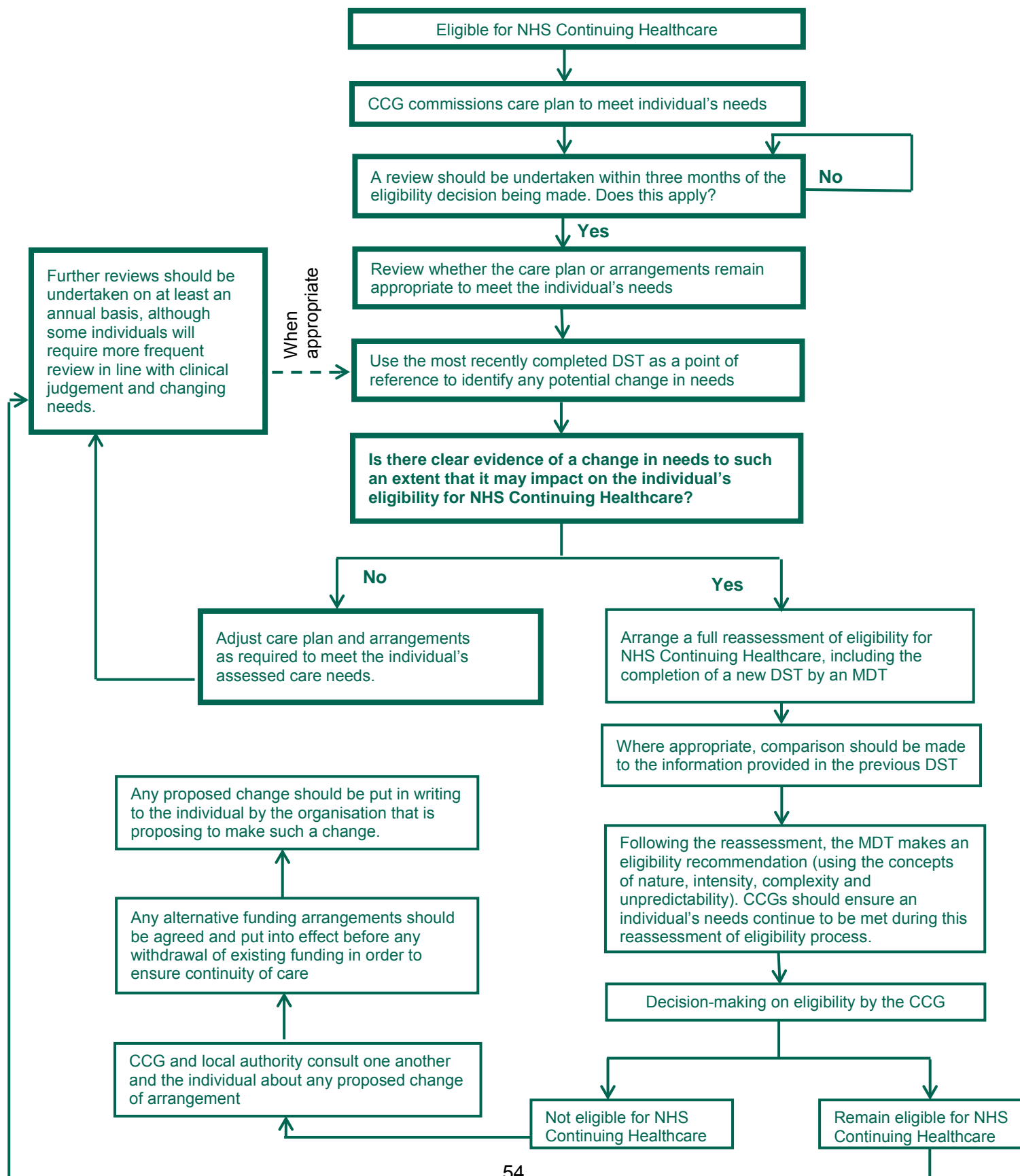
188. When undertaking NHS Continuing Healthcare reviews, care must be taken not to misinterpret a situation where the individual's care needs are being well-managed as being a reduction in their actual day-to-day care needs. This may be particularly relevant where the individual has a progressive illness or condition, although it is recognised that with some progressive conditions care needs can reduce over time. More information on well-managed needs can be found in the Assessment of Eligibility section in this National Framework.

Outcomes of an NHS Continuing Healthcare review

189. The outcome of an NHS Continuing Healthcare review will determine whether:
- a) the individual's needs are being met appropriately, and
 - b) whether eligibility should be reconsidered through reassessment for NHS Continuing Healthcare.
190. It is a core principle that neither a CCG nor a local authority should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement. Therefore, if there is a change in eligibility, it is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding, in order to ensure continuity of care. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If agreement between the local authority and the NHS cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding and care management responsibilities should remain in place until the dispute has been resolved. There is a separate disputes procedure for when the individual disagrees with the decision (refer to paragraphs 192-207).
191. The risks and benefits to the individual of a change of location or support (including funding) should be considered carefully before any move or change is confirmed. Neither the CCG nor the local authority should unilaterally withdraw from funding of an existing package until there has been appropriate reassessment and agreement on future funding responsibilities and any

alternative funding arrangements have been put into effect. Further details on responsibilities during changes (including approaches to disputes) are set out in Annex E.

Figure 2: Flow diagram for 3 months 12 month reviews of NHS Continuing Healthcare



Individual Requests for a Review of an Eligibility Decision

192. The formal responsibility for informing individuals of the decision about eligibility for NHS Continuing Healthcare and of their right to request a review lies with that CCG with which the individual is a patient for the purposes of NHS Continuing Healthcare, in line with current legislation.
193. The CCG should give clear reasons for its decision on whether or not an individual has a primary health need. The CCG should set out the basis on which the decision of eligibility was made. The CCG should also explain the arrangements, and timescales, for dealing with a request to review an eligibility decision where the individual or their representative disagrees with it.

Local resolution

194. Where an individual or their representative asks the CCG to review the eligibility decision, this should be addressed through the local resolution procedure, which is normally expected to resolve the matter. CCGs should deal with requests for review in a timely manner. For guidance on this issue please refer to NHS England website.
195. All CCGs must have an NHS Continuing Healthcare local resolution process. They should therefore develop, deliver and publish a local resolution process that is fair, transparent, includes timescales and takes account of the following guidelines:
 - a) There should be an attempt to resolve any concerns initially through an informal two-way meaningful discussion between the CCG representative and the individual and/or their representative. There should be a written summary of this for both parties. The discussion should be an opportunity for the individual or their representative to receive clarification of anything they have not understood. The CCG should explain how it has arrived at the decision regarding eligibility, including reference to the completed DST and primary health need assessment. Where required this should also be an opportunity for the individual or their representative to provide any further information that had not been considered.
 - b) Where a formal meeting involving the individual and/or their representative is required, this should involve someone with the authority to decide next steps on behalf of the CCG (e.g. to request further reports, or seek further clarification/reconsideration by the MDT). The individual should be able to put forward the reasons why they remain dissatisfied with the CCG's decision.

There should be a full written record of the formal meeting for both parties. The CCG will agree next steps with the individual or their representative.

- c) Following the formal meeting and outcome of the next steps, the CCG will either uphold or change the original eligibility decision.
- d) A key principle of the local resolution process is that, as far as possible, if the CCG does not change the original decision, the individual or their representative has had a clear and comprehensive explanation of the rationale for the CCG decision.
- f) Where individuals wish to move straight to a formal meeting this should be considered. CCGs should use every opportunity to learn from these meetings, and should consider how they share their learning with other CCGs.
- g) CCGs may choose to prioritise cases for individuals currently in receipt of care.

Independent review

- 196. Where it has not been possible to resolve the matter through the local resolution procedure, the individual may apply to NHS England for an independent review of the decision, if they are dissatisfied with:
 - the decision regarding eligibility for NHS Continuing Healthcare; or
 - the procedure followed by the CCG in reaching its decision as to the person's eligibility for NHS Continuing Healthcare.
- 197. When NHS England receives a request for an independent review they should contact the relevant CCG to establish what efforts have been made to achieve local resolution and the outcome. NHS England can consider asking CCGs to attempt further local resolution prior to the independent review. If using local processes would cause undue delay, NHS England has the discretion to agree that the matter should proceed direct to an independent review, without completion of the local resolution process.
- 198. Where NHS England, rather than a CCG, has taken an eligibility decision which is subsequently disputed by the individual, NHS England must ensure that, in organising a review of that decision, it makes appropriate arrangements as regards the manner in which it organises this review so as to avoid any conflict of interest.
- 199. The key elements involved in considering requests for independent reviews of NHS Continuing Healthcare eligibility include:
 - scrutiny of all available and appropriate evidence as described in the Local Resolution section;

- a full record of deliberations of relevant panel meetings, made available to all parties (subject to any legal restrictions on sharing such documentation); and
 - clear and evidenced written conclusions on the process followed by the NHS body and also on the individual's eligibility for NHS Continuing Healthcare, together with appropriate recommendations on actions to be taken. This should include the appropriate rationale related to this guidance.
200. NHS England is responsible¹ for convening independent review panels consisting of:
- An independent chair (appointed by NHS England);
 - A CCG representative (who is not from the CCG that made the decision which is the subject of the review);
 - A local authority Social Services representative (who is not from a local authority where all or part of the CCG involved in the decision is located).
201. All parties involved should be able to view and comment on all evidence to be considered under the relevant disputes procedure (subject to any legal restrictions on sharing such documentation). Where written records or other evidence are requested, the CCG making the request should ensure that those providing the evidence are aware that it will be made available to those involved in the independent review panel. Where, in exceptional circumstances, those providing written records place any restrictions on their availability to all parties, the position should be discussed with the chair of the relevant disputes resolution body. The chair should consider the most appropriate way forward to ensure that all parties can play a full and informed role in the process.
202. Independent review panels have a scrutiny and reviewing role. It is therefore not necessary for any party to be legally represented at independent review panel hearings, although individuals may choose to be represented by family, advocates, advice services or others in a similar role if they wish.
203. The role of the independent review panel is advisory, but its recommendations should be accepted by NHS England (and subsequently by the CCG) in all but exceptional circumstances (see Annex D). The individual's rights under the existing NHS and social services complaints procedures remain unaltered by the above.
204. Following an independent review panel, if the original decision is upheld but there is still a challenge the individual has the right to make a complaint to the Parliamentary and Health Service Ombudsman.
205. On some occasions, NHS England may receive requests for an independent review or other challenge from a close relative, friend or other representative who does not have lasting power of attorney (LPA) or deputy status. Where the individual has capacity, the CCG should ask them whether this request is in

accordance with their instructions, and where they do not have capacity, a 'best interests' process should be used to consider whether to proceed with the request for an independent review or other challenge.

206. NHS England does have the right to decide in any individual case not to convene an independent review panel. It is expected that such a decision will be confined to those cases where the individual falls well outside the eligibility criteria, as set out in the standing rules, or where the case is very clearly not appropriate for the independent review panel to consider (see Annex D). Before taking such a decision, NHS England should seek the advice of an independent review chair who may require independent clinical advice. In such cases where a decision not to convene an independent review panel is made the individual, their family or carer should receive a clear written explanation of the basis for this decision, together with a reminder of their rights under the NHS complaints procedure.
207. CCGs should consider publishing local processes and timescales for responding to complaints and concerns relating to NHS Continuing Healthcare on issues that fall outside of the independent review panel process.

Inter-agency disputes

Disputes between local authorities and CCGs

208. A fundamental principle is for CCGs and local authorities to minimise the need to invoke formal inter-agency dispute resolution procedures by, for example:
- a) all parties following the guidance set out in this National Framework;
 - b) agreeing and following local protocols and/or processes which make clear how the CCG discharges its duty to consult with the local authority (refer to paragraph 21) and how the local authority discharges its duty to co-operate with the CCG (refer to paragraphs 25-30);
 - c) developing a culture of genuine partnership working in all aspects of NHS Continuing Healthcare;
 - d) ensuring that eligibility decisions are based on thorough, accurate and evidence-based assessments of the individuals' needs;
 - e) always keeping the individual at the heart of the process and ensuring a person-centred approach to decision-making;
 - f) always attempting to resolve inter-agency disagreements at an early and preferably informal stage;
 - g) dealing with genuine disagreements between practitioners in a professional manner without drawing the individual concerned into the debate in order to gain support for one professional's position or the other;
 - h) ensuring practitioners in health and social care receive high-quality joint training (i.e. health and social care) which gives consistent messages about the correct application of the National Framework.

Individuals must never be left without appropriate support while disputes between statutory bodies about funding responsibilities are resolved.

209. CCGs and local authorities in each local area must agree a local disputes resolution process to resolve cases where there is a dispute between them about:
- a decision as to eligibility for NHS Continuing Healthcare, or
 - where an individual is not eligible for NHS Continuing Healthcare, the contribution of a CCG or local authority to a joint package of care for that person, or
 - the operation of refunds guidance (see Annex E).

210. When developing and agreeing local inter-agency disagreement and dispute resolution protocols, CCGs and local authorities should ensure that they encompass the following elements:
- A brief summary of principles including a commitment to work in partnership and in a person-centred way.
 - The CCG duty to consult with the local authority (refer to paragraph 21) and the local authority duty to co-operate with the CCG (refer to paragraphs 25-30). This should include arrangements for situations where the local authority has not been involved in the MDT and in formulating the recommendation.
 - An ‘informal’ stage at operational level whereby disagreements regarding the correct eligibility recommendation can be resolved – this might, for example, involve consultation with relevant managers immediately following the MDT meeting to see whether agreement can be reached. This stage might include seeking further information/clarification on the facts of the case or on the correct interpretation of the National Framework.
 - A formal stage of resolving disagreements regarding eligibility recommendations involving managers and/or practitioners who have delegated authority to attempt resolution of the disagreement and can make eligibility decisions. This stage could involve referral to an inter-agency NHS Continuing Healthcare panel.
 - If the dispute remains unresolved, the dispute resolution agreement may provide further stages of escalation to more senior managers within the respective organisations.
 - A final stage involving independent arbitration. This stage should only be invoked as a last resort and should rarely, if ever, be required. It can only be triggered by senior managers within the respective organisations who must agree how the independent arbitration is to be sourced, organised and funded.
 - Clear timelines for each stage.
 - Agreement as to how the placement and/or package for the individual is to be funded pending the outcome of dispute resolution and arrangements for reimbursement to the agencies involved once the dispute is resolved. Individuals must never be left without appropriate support whilst disputes between statutory bodies about funding responsibility are resolved.
 - Arrangements to keep the individual and/or their representative informed throughout the dispute resolution process.
 - Arrangements in the event of an individual requesting a review of the eligibility decision made by the CCG.
211. It should be remembered that decisions regarding eligibility for NHS Continuing Healthcare are the responsibility of the CCG, who may choose to make their

decision before an inter-agency disagreement has been resolved. In such cases it is possible that the formal dispute resolution process will have to be concluded after the individual has been given a decision by the CCG.

212. Where disputes relate to local authorities and CCGs in different geographical areas, the dispute resolution process of the responsible CCG should normally be used in order to ensure resolution in a robust and timely manner.

Disputes regarding ‘responsible commissioner’ or ‘ordinary residence’

213. In situations where there is a dispute between CCGs regarding responsibility for an individual, then the underlying principle is that there should be no gaps in responsibility as a result. No treatment should be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual’s healthcare provision. CCGs should agree interim responsibilities for who funds the package until the dispute is resolved. Where the CCGs are unable to resolve their dispute using current guidance, as a last resort the matter should be referred to NHS England.
214. The Care Act 2014 (sections 39-41), associated regulations²² and chapter 19 of the Care and Support Statutory Guidance, set out and give guidance on updated rules regarding ‘ordinary residence’, which is the key concept in determining which local authority is responsible for assessing and addressing the care and support needs of individuals and their carers. As with ‘responsible commissioner’ guidance a key principle is that individuals should not be left without support whilst any disagreement about which local authority is responsible is resolved.
215. CCGs and local authorities in each local area must agree a local dispute resolution process to resolve cases where there is a dispute between them about eligibility for NHS Continuing Healthcare, about the apportionment of funding in joint funded care/support packages, or about the operation of refunds guidance (see Annex E). Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to local authorities and CCGs in different geographical areas, the dispute resolution process of the responsible CCG should normally be used in order to ensure resolution in a robust and timely manner. This should include agreement on how funding will be provided during the dispute, and arrangements for reimbursement to the agencies involved once the dispute is resolved. Individuals must never be left without appropriate support

²² [The Care and Support \(Ordinary Residence\) \(Specified Accommodation\) Regulations 2014](#) and [The Care and Support \(Disputes Between Local Authorities\) Regulations 2014](#)

whilst disputes between statutory bodies about funding responsibility are resolved.

Fast track

216. There are a number of end-of-life pathways which may be appropriate within local health and care systems and therefore not everyone at the end of their life will be eligible for, or require, NHS Continuing Healthcare. Care planning and commissioning for those with end of life needs should be carried out in an integrated manner, as part of the individual's overall end of life care pathway and taking into account individual preferences. The Government's *End of Life Care Choice Commitment*²³ sets out what everyone should expect from their care at the end of life, and the action being taken to make high quality and personalisation a reality for all.

Fast Track Pathway Tool for NHS Continuing Healthcare

217. Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require 'fast tracking' for immediate provision of NHS Continuing Healthcare.
218. The intention of the Fast Track Pathway is that it should identify individuals who need to access NHS Continuing Healthcare quickly, with minimum delay, and with no requirement to complete a Decision Support Tool (DST). Therefore, the completed Fast Track Pathway Tool, with clear reasons why the individual fulfils the criteria and which clearly evidences that an individual is both rapidly deteriorating and may be entering terminal phase, is in itself sufficient to establish eligibility.
219. In Fast Track cases, Standing Rules²⁴ state that it is the 'appropriate clinician' who determines that the individual has a primary health need. The CCG must therefore decide that the individual is eligible for NHS Continuing Healthcare and should respond promptly and positively to ensure that the appropriate funding and care arrangements are in place without delay.
220. An 'appropriate clinician' is defined as a person who is:
- responsible for the diagnosis, treatment or care of the individual under the 2006 Act in respect of whom a Fast Track Pathway Tool is being completed; and
 - a registered nurse or a registered medical practitioner.

²³ [End of Life Care Choice Commitment](#)

²⁴ [Regulation 8 and 13 of the National Health Service Commissioning Board and Clinical Groups \(Responsibilities and Standing Rules\) Regulations 2012](#)

221. The 'appropriate clinician' should be knowledgeable about the individual's health needs, diagnosis, treatment or care and be able to provide an assessment of why the individual meets the Fast Track criteria.
222. An 'appropriate clinician' can include clinicians employed in voluntary and independent sector organisations that have a specialist role in end of life needs (for example, hospices), provided they are offering services pursuant to the 2006 Act.
223. Others who are not approved clinicians as defined above, but involved in supporting those with end of life needs, (including those in wider voluntary and independent sector organisations) may identify the fact that the individual has needs for which use of the Fast Track Pathway Tool might be appropriate. They should contact the appropriate clinician who is responsible for the diagnosis, care or treatment of the individual and ask for consideration to be given to completion of the Fast Track Pathway Tool.

Completion of the Fast Track Pathway Tool

224. The Fast Track Pathway Tool must only be used when the individual has a rapidly deteriorating condition and may be entering a terminal phase.
225. The Fast Track Pathway Tool replaces the need for a Checklist and DST to be completed. However, a Fast Track Pathway Tool can also be completed after a Checklist if it becomes apparent at that point that the Fast Track criteria are met.
226. The Fast Track Pathway Tool can be used in any setting. This includes where such support is required for individuals who are already in their own home or are in a care home and wish to remain there.
227. The completed Fast Track Pathway Tool should be supported by a prognosis, where available. However, strict time limits that base eligibility on a specified expected length of life remaining should not be imposed:
 - 'rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining; and
 - 'may be entering a terminal phase' is not intended to be restrictive to only those situations where death is imminent.

It is the responsibility of the appropriate clinician to make a decision based on whether the individual's needs meet the Fast Track criteria.
228. When completing the Fast Track Pathway Tool clinicians should sensitively explain to the individual that their needs may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review.
229. Also, an individual may currently be demonstrating few symptoms yet the nature of the condition is such that it is clear that rapid deterioration is to be expected in the

near future. In order to avoid the need for unnecessary or repeat assessments it may therefore be appropriate to use the Fast Track Pathway Tool now in anticipation of those needs arising and agreeing the responsibilities and actions to be taken once they arise, or to plan an early review date to reconsider the situation. It is the responsibility of the appropriate clinician referring an individual to base their decision on the facts of the individual's case and healthcare needs at the time.

230. It is important to bear in mind that this is not the only way that an individual can qualify for NHS Continuing Healthcare towards the end of their life. The DST asks practitioners to document deterioration (including observed and likely deterioration) in an individual's condition, so that they can take this into account in determining eligibility using the DST. However, this should not be used as a means of circumventing use of the Fast Track Pathway Tool when individuals satisfy the criteria for its use.
231. It is helpful if an indication of how the individual presents in the current setting is included with the Fast Track Pathway Tool, along with the likely progression of the individual's condition, including anticipated deterioration and how and when this may occur. However, CCGs should not require this information to be provided as a prerequisite for establishing entitlement to NHS Continuing Healthcare using the Fast Track Pathway Tool.
232. It is also important for the CCG to know what the individual or their family have been advised about their condition and prognosis and how they have been involved in agreeing the end of life care pathway.
233. If an individual meets the criteria for the use of the Fast Track Pathway Tool then the Tool should be completed even if an individual is already receiving a care package (other than one already fully funded by the NHS) which could still meet their needs. This is important because the individual may at present be funding their own care or the local authority may be funding (and/or charging) when the NHS should now be funding the care in full.
234. The setting where an individual wishes to be supported as they approach the end of their life may be different to their current arrangements (e.g. even though they are currently in a care home setting they may wish to be supported in their family environment). The important issue is that (wherever possible) the individual concerned receives the support they need in their preferred place as soon as reasonably practicable, without having to go through the full process for consideration of NHS Continuing Healthcare eligibility.
235. The overall Fast Track process should be carefully and sensitively explained to the individual and (where appropriate) their representative. Careful decision-making is essential in order to avoid the undue distress that might result from changes in NHS Continuing Healthcare eligibility within a very short period of time.

CCG responsibilities upon receiving a completed Fast Track Pathway Tool

236. In order to comply with Standing Rules a CCG must accept and immediately action a Fast Track Pathway Tool where the Tool has been properly completed.
237. Exceptionally, there may be circumstances where CCGs receive a completed Tool which appears to show that the individual's condition is not related to the above criteria at all. For example, if a completed Fast Track Pathway Tool states that the person has mental health needs and challenging behaviour but makes no reference to them having a rapidly deteriorating condition which may be entering a terminal phase. In these circumstances, the CCG should urgently ask the relevant clinician to clarify the nature of the person's needs and the reason for the use of the Fast Track Pathway Tool. Where it then becomes clear that the use of the Fast Track Pathway Tool was not appropriate, the clinician should be asked to submit a completed Checklist (if required) for assessment of eligibility through the process outlined in this National Framework.
238. Action should be taken urgently to agree and commission the care package. CCGs should have processes in place to enable such care packages to be commissioned quickly. Given the nature of the needs, this time period should not usually exceed 48 hours from receipt of the completed Fast Track Pathway Tool. CCGs should ensure that they have commissioned sufficient capacity in the care system to ensure that delays in the delivery of care packages are minimal. It is not appropriate for individuals to experience delay in the delivery of their care package while concerns over the use of the Fast Track Pathway Tool are resolved.
239. CCGs should ensure that robust systems are in place to audit and monitor use of the tool and raise any specific concerns with clinicians, teams and organisations, bearing in mind the importance of the Tool being used appropriately and only for the genuine purpose for which it is intended. CCG should consider how the use of the standard NHS contract can support this. Such concerns should be treated as a separate matter from the task of arranging for service provision in the individual case.

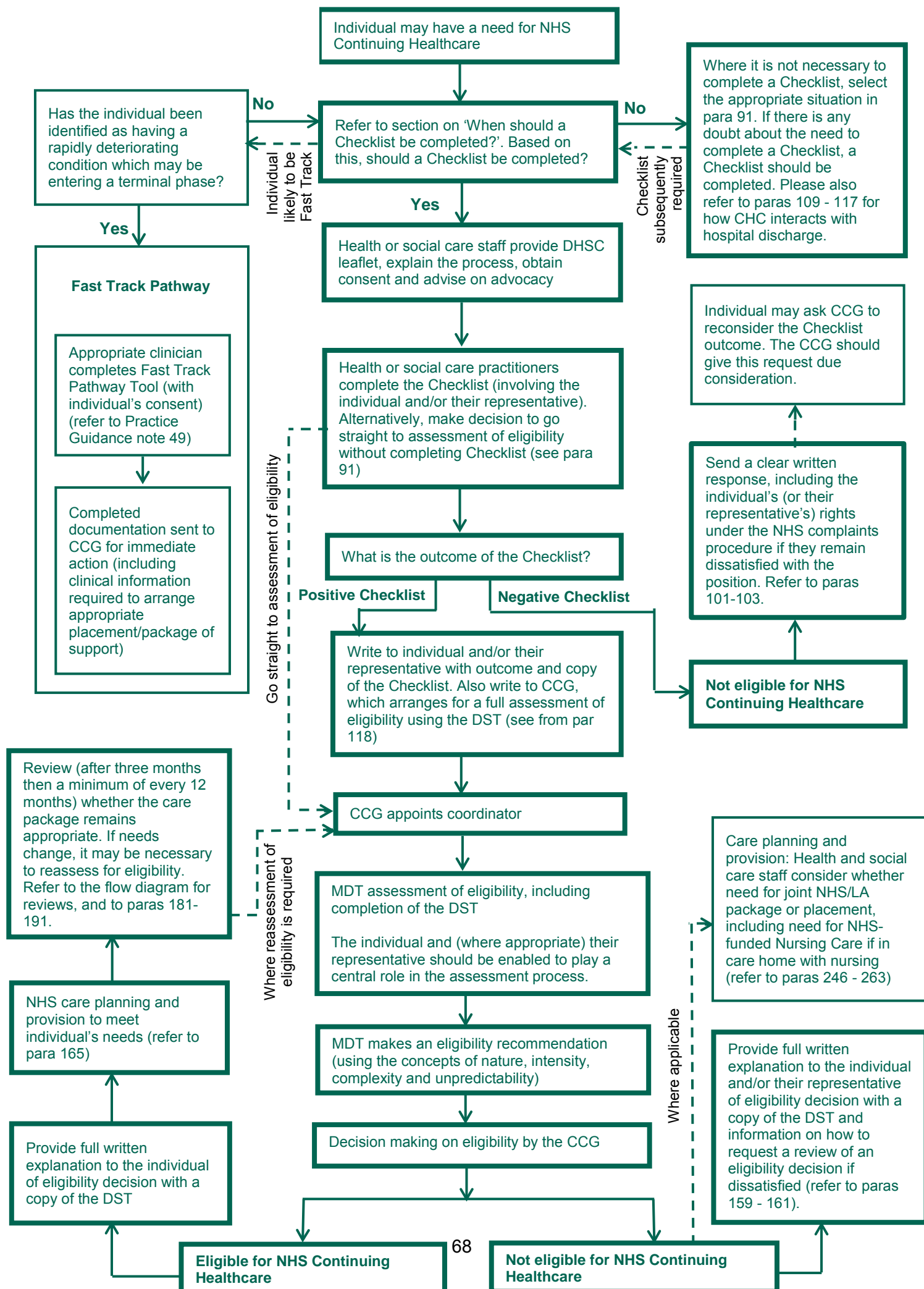
Reviews of Fast Track

240. The aim of the Fast Track Pathway Tool is to ensure quick determination of eligibility for NHS Continuing Healthcare and commission an appropriate care package.
241. Once this has happened, it will be important to review an individual's care needs and the effectiveness of the care arrangements. In doing this, there may be

certain situations where the needs indicate that it is appropriate to review eligibility for NHS Continuing Healthcare. CCGs should make any decisions about reviewing eligibility in Fast Track cases with sensitivity.

242. Where an individual who is receiving services from use of the Fast Track Pathway Tool is expected to die in the very near future, the CCG should continue to take responsibility for the care package until the end of life.
243. CCGs should monitor care packages to consider when and whether a reassessment of eligibility is appropriate. Where it is apparent that the individual is nearing the end of their life and the original eligibility decision was appropriate it is unlikely that a review of eligibility will be necessary.
244. No individual identified through the Fast Track Pathway Tool who is eligible for NHS Continuing Healthcare should have this funding removed without their eligibility being re-considered through the completion of a DST by a multidisciplinary team (MDT), including this MDT making a recommendation on eligibility for NHS Continuing Healthcare.
245. The individual affected should be notified in writing of any proposed change in funding responsibility. They should be given details of their right to request a review of the decision. Such communications should be conducted in a sensitive, timely and person-centred manner.

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



Joint packages of care, including NHS-funded Nursing Care

NHS-funded Nursing Care

246. NHS-funded Nursing Care is the funding provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible for NHS-funded Nursing Care. Section 22 of the Care Act 2014 prohibits local authorities from providing, or arranging for the provision of, nursing care by a registered nurse, save in the very limited circumstances set out in Section 22 (4).
247. If an individual is not eligible for NHS Continuing Healthcare, the need for care from a registered nurse may need to be determined. An individual is eligible for NHS-funded Nursing Care if:
- the individual has such a need;
- and
- it is determined that the individual's overall needs would be most appropriately met in a care home with nursing.
248. The registered nurse¹ input is defined in the following terms:
- 'Services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse'*.
- 'Nursing care by a registered nurse' covers:
- time spent on nursing care, in the sense of care which can only be provided by a registered nurse, including both direct and indirect nursing time;
 - paid breaks;
 - time receiving supervision;
 - stand-by time; and
 - time spent on providing, planning, supervising or delegating the provision of other types of care which in all the circumstances ought to be provided by a registered nurse because they are ancillary to or closely connected with or part and parcel of the nursing care which the nurse has to provide.

¹ [Supreme Court judgment, R \(on the application of Forge Care Homes Ltd and others\) v Cardiff and Vale University Health Board and others \(Secretary of State for Health intervening\) \[2017\] UKSC 56](#)

249. Where an individual may have a nursing need a nursing needs assessment, which specifies the day-to-day care and support needs of the individual, should be used to assess whether an individual is eligible for NHS-funded Nursing Care. More information is provided in the NHS-funded Nursing Care best practice guidance.
250. Eligibility for NHS Continuing Healthcare must be considered, and a decision made and recorded (either at the Checklist or DST stage), prior to any decision on eligibility for NHS-funded Nursing Care. For clarity, people who do not require a full assessment of eligibility for NHS Continuing Healthcare can still be eligible for NHS-funded Nursing Care. If an individual has a negative Checklist this simply means that they are not eligible for, and do not require, assessment of eligibility for NHS Continuing Healthcare at this point in time. However, they may require registered nursing in a care home with nursing. The decision regarding this must be based on a nursing needs assessment, which specifies their day-to-day care and support needs and how they meet the criteria outlined above. More on NHS-funded Nursing Care reviews can be found below.
251. Once the need for such care is agreed, the CCG is responsible for paying a flat-rate contribution to the care home with nursing towards registered nursing care costs.

The NHS-funded Nursing Care rate

252. Since 2007, NHS-funded Nursing Care has been based on a single-band rate, set out in the Standing Rules and amended each financial year by the Department of Health and Social Care.
253. Individuals who are in receipt of NHS-funded Nursing Care are entitled to continue to receive this until:
 - a) on review, it is determined that they no longer have any need for registered nursing care; or
 - b) they are no longer resident in a care home that provides registered nursing care; or
 - c) they become eligible for NHS Continuing Healthcare; or
 - d) they die.
254. Individuals who were in receipt of the high band of NHS-funded Nursing Care under the three-band system that was in force until 30 September 2007 are entitled to continue on the high band rate subject to a) – d) above. In addition, if on review, it is determined that their needs have changed, so that under the previous three-band system they would have moved onto the medium or low bands, the individual should be moved onto the single rate.

255. The NHS-funded Nursing Care rate is the contribution provided by the NHS to support the provision of 'nursing care by a registered nurse', as defined in paragraphs 247-248 above. This does not include the time spent by non-nursing staff such as care assistants (although it does cover the time spent by the registered nurse in monitoring or supervising care that is delegated to others). Neither does it cover the costs of the wider non-nursing care or accommodation provided for the individual.
256. The Care home provider should set an overall fee level for the 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.
257. Contracts between individuals and/or local authorities, with providers, should have terms and conditions which are transparent and fair, including setting out what happens if a resident is admitted to hospital or what happens if a resident dies.

NHS-funded Nursing Care reviews

258. When reviewing the need for NHS-funded Nursing Care, potential eligibility for NHS Continuing Healthcare must always be considered. This will normally be achieved by completing a Checklist and where necessary a full assessment for NHS Continuing Healthcare using the DST.
259. However, where:
- a Checklist and/or DST has previously been completed (with the result that the individual was not found eligible for NHS Continuing Healthcare), and
 - it is clear that there has been no material change in need
- then it will not be necessary to repeat the Checklist and/or DST and this should be recorded. The individual should be informed of this outcome and the reasons for it.
260. Where a new Checklist is completed and indicates that a full assessment of eligibility for NHS Continuing Healthcare is required, then an MDT should complete a DST and follow the normal decision-making process.
261. In order to determine whether there has been a material change in need, the previously completed Checklist or DST should be available at the NHS-funded Nursing Care review. Each of the domains and previously assessed need levels

should be considered as part of the review, in consultation with the person being reviewed and any other relevant people who know the individual who are present.

262. If at the NHS-funded Nursing Care review it is determined that the individual does not require assessment for NHS Continuing Healthcare, they or their representative should be advised of this and provided with a copy of the annotated Checklist or DST which indicates that there has been no material change in their needs. They should be given information explaining how they can request a review of the outcome of the NHS-funded Nursing Care review, should they wish to do so.

Joint packages of health and social care

263. If a person is not eligible for NHS Continuing Healthcare, they may potentially receive a joint package of health and social care. This is where an individual's care or support package is funded by both the NHS and the local authority. This may apply where specific needs have been identified through the DST that are beyond the powers of the local authority to meet on its own. This could be because the specific needs are not of a nature that a local authority could be expected to meet, or because they are not incidental or ancillary to something which the Local Authority would be doing to meet needs under sections 18-20 of the Care Act 2014. It should be noted that joint packages can be provided in any setting.
264. CCGs should work in partnership with their local authority colleagues to agree their respective responsibilities in such cases. These should be identified by considering the needs of the individual. Where there are overlapping powers and responsibilities, a flexible, partnership-based approach should be adopted, including which party will take the lead commissioning role.
265. Apart from NHS-funded Nursing Care, additional health services may also be delivered by existing NHS services or funded by the NHS, if these are identified and agreed as part of an assessment and care plan. The range of services that the NHS is expected to arrange and fund includes, but is not limited to:
- primary healthcare;
 - assessment involving doctors and registered nurses;
 - rehabilitation/reablement and recovery (where this forms part of an overall package of NHS care, as distinct from intermediate care);
 - respite healthcare;
 - community health services;
 - specialist support for healthcare needs; and

- palliative care and end of life healthcare.
266. Subject to the national eligibility criteria for adult care and support (refer to paragraph 51) and to means testing where appropriate, each local authority is responsible for providing such care and support as can lawfully be provided. More information on this can be found in the section on Legislation in this National Framework.
267. In a joint package of care the CCG and the local authority can each contribute to the package by any one, or more, of the following:
- a) delivering direct services to the individual
 - b) commissioning care/services to support the care package
 - c) transferring funding between their respective organisations
 - d) contributing to an integrated personal budget
268. Although the funding for a joint package comes from more than one source it is possible that one provider, or the same worker(s), could provide all the support. Examples can include:
- an individual in their own home with a package of support comprising both health and social care elements;
 - an individual in a care home (with nursing) who has nursing or other health needs, that are beyond the scope of the NHS-funded Nursing Care contribution; or
 - an individual in a care home (without nursing) who has some specific health needs requiring skilled intervention or support, that cannot be met by community nursing services and are beyond the power of the local authority to meet.
269. Jointly coordinated CCG and local authority reviews should be considered for any joint package of care in order to maximise effective care and support for the individual.

Further information related to care and support arrangements

Guidance on NHS patients who wish to pay for additional private care

270. The NHS care package provided should meet the individual's health and associated social care needs as identified in their care plan. The care plan should set out the services to be funded and/or provided by the NHS. It may also identify services to be provided by other organisations such as local authorities but the NHS element of the care should always be clearly identified.
271. The decision to purchase additional private care services should always be a voluntary one for the individual. Providers should not require the individual to purchase additional private care services as a condition of providing, or continuing to provide, NHS-funded services to them. The CCG should make this clear when negotiating terms and conditions with the provider.
272. Where an individual advises that they wish to purchase additional private care or services, CCGs should discuss the matter with the individual to seek to identify the reasons for this. If the individual advises that they have concerns that the existing care package is not sufficient or not appropriate to meet their needs, CCGs should offer to review the care package in order to identify whether a different package would more appropriately meet the individual's assessed needs.
273. In March 2009, the Department published *Guidance on NHS patients who wish to pay for additional private care*¹ (referred to below as the 'Additional Private Care Guidance') regarding NHS patients who wish to pay for additional private care, in addition to their NHS care package. Although it is primarily aimed at situations where NHS patients want to buy additional secondary and specialist care services that the NHS does not fund, it contains a set of principles applicable to all NHS services:
- a) As affirmed by the NHS Constitution:
- the NHS provides a comprehensive service, available to all;
 - access to NHS services is based on clinical need, not an individual's ability to pay; and
 - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

¹ [Guidance on NHS patients who wish to pay for additional private care](#)

b) The fact that some NHS patients also receive private care separately should never be used as a means of downgrading or reducing the level of service that the NHS offers. NHS organisations should not withdraw any NHS care simply because a patient chooses to buy additional private care.

c) As overriding rules, it is essential that:

- the NHS should never subsidise private care with public money, which would breach core NHS principles; and
- patients should never be charged for their NHS care, or be allowed to pay towards an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.

274. There should be as clear a separation as possible between NHS and private care. In the Additional Private Care guidance, 'separation' is described as usually requiring the privately-funded care to take place in a different location and at a different time to the NHS-funded care. However, many individuals eligible for NHS Continuing Healthcare have limitations on their ability to leave their home due to their health needs. Moreover, the majority of the care they receive is often by its nature focused on supporting them within their own home and any additional private care may well also be focused on home-based support. Therefore, although the principle of separation still applies to NHS Continuing Healthcare, a different approach may be necessary. For example, where a person receives 24-hour NHS-funded support by way of a care home package it may not be possible for privately-funded care to be provided at a time that is separate to NHS-funded care. However, in such circumstances, the private care should be delivered by different staff to those involved in delivering the NHS-funded care at the time it takes place and they should not be delivering treatment, care or support identified within the care plan as being part of the NHS-funded service.
275. Based on the above principles, examples of additional private services which might be purchased separately include hairdressing, aromatherapy, beauty treatments and entertainment services.
276. CCGs should seek to ensure that providers are aware of the above principles. Where a provider receives a request for additional privately-funded services from an individual who is funded by NHS Continuing Healthcare they should refer the matter to the CCG for consideration.
277. Although NHS-funded services must never be reduced or downgraded to take account of privately-funded care, the CCG and the organisations delivering NHS-funded care should, wherever appropriate, liaise with those delivering privately-funded care in order to ensure safe and effective coordination between the services provided. Transfers of responsibility between privately-funded and NHS

care should be carried out in a way which avoids putting individuals receiving services at any unnecessary risk. The CCG, the NHS-funded provider and the privately-funded provider should work collaboratively to put in place protocols to ensure effective risk management, timely sharing of information, continuity of care and coordination between NHS-funded and privately-funded care at all times. If different staff are involved in each element of care, these protocols should include arrangements for the safe and effective handover of the patient between those in charge of the NHS care and those in charge of the privately-funded care.

278. CCGs should also be aware that individuals in receipt of NHS Continuing Healthcare continue to be eligible for all other services available to patients of their CCG. In developing or reviewing care packages, CCGs should consider whether other services commissioned or provided by the CCG would help meet the individual's needs.

Higher cost care packages

279. The funding provided by CCGs in NHS Continuing Healthcare packages should be sufficient to meet the needs identified in the care plan, based on the CCG's knowledge of the costs of services for the relevant needs in the locality where they are to be provided.
280. Where an individual indicates a preference for higher-cost accommodation or services, the CCG should liaise with the individual to identify the reasons for their preference.
281. Where an individual's indicated preference is identified by the CCG to be necessary to meet their assessed needs, the CCG should meet this as part of the NHS Continuing Healthcare package. For example, an individual with challenging behaviour may need to have a larger room because it is identified that the behaviour is linked to feeling confined, or it may be agreed that the individual requires a care provider with specialist skills rather than a generic care provider.
282. Where an individual's indicated preference is not an assessed need, it is subject to the criteria outlined in the Additional Private Care guidance above. An example of this might be where an individual would like a larger room which is not related to their needs.
283. In some circumstances individuals become eligible for NHS Continuing Healthcare when they are already resident in care home accommodation for which the fees are higher than the relevant CCG would usually meet for an individual with their needs. This may be where the individual was previously funding their own care or where they were previously funded by a local authority and a third party had contributed to the fees payable. This is permissible under

legislation governing local authority provision but is not permissible under NHS legislation. For this reason, there are some circumstances where a CCG may propose a move to different accommodation or a change in care provision.

284. In such situations, CCGs should consider if there are reasons why they should meet the full cost of the existing care package, notwithstanding that it is at a higher rate. This could include that the frailty, mental health needs or other relevant needs of the individual mean that a move to other accommodation could involve significant risk to their health and well-being.
285. Where an individual in an existing out of area placement becomes eligible for NHS Continuing Healthcare the care package may be of a higher cost than the responsible CCG would usually fund for the person's needs. The CCG should consider whether the cost is reasonable, taking into account the market rates in the locality of the placement. They should also consider whether there are other circumstances that make it reasonable to fund the higher rate. Examples might include: where the location of the placement is close to family members who play an active role in the life of the individual, or where the individual has lived there for many years and it would be significantly detrimental to the individual to move them.
286. CCGs should deal with the above situations with sensitivity and in close liaison with the individuals affected and, where appropriate, their families, the existing service provider and the local authority. Where a CCG is considering moving such an individual because there is no justification for funding a higher cost placement, any decisions on moves to other accommodation or changes in care provider should be taken in full consultation with the individual concerned and put in writing with reasons given. Advocacy support should be provided where this is appropriate. Where the individual concerned lacks mental capacity, decisions about their accommodation must be made in compliance with the Mental Capacity Act 2005. An Independent Mental Capacity Act Advocate (IMCA) must be appointed where the statutory requirements are met.
287. Where the decision is made not to fund the higher cost package, the new accommodation and/or services should reflect the individual's assessed needs as identified in their care plan. This should take into account personal needs such as proximity to family members. Individuals should be provided with a reasonable choice of providers wherever possible.
288. In such cases, a transition care plan should be developed by the existing and new provider which identifies key needs and preferences. This should address how any specific needs and risks will be managed during the transition process. The CCG should keep in regular contact with the new provider and with the individual during the initial weeks of the new services to ensure that the transition has proceeded successfully and to ensure that any issues that arise are being appropriately addressed.

- 289. Where an individual becomes eligible for NHS Continuing Healthcare and has an existing high-cost care package, CCGs should consider funding the full cost of the existing higher-cost package until a decision is made on whether to meet the higher cost package on an ongoing basis or to arrange an alternative placement.
- 290. Where an individual wishes to dispute a decision not to pay for higher-cost accommodation, they should do this via the NHS complaints process. The letter from the CCG advising them of the decision should also include details of the complaints process and who to contact if the individual wishes to make a complaint. Refer to Practice Guidance notes 54-55 for two case studies.

Supporting individuals eligible for NHS Continuing Healthcare in their own home

- 291. Where an individual is eligible for NHS Continuing Healthcare and chooses to live in their own home, the CCG is financially responsible for meeting all assessed health and associated social care needs. This could include: equipment provision (refer to Practice Guidance note 56), routine and incontinence laundry, daily domestic tasks such as food preparation, shopping, washing up, bed-making and support to access community facilities, etc. (including additional support needs for the individual whilst the carer has a break). However, the NHS is not responsible for funding rent, food and normal utility bills.
- 292. There is a range of everyday household costs that are expected to be covered by personal income or through welfare benefits (e.g. food, rent/mortgage interest, fuel, clothing and other normal household items).
- 293. Whilst CCGs can take comparative costs and value for money into account, they must not set arbitrary limits on care at home packages based purely on the notional costs of caring for an individual in a home, if this does not represent a personalised approach or an accurate appraisal of the cost of meeting the assessed needs of the individual concerned. Such arbitrary limits are incompatible with personal health budgets which have been developed to enable people to live independently, work or participate in society. For more detail please see below and Practice Guidance note 45.
- 294. People who are eligible for NHS Continuing Healthcare and who choose to live in their own home may have additional support needs which it may be appropriate for the local authority to address subject to Care Act 2014 provisions and eligibility guidance, e.g. assistance and advice regarding property adaptation (refer to Practice Guidance note 56), support with essential parenting activities, deputyship or appointeeship services, safeguarding concerns, carer support or services required to enable the carer to maintain his/her caring responsibilities (bearing in mind paragraphs 323-330).

295. Where agencies and/or organisations have potentially overlapping powers and responsibilities there should be a discussion between the parties involved. As individual circumstances will differ considerably it is not possible to give hard and fast rules on how best to divide responsibilities in all situations where overlapping powers exist; reference should be made to each agency's statutory responsibilities.

Personal Health Budgets

296. A Personal Health Budget (PHB) is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local CCG. Personal Health Budgets are a means by which an individual can be given more choice and control. It is not new money, but a different way of spending health funding to meet the needs of an individual.
297. Individuals who are eligible for NHS Continuing Healthcare have had a right to have a Personal Health Budget since October 2014. Personal Health Budget Standing Rules require CCGs to provide people eligible for NHS Continuing Healthcare with information about Personal Health Budgets to offer them the option of taking them up, and support to do so.
298. Personal health budgets can be provided in three different ways, or in a combination of these ways:
- a) a notional budget held by the commissioner;
 - b) a budget managed on the individual's behalf by a third party;
 - c) a cash payment to the individual (a 'direct payment').
299. A wide variety of resources are available via the personal health budgets pages of NHS England's website¹.
300. CCGs and local authorities are encouraged to work closely together with regard to the personalisation of care and support in order to share expertise and develop arrangements that provide for smooth transfers of care where necessary.

¹ [NHS England website: Personal Health Budgets](#)

Equipment

301. Where individuals in receipt of NHS Continuing Healthcare require equipment to meet their care needs, there are several routes by which this may be provided:
- a) If the individual is, or will be, supported in a care home setting, the care home may need to provide certain equipment in order to meet regulatory standards or as part of its contract with the CCG. Further details of the regulatory standards can be found on the Care Quality Commission's website¹.
 - b) Individuals who are eligible for NHS Continuing Healthcare should have the same access to standard joint equipment services as other people. Therefore, when planning, commissioning and funding joint equipment services CCGs should ensure that the needs of current and future recipients of NHS Continuing Healthcare are taken into account.
 - c) Some individuals in receipt of NHS Continuing Healthcare will require bespoke equipment (or other non-bespoke equipment that is not available through routes (a) and (b) above) to meet specific assessed needs. CCGs should make appropriate arrangements to assess and meet these and any subsequent equipment needs that might arise, including responsibility for any essential servicing and repair that might be required for particular items of equipment.
302. CCGs should ensure that there is clarity about which of the above arrangements is applicable in each individual situation, including responsibility for any essential servicing and repair that might be required for particular items of equipment. CCGs are reminded of their ability to utilise Personal Health Budgets as a means of meeting equipment needs (including servicing and repair).
303. Where an individual is assessed in a hospital setting as being eligible for NHS Continuing Healthcare, CCGs must have systems in place to minimise delays to discharge due to equipment provision.

Access to other NHS-funded services

304. Those in receipt of NHS Continuing Healthcare continue to be entitled to access to the full range of primary, community, secondary and other health services. The CCG responsible for the individual should be determined in accordance with the principles set out in responsible commissioner guidance. CCGs should ensure that their contracting arrangements with care homes that provide nursing care give clarity on the responsibilities of nurses within the care home and of

¹ www.cqc.org.uk

community nursing services, respectively. No gap in service provision should arise between the two sectors.

Other existing commitments to NHS-funded care

305. Apart from a CCG's responsibilities for NHS Continuing Healthcare and their respective responsibilities under the Mental Health Act 1983, there may be other circumstances when the NHS is expected to take responsibility for a person's long-term care. One example might be people with learning disabilities, where there may be an existing agreement to fund ongoing care for individuals following the closure of long-stay hospitals or campuses. These responsibilities arise independently of a CCG's responsibility to provide NHS Continuing Healthcare, and there should be no assumption that these responsibilities equate to eligibility for NHS Continuing Healthcare or vice versa. Such agreements vary in terms of the commitments they make to fund needs that subsequently arise. Where additional needs do arise, it will be important for the CCG to first check whether there is clarity in such agreements on whether or not they cover responsibilities to meet such needs. If the additional needs fall outside the agreement, CCGs must consider their responsibilities to meet them, in terms both of the CCG's general responsibilities and potential eligibility for NHS Continuing Healthcare.

Advocacy

306. The Mental Capacity Act 2005 made provision for the statutory Independent Mental Capacity Advocate (IMCA) service. Its purpose is to represent and support vulnerable people who lack mental capacity and who are facing important decisions made by the NHS or local authorities, including about serious medical treatment or change of residence – for example, moving to a hospital or care home. An IMCA is normally instructed and consulted where an individual lacks mental capacity in relation to the relevant decision and has no family or friends that are available (or appropriate) to provide independent consultation regarding their best interests. An IMCA must be instructed for specific important decisions, including about the proposed provision of serious medical treatment or the provision of accommodation in a hospital or care home, including a change of accommodation (refer to Practice Guidance notes 9 and 56).
307. Even if an individual does not meet the criteria for use of the IMCA service, and regardless of whether or not they lack capacity, they may wish to be supported by an advocate to help ensure that their views and wishes are represented and taken into account. Any person may choose to have a family member or other person (who should operate independently of local authorities and CCGs) to act as an advocate on their behalf. CCGs should ensure that individuals are made aware of local advocacy and other services that may be able to offer advice and support and, in conjunction with local authority partners, may wish to consider whether there are any joint commissioning opportunities to enhance general advocacy services in their local area.
308. Although not related to the eligibility decision-making process, local authorities have a duty under the Care Act 2014 to promote the well-being of the individual at all times. Where relevant, this includes making arrangements for independent advocacy in relation to safeguarding enquiries relevant to the individual. Please see paragraph 170.

Mental health legislation

Section 117

309. CCGs and local authorities should be familiar with the relevant sections of the Mental Health Act 1983 (as amended).
310. Under section 117 of the Mental Health Act 1983 ('section 117'), CCGs and local authorities have a joint duty to provide after-care services to individuals who have been detained under certain provisions of the Mental Health Act 1983. The duty applies when those individuals cease to be detained and are discharged from hospital (including on Section 17 leave, or under a Community Treatment Order under section 17a) until such time as the CCG and local authority are satisfied that the person is no longer in need of such services. Section 117 is a freestanding duty to provide after-care services to the individual for needs arising from, or related to, their mental disorder. CCGs and local authorities should have in place local policies detailing their respective responsibilities, including funding arrangements.
311. The Care Act 2014 introduced a definition of section 117 after-care services as follows:
- 'services which have both of the following purposes—*
- (a) meeting a need arising from or related to the person's mental disorder; and*
- (b) reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder).'*
312. It is important to make a distinction between needs that must be met under section 117 arrangements, and needs to be met under a different arrangement.
313. Responsibility for the provision of section 117 services lies jointly with local authorities and the NHS. Where an individual is eligible for services under section 117 these must be provided under section 117 and not under NHS Continuing Healthcare. It is important for CCGs to be clear in each case whether the individual's needs (or in some cases which elements of the individual's needs) are being funded under section 117, NHS Continuing Healthcare or any other powers.
314. There are no powers to charge for services provided under section 117, regardless of whether they are provided by the NHS or local authorities. Accordingly, the question of whether services should be free NHS services (rather than potentially charged-for social services) does not arise. It is not, therefore, necessary to assess eligibility for NHS Continuing Healthcare if all the

services in question are in fact to be provided as after-care services under section 117.

315. However, a person in receipt of after-care services under section 117 may also have ongoing needs that do not arise from, or are not related to, their mental disorder and that may, therefore, not fall within the scope of section 117. Also a person may be receiving services under section 117 and then develop separate physical health needs (e.g. through a stroke) which may then trigger the need to consider NHS Continuing Healthcare, but only in relation to these separate needs, bearing in mind that NHS Continuing Healthcare must not be used to meet section 117 needs. Where an individual in receipt of section 117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase, consideration should be given to the use of the Fast Track Pathway Tool.
316. Local policies should be in place dealing with the approach to section 117 which should include apportionment of financial responsibility having regard to the nature of the services being provided.
317. Local authorities and CCGs may use a variety of different models and tools as a basis for working out how section 117 funding costs should be apportioned. However, where this results in a CCG fully funding a section 117 package this does not constitute NHS Continuing Healthcare.
318. It is preferable for the CCG to have separate budgets for funding section 117 and NHS Continuing Healthcare. Where they are funded from the same budget they still continue to be distinct and separate entitlements.
319. The legislation relating to assessment for NHS-funded Nursing Care contained in the Standing Rules, applies to section 117 individuals as it does to other individuals.

Deprivation of Liberty Safeguards

320. The Mental Capacity Act 2005 contains provisions that apply to an individual who lacks capacity and who, in their best interests, needs to be deprived of their liberty in a care home or hospital, in order for them to receive the necessary care or treatment. In such situations the deprivation of liberty can be authorised using the Deprivation of Liberty Safeguards (DoLS) process set out in the Act. These safeguards are in place in order to ensure that an individual is not deprived of their liberty unlawfully. The fact that an individual who lacks capacity needs to be deprived of his or her liberty in these circumstances does not, in itself, preclude or require consideration of whether that individual is eligible for NHS Continuing Healthcare.

321. Where an individual is in receipt of NHS Continuing Healthcare, and they lack mental capacity to consent to their accommodation, or care and support arrangements, the CCG must ensure that the arrangements they commission are lawful and compliant with the Mental Capacity Act. This means that, where the person is placed in a care home or hospital and they will be subject to restrictions that constitute a deprivation of their liberty, the care provider must request authorisation from the relevant local authority (or in some specific circumstances, the Court of Protection) for this deprivation of liberty. The request for Deprivation of Liberty Safeguards (DoLS) authorisation should be made by the care home or hospital to the local authority before the placement is made.
322. Where the individual who lacks capacity is in receipt of NHS Continuing Healthcare in their own home, including tenancy based accommodation (e.g. supported living), and is subject to restrictions that may constitute a deprivation of liberty, the deprivation of liberty cannot be authorised using the Deprivation of Liberty Safeguards (DoLS) process, instead authorisation must be obtained from the Court of Protection. In these circumstances, because the CCG is the primary funding authority, it is responsible for applying to the Court of Protection for this authorisation and should seek their own legal advice for this reason. The CCG is responsible for its own associated legal costs, but is not responsible for the legal costs of the individual concerned. However, the CCG should ensure that the individual has access to legal advice in their own right.

Carers

- 323. The important role played by carers is recognised by both central and local government, irrespective of how the cared-for individual has their care funded. CCGs and local authorities have a joint responsibility to identify, and work in partnership with, carers and young carers so that they can be better supported to continue with their caring role, if they are willing and able to do so.
- 324. A carer is anyone who, usually unpaid, looks after a friend or family member in need of extra help or support with daily living, for example, because of illness, disability or frailty.
- 325. Healthcare professionals and social care practitioners should be proactive in identifying carers and be sensitive to the level of support they need and desire. This empathetic approach should be reflected in any Checklist and/or full assessment of eligibility for NHS Continuing Healthcare with carers and family members involved where appropriate.
- 326. When a CCG is supporting a home-based package where the involvement of a family member or friend is an integral part of the care plan, it should agree with the carer the level of support they will provide. It should also undertake an assessment of the carer's ability to continue to care, satisfying themselves that the responsibilities on the carer are appropriate and sustainable, and establish whether there is an 'appearance of need for support', which would mean that the carer should be referred for a carer's assessment (see paragraph 329 below).
- 327. The CCG may need to provide additional support to care for the individual whilst the carer(s) has a break from his or her caring responsibilities and will need to assure carers of the availability of this support when required. This could take the form of the CCG providing the cared-for person with additional services in their own home or providing the necessary support to enable them to spend a period of time away from home (e.g. a care home). The CCG should also give consideration to meeting any training needs that the carer may have to carry out this role.
- 328. Carers should have a single point of contact with the CCG to facilitate communication about any aspect of the care and support arrangements. CCGs should also work collaboratively with carers to agree contingency plans should the carer be unexpectedly unable to continue their caring role. This should include information on who to contact out of hours.
- 329. Consideration should also be given to making a referral for a separate carer's assessment by the relevant local authority. Under the Care Act 2014, all NHS bodies have a reciprocal duty to cooperate with local authorities in exercise of

their respective functions relating to carers¹. Of particular relevance is the local authority's duty to conduct a carer's assessment 'on the appearance of need for support'². This means that where on the basis of the steps above the CCG believes that there may be a need for support, a referral should be made. This may be particularly relevant where the carer has needs in relation to education, leisure or work (unrelated to their caring role) as these fall outside the scope of NHS Continuing Healthcare but can be addressed through Care Act 2014 provisions.

330. In May 2016, NHS England published *An Integrated Approach to Identifying and Assessing Carer Health and Wellbeing* to help health and social care organisations work together in identifying, assessing and supporting carers³. The Children and Families Act 2014⁴ also includes duties for the assessment of young carers and parent carers of children under 18.

¹ [Section 6\(1\)\(b\) of the Care Act 2014](#)

² [Section 10\(1\) of the Care Act 2014](#)

³ [An Integrated Approach to Identifying and Assessing Carer Health and Wellbeing](#)

⁴ [Children and Families Act 2014](#)

Transition from child to adult services

331. The National Framework for NHS Continuing Healthcare and the supporting guidance and tools should be used to determine what ongoing care services individuals aged 18 years or over should receive from the NHS.
332. Legislation and the respective responsibilities of the NHS, social care and other services are different in child and adult services. For children and young people, from birth to 18 (i.e. their 18th birthday), needs are assessed against a children's national framework, with a recommendation made to a multi-agency panel¹.
333. The term 'continuing care' has different meanings in child and adult services. For children and young people, continuing care refers to additional health support to that which is routinely available from GP practices, hospitals or in the community, and it can include care jointly commissioned by a local authority and CCG. It is important that young people and their families are helped to understand this and its implications right from the start of transition planning from children into adult services.
334. Eligibility for children's continuing care does not pre-suppose eligibility for NHS Continuing Healthcare.
335. There are a range of sources to support good practice in relation to transition for young people with complex health needs or disabilities. All transition planning for young people should take full account of the approaches set out in these documents. These documents set out below:
- The NICE quality standard QS140 Transition from children's to adults' services sets out some fundamental principles of assuring an effective transition².
 - *Transition: moving on well*³ sets out good practice for health professionals and their partners in transition planning for young people with complex health needs or disabilities.
 - *A transition guide for all services*⁴ explains how all relevant services should work together with a young person to identify how they can best support that person to achieve their desired outcomes.

¹ [Children and young people's continuing care national framework](#)

² [NICE quality standard QS140 Transition from children's to adults' services](#)

³ [Transition: moving on well](#)

⁴ [A transition guide for all services](#)

- 336. CCGs and local authorities should have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a young person who, on reaching adulthood, may have a need for services from the other agency.
- 337. CCGs should ensure that they are actively involved, with their partners, in the strategic development and oversight of their local transition planning processes, and that their representation includes those who understand and can speak on behalf of adult NHS Continuing Healthcare. CCGs should also ensure that adult NHS Continuing Healthcare is appropriately represented at all transition planning meetings to do with individual young people whose needs suggest that there may be potential eligibility.
- 338. The needs of a young person, and any future entitlement to adult NHS Continuing Healthcare should be clarified as early as possible in the transition planning process, especially if the young person's needs are likely to remain at a similar level until adulthood.
- 339. Children's services should identify those young people for whom it is likely that adult NHS Continuing Healthcare will be necessary, and should notify whichever CCG will have responsibility for them as adults. This should occur when a young person reaches the age of 14.
- 340. This should be followed up by a formal referral for screening to the adult NHS Continuing Healthcare team at the relevant CCG, when the child or young person is 16.
- 341. As soon as practicable after the young person's 17th birthday, eligibility for adult NHS Continuing Healthcare should be determined in principle by the relevant CCG, so that, wherever applicable, effective packages of care can be commissioned in time for the individual's 18th birthday. In order to do this staff from adult services (who are familiar with the adult NHS Continuing Healthcare National Framework) will need to be involved in both the assessment and care planning to ensure smooth transition to adult services. If needs are likely to change, it may be appropriate to make a provisional decision, and then to recheck it by repeating the process as adulthood approaches.
- 342. Entitlement to adult NHS Continuing Healthcare should initially be established using the decision-making process set out in this adult National Framework, including the Checklist and the Decision Support Tool. The decision on eligibility should be made using the relevant CCG's usual adult NHS Continuing Healthcare decision-making processes (although the usual 28 calendar day timescale between Checklist and decision does not apply for young people in transition). The health plans and other assessments and plans developed as part of the transition process will provide key evidence to be considered in the decision-making process. Any entitlement that is identified by means of these processes before a young person reaches adulthood will come into effect on their

18th birthday, subject to any change in their needs. The first review for NHS Continuing Healthcare would then normally take place three months after the person's 18th birthday and thereafter at least annually.

343. Where a young person has been assessed as being eligible for adult NHS Continuing Healthcare when they reach 18 years but lacks the mental capacity to decide about their future accommodation and support arrangements, a best interest decision will have to be made about these issues. This process must be compliant with the 2005 Mental Capacity Act, in particular with regards to consulting relevant people. If there is a significant difference of opinion between the responsible commissioner and the young person's family as to what arrangements would be in their best interests, this needs to be resolved before their 18th birthday. Normal best practice is that such resolution is achieved through open and collaborative discussion between all parties. If there remains disagreement, timely application should be made to the Court of Protection early enough for care and support arrangements to be in place when the young person reaches 18.
344. If a young person who receives children's continuing care has been determined by the relevant CCG not to be eligible for a package of adult NHS Continuing Healthcare in respect of when they reach the age of 18, then they and their parents or guardians – or in the case of looked after children their social worker and Independent Reviewing Officer – should be advised of their non-eligibility and of their right to request an independent review, on the same basis as NHS Continuing Healthcare eligibility decisions regarding adults. The CCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care.
345. Where a young person receives support via a placement outside the CCG's area, it is important that, at an early stage in the transition planning process, there is clear agreement between the CCGs involved as to whom the responsible commissioner presently is, and whether this could potentially change. This should be determined by applying the principles set out in the relevant legislation. All parties with current or future responsibilities should be actively represented in the transition planning process. A dispute or lack of clarity over commissioner responsibilities must not result in a lack of appropriate input into the transition process.
346. Even if a young person is not eligible for adult NHS Continuing Healthcare, they may have certain health needs that are the responsibility of the NHS. In such circumstances, CCGs should continue to play a full role in transition planning for the young person, and should ensure that appropriate arrangements are in place for services that meet these needs to be commissioned or provided. The focus

should always be on the individual's desired outcomes and the support needed to achieve these.

347. Where a child has an Education, Health and Care plan (EHC plan) for special educational needs in addition to a continuing care plan, this may continue up to age 25; the transitional period will provide an opportunity for aligning a review of that EHC plan, and the assessment for NHS Continuing Healthcare.
348. A key aim is to ensure that a consistent package of support is provided during the years before and after the transition to adulthood. The nature of the package may change because the young person's needs or circumstances change. However, it should not change simply because of the move from children's to adult services or because of a change in the organisation with commissioning or funding responsibilities. Where change is necessary, it should be carried out in a planned manner, in full consultation with the young person, bearing the options available through Personal Health Budgets (refer to paragraphs 296-300 of the National Framework). No services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place.
349. The legal responsibilities for child and adult services overlap in certain circumstances. In developing individual transition plans, partners should be clear where such overlaps occur, and the plans should clearly set out who will take responsibility and why. Some local health services for children and young people are only offered up to an age short of adulthood (i.e. 16). CCGs and other partners responsible for children and young people's services should ensure that appropriate services are commissioned to meet needs through to adulthood. A gap in service provision based on age does not mean that adult NHS Continuing Healthcare services acquire early responsibility. Where service gaps are identified, CCGs should consider how to address these as part of their strategic commissioning responsibilities.

Practice Guidance

Leadership and Governance

PG 1 What are the key governance functions of the CCG in relation to NHS Continuing Healthcare?

1.1 CCGs have the lead responsibility for NHS Continuing Healthcare in their locality.

1.2 Paragraph 21 of the National Framework sets out best practice governance responsibilities of CCGs. These are expanded on below.

1.3 Ensuring consistency in the application of the national policy on eligibility for NHS Continuing Healthcare

This may be achieved, for example, through the CCGs:

- monitoring patterns of eligibility decision-making
- using monitoring data to identify and address variations between areas and client groups (including use of the equality monitoring forms)
- peer review of eligibility decisions
- management audits of practice
- developing consistent protocols around completion of the Decision Support Tool (DST)
- working with staff to disseminate learning from the above processes and to identify development issues
- providing effective equality, diversity and human rights training and development, with a particular emphasis on understanding the cultures of the people they are most likely to encounter in their local area.

1.4 Promoting awareness of NHS Continuing Healthcare

This may be achieved, for example, through:

- ensuring that public information is available in appropriate formats and languages at key locations
- providing up to date information on the CCG and LA websites
- providing awareness-raising sessions for staff

- using existing networks to promote better understanding of NHS Continuing Healthcare
- working with independent and/or voluntary organisations to promote awareness.

1.5 Implementing and maintaining good practice

- This may be achieved, for example, through:
- clinical supervision arrangements with staff both individually and as a team
- ensuring that training is jointly developed and delivered with LA partners and tailored to identify and promote good practice
- use of regional meetings to identify and promote good practice and consistency
- use of pathway/process analysis to identify areas for development.

1.6 Ensuring that quality standards are met and sustained

This could, for example, include:

- agreement of quality standards across key agencies
- monitoring contracts for delivery of delegated NHS Continuing Healthcare functions
- use of auditing tools to check process and quality at different stages
- learning from complaints/compliments.

1.7 Providing training and development opportunities for practitioners

The CCG's responsibility is to maintain an oversight as to whether staff across relevant agencies are appropriately trained in relation to NHS Continuing Healthcare, though this does not necessarily mean the CCG has to carry out or fund all the training itself. The CCG's actions could, for example, include:

- providing core training courses on a rolling programme, jointly developed and delivered with other NHS organisations and the local authority
- providing specialist training sessions for coordinators/nurse assessors/social workers and others in NHS Continuing Healthcare roles across organisations
- ensuring training is available for relevant independent sector provider staff
- making training materials available for other organisations to use
- inclusion of NHS Continuing Healthcare in induction training for all relevant staff.

1.8 Identifying and acting on issues arising in the provision of NHS Continuing Healthcare

This could, for example, include:

- systematically reviewing complaints and disputes, including looking for patterns of unlawful discrimination or disproportionate negative impact on individuals, groups and communities
- undertaking 'root cause analysis' when a problem arises
- addressing the issues through contract management processes with provider organisations
- using some form of 'joint solutions group' with the local authority
- establishing robust risk management systems
- being a 'learning organisation' so that the whole team discusses and identifies necessary practice changes.

1.9 Informing commissioning arrangements, both on a strategic and an individual basis

The key to high quality cost-effective care is through robust commissioning and contracting arrangements. Achieving this could, for example, involve:

- use of activity and other monitoring data together with information from individual assessments and joint strategic needs assessments to forecast future patterns of demand
- joint analysis of needs with the local authority through strategic needs analysis processes
- a coordinated approach between the local authority and CCG at all levels of commissioning, brokerage and purchasing to provide a single and coherent interface with the market
- consideration of regional commissioning for cost-effective specialist provision, though care needs to be taken to ensure models that enable personalisation and choice, particularly for socially excluded, vulnerable and hard to reach groups
- liaising with local providers and providing information about likely future demand, possibly through a joint provider forum with the relevant local authority and by having an identified CCG lead for liaison with providers.
- having clear systems in place for the provision of Personal Health Budgets (PHBs).

Legal Context

PG 2 Is there an authoritative definition of ‘beyond the responsibility of the local authority’?

2.1 Local authorities have a duty to carry out an assessment of needs where it appears that an individual may have needs for care and support, and a duty to meet eligible needs (subject to means testing). However, local authorities cannot lawfully commission services that are clearly the responsibility of the NHS (such as registered nursing care and services that the NHS has to provide because the individual has a primary health need and is therefore eligible for NHS Continuing Healthcare).

2.2 Whilst there is no legal lower limit to what the NHS can provide, there is a legal limit to nursing and healthcare that can be provided by local authorities. This is a complex area of law. The powers and duties of local authorities derive from statute and case law, including the Coughlan Judgment (refer to Annex B).

2.3 Section 22 (1) of the Care Act 2014 confirms the general limits of local authority responsibility (as clarified in the Coughlan Judgment) stating that the local authority may not meet needs by providing or arranging for the provision of a service or facility that is required to be provided under the NHS Act 2006 unless:

- doing so would be merely incidental or ancillary to doing something else to meet needs under sections 18-20 of the Care Act 2014, and
- the service or facility in question would be of a nature that the local authority could be expected to provide.

2.4 Therefore, whilst local authorities can and do commission care in care homes (with or without nursing) where the person’s needs to be met include elements of ‘general nursing’ which can be provided by healthcare assistants or care assistants, this can only lawfully occur when this ‘nursing care’ is both incidental and ancillary to the individual’s accommodation and of a nature that a local authority can be expected to provide.

2.5 Where a local authority is funding an individual in a care home with nursing who requires registered nursing care, the CCG will be responsible for funding ‘NHS-funded Nursing Care’, so long as it has first been established that the individual is not eligible for NHS Continuing Healthcare. The Care Act 2014 (section 22(3)) clarifies that a local authority may not meet needs by providing or arranging for the provision of nursing care by a registered nurse (except under very specific circumstances set out in Section 22 (4) of the Care Act 2014).

Primary Health Need

PG 3 When identifying a primary health need, how should the four key characteristics be approached?

3.1 Four characteristics of need – namely ‘nature’, ‘intensity’, ‘complexity’ and ‘unpredictability’ – ‘may help determine whether the ‘quality’ or ‘quantity’ of care required is beyond the limit of a local authority’s responsibilities, as outlined in the Coughlan case (a summary of the case can be found at Annex B). It is important to remember that each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual’s needs.

3.2 It may be helpful for MDTs to think about these characteristics in terms of the sorts of questions that each generates. By the MDT answering these questions they can develop a good understanding of the characteristic in question. The following questions are not an exhaustive list and are not intended to be applied prescriptively.

3.3 **‘Nature’** is about the characteristics of both the individual’s needs and the interventions required to meet those needs.

Questions that may help to consider this include:

- How does the individual or the practitioner describe the needs (rather than the medical condition leading to them)? What adjectives do they use?
- What is the impact of the need on overall health and well-being?
- What types of interventions are required to meet the need?
- Is there particular knowledge/skill/training required to anticipate and address the need? Could anyone do it without specific training?
- Is the individual’s condition deteriorating/improving?
- What would happen if these needs were not met in a timely way?

3.4 **‘Intensity’** is about the quantity, severity and continuity of needs.

Questions that may help to consider this include:

- How severe is this need?
- How often is each intervention required?
- For how long is each intervention required?

- How many carers/care workers are required at any one time to meet the needs?
- Does the care relate to needs over several domains?

3.5 '**Complexity**' is about the level of skill/knowledge required to address an individual need or the range of needs and the interface between two or more needs.

Questions that may help to consider this include:

- How difficult is it to manage the need(s)?
- How problematic is it to alleviate the needs and symptoms?
- Are the needs interrelated?
- Do they impact on each other to make the needs even more difficult to address?
- How much knowledge is required to address the need(s)?
- How much skill is required to address the need(s)?
- How does the individual's response to their condition make it more difficult to provide appropriate support?

3.6 '**Unpredictability**' is about the degree to which needs fluctuate and thereby create challenges in managing them. It should be noted that the identification of unpredictable needs does not, of itself, make the needs 'predictable' (i.e. 'predictably unpredictable') and they should therefore be considered as part of this key indicator.

Questions that may help to consider this include:

- Is the individual or those who support him/her able to anticipate when the need(s) might arise?
- Does the level of need often change? Does the level of support often have to change at short notice?
- Is the condition unstable?
- What happens if the need isn't addressed when it arises? How significant are the consequences?
- To what extent is professional knowledge/skill required to respond spontaneously and appropriately?
- What level of monitoring/review is required?

Core Values and Principles

PG 4 What are the key elements of a 'person-centred' approach in NHS Continuing Healthcare?

4.1 The whole process of determining eligibility and planning and delivering services for NHS Continuing Healthcare should be 'person-centred'. This is vital since individuals going through this process will be at a very vulnerable point in their lives. There may well be difficult and significant choices to be made, so empowering individuals at this time is essential. This approach is also at the heart of wider policy on the personalisation of health and social care services (refer to paragraphs 296-300 of the National Framework).

4.2 Despite professional intentions to treat individuals with dignity and respect, the perception of individuals can be that this is not always the case. It is important for practitioners to put themselves in the position of the individual by asking questions like:

- 'How would I feel if this was happening to me?'
- 'Have I really tried to understand what this person wants, and what is important to them now and for the future?'

4.3 There are many elements to a person-centred approach but as a minimum it is necessary to:

- a) ensure that the individual and/or their representative concerned is fully and directly involved in the assessment and the decision-making process;
- b) take full account of the individual's own views and wishes, ensuring that their perspective is clearly the starting point of every part of the assessment process;
- c) address communication and language needs;
- d) obtain consent to assessment and sharing of records (where the individual has mental capacity to give this);
- e) deal openly with issues of risk;
- f) keep the individual (and/or their representative) fully informed.

a), b) and c) are explained further below, d), e) and f) are explained further in later sections of this guidance (refer to Practice Guidance notes 57-58).

a) Ensuring that the individual concerned and/or their representative is fully and directly involved in the assessment and the decision-making process

Individuals being assessed for NHS Continuing Healthcare are frequently facing significant changes in their life. It is essential that a person-centred approach is taken throughout the assessment process. A positive experience of the assessment process that promotes genuine choice and control can empower the person, resulting in a much better outcome.

The DST specifically asks whether the individual was involved in its completion, whether they were offered the opportunity to have a representative and whether the representative attended the DST completion. It also asks for details of the individual's view of their own care/support needs, whether the MDT assessment accurately reflects these and whether they contributed to the assessment. It also asks for the individual's views on the completion of the DST, including their view on the domain levels selected. The provision of advocacy, where appropriate, is an important means of achieving meaningful participation (refer to Practice Guidance note 9 and 57 below). 'All reasonable efforts should be made to involve the individual and/or their representative in the assessment process.

b) Taking full account of the individual's own views and wishes, ensuring that their perspective is clearly the starting point of every part of the assessment process

The individual's own views of their needs and their preference as to how they should be met should be documented and given due regard at each stage. Whilst accepting that they are not clinicians, it is important to recognise that some individuals can be experts in managing their own care needs. They should be given as much choice as possible, particularly in the care planning process. Where mental capacity issues impact on an individual's ability to express their views the approaches set out in this guidance should be used, including using family members and others who know the individual well to find out as much as possible on what the individual would want if they were able to express a view.

Where issues arise from needs and risks that may affect the care/support options available, these should be fully discussed with the individual. Care should be taken to avoid indicating any firm conclusions about care/support arrangements until needs have been fully assessed and it is clear what the funding arrangements may be.

c) Addressing communication and language needs

It is important to establish at the outset whether the individual has any particular communication needs and, if so, how these can be addressed. If English is not their first language an interpreter may be required, or if they have a learning disability the use of photographs, pictures or symbols may be helpful to support communication. Hearing difficulties are often exacerbated where there is background noise (so a quiet room might be needed), and many older people in particular struggle to use

any hearing aid they may have. If the individual uses British Sign Language (BSL) it will be necessary to arrange for a BSL interpreter, which may have to be booked well ahead. CCGs should consider the most likely communication needs to arise in the course of assessing for NHS Continuing Healthcare and make ongoing arrangements for appropriate support to be readily accessible. This could be, for example, by having arrangements with identified formal interpreters to be available at short notice.

Preferred methods of communication should be checked with the person or their relatives, friends or representatives in advance. Where a person has specific communication needs such that it takes them longer than most people to express their views, this should be planned into the time allocated to carry out their assessment.

Reasonable adjustments may need to be made (in accordance with the Equalities Act 2010) to enable the individual or their representative to fully participate in the process. For example, if the individual or their representative is not able to take or read written notes it may be considered a reasonable adjustment for them to take an audio recording of a meeting which they can refer to at a later date. However, it is important to be mindful of confidentiality issues and for an explicit agreement to be reached regarding the purpose and use of the recording. This is particularly important when a third party is recording the meeting rather than the individual concerned. In these circumstances either the individual concerned should give consent or, if they lack capacity, a best interest decision should be made by the professional chairing or leading the meeting.

The overall approach to carrying out the assessment is of equal importance in terms of accessibility to the technical arrangements that are put in place. Many people will find it easier to explain their view of their needs and preferred outcomes if the assessment is carried out as a conversation, dealing with key issues as the discussion naturally progresses, rather than working through an assessment document in a linear fashion. It is important that the person's own view of their needs is given due regard alongside professional views.

Consent

PG 5 What specific guidance is there in relation to dealing with confidentiality?

General Principles:

5.1 Where the person has mental capacity their informed consent is required before completion of the Checklist and for every stage of the process. It is good practice to seek consent for the whole process at the same time as obtaining consent for the Checklist (i.e. for the individual to also explicitly agree to the MDT sharing assessment information and completing the DST), although it should be made clear to individuals that they can withdraw their consent at any time and it would be good practice to ensure that the person is still consenting at each stage.

*Confidentiality: NHS Code of Practice*¹ is applicable to decisions on NHS Continuing Healthcare eligibility. The Code states:

‘It is extremely important that patients are made aware of information disclosures that must take place in order to provide them with high quality care’ ... ‘whilst patients may understand that information needs to be shared between members of care teams and between different organisations involved in healthcare provision, this may not be the case and the efforts made to inform them should reflect the breadth of the required disclosure. This is particularly important where disclosure extends to non-NHS bodies’

and:

‘... Patients generally have the right to object to the use and disclosure of confidential information that identifies them, and need to be made aware of this right. Sometimes, if patients choose to prohibit information being disclosed to other health professionals involved in providing care, it might mean that the care that can be provided is limited and, in extremely rare circumstances, that it is not possible to offer certain treatment options.’

‘Patients must be informed if their decisions about disclosure have implications for the provision of care or treatment. Clinicians cannot usually treat patients safely, nor provide continuity of care, without having relevant information about a patient’s condition and medical history.’

¹ [Confidentiality: NHS Code of Practice](#) and [Confidentiality: NHS Code of Practice - supplementary guidance: public interest disclosures](#)

‘Where patients have been informed of:

the use and disclosure of their information associated with their healthcare; and

the choices that they have and the implications of choosing to limit how information may be used or shared then explicit consent is not usually required for information disclosures needed to provide that healthcare. Even so, opportunities to check that patients understand what may happen and are content should be taken...’

5.2 When explicit consent is sought from patients, the Code advises that there should be evidence that consent has been given, either by noting this within a patient’s health record or by including a consent form signed by the patient.

5.3 When requesting consent to consider an individual’s eligibility for NHS Continuing Healthcare, this should also include consent to obtain relevant health and social care records necessary to inform determination of eligibility and also consent for these to be shared appropriately with those involved in the eligibility process. Individuals should be made aware of the range of records which may be disclosed and the range of health and social care professionals who may need to read them. The records that may be required to reach an informed conclusion on eligibility could include those from GPs, hospitals, community health services, LA social care, care homes and domiciliary care/support services.

5.4 Whilst it may not be possible at the outset in every case to indicate the exact records that may be required, individuals should be aware of the range of records that may be requested and explicitly give their consent to this range. A key question to consider is whether a professional receiving a request for access to the individual’s records, exercising reasonable care, would be satisfied that the consent supplied by the individual is sufficiently clear and specific for them to be able to release the records. Whilst it is preferable for consent to be recorded in writing, there may be circumstances where an individual is not physically able to provide written evidence of consent but is able to express their consent through verbal or other means. In such cases, the fact that consent has been given should be recorded in the patient’s notes and evidence of it made available to other professionals when records are required.

5.5 Individuals should always be given the option to withhold consent to accessing specific records where they wish, or for personal information being shared with particular people or agencies. The implications of withholding consent on the ability of the MDT or CCG to reach an informed decision in eligibility should be explained to the individual. However, they should never be put under pressure to give consent. Practitioners should respect confidentiality and ensure that information is not shared with third parties where consent has not been given.

Where the individual lacks capacity

5.6 Where the individual lacks mental capacity to consent to sharing personal information with relevant 3rd parties, a decision should be made as to whether sharing the information is in the individual's 'best interests' in accordance with the Mental Capacity Act 2005. Information sharing between professionals regarding a person who lacks capacity which is necessary for the purpose of their care or treatment will normally be in the person's best interest, in which case information can be shared subject to any local information sharing protocol that may be in place. In the context of this National Framework 'for the purpose of care and treatment' is taken to include the assessment of eligibility for NHS Continuing Healthcare.

5.7 Anyone who holds information regarding an individual who lacks mental capacity has a responsibility to act in that person's best interests and this can extend to sharing that information with relevant 3rd parties in appropriate circumstances.

5.8 There are some specific circumstances where information must be shared with a third party e.g. where they have a registered Lasting Power of Attorney (Health and Welfare) or are a court appointed Deputy (Health and Welfare).

5.9 There are also circumstances where it would be acceptable for a third party who is assuming responsibility for acting in a person's best interests (but may not have the formal authority of being an LPA (LPA) (health and welfare) or Court Appointed Deputy (health and welfare) to legitimately request information. In deciding whether to share personal/clinical information regarding an individual who lacks mental capacity with a family member, or anyone purporting to be representing the individual, the information holder must act within the following principles:

- any decision to share information must be in the individual's best interests;
- the information which is shared should only be that which it is necessary in order for the third party to act in the individual's best interests.

5.10 Subject to the above principles, information should not be unreasonably withheld.

5.11 There are a number of situations where a third party may legitimately be given information so long as the above principles are followed. Some common examples include:

- someone making care arrangements who requires information about the individual's needs in order to arrange appropriate support;
- someone with an LPA (property and finance), Deputyship (property and finance) or a registered Enduring Power of Attorney (EPA) seeking to

challenge an eligibility decision, or any other person acting in the person's best interests to challenge an eligibility decision.

5.12 If the person lacks capacity, information can be shared where the local authority is satisfied that doing so is in the person's best interests as stated in the Mental Capacity Act 2005.

5.13 One of the key principles behind adult safeguarding work is empowerment: people should be being supported and encouraged to make their own decisions and informed consent. This should be prioritised for the local decision making process.

5.14 Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action, for example because a criminal offence has occurred.

5.15 Because an adult initially refuses the offer of assistance he or she should not therefore be lost to or abandoned by relevant services. The situation should be monitored and the individual informed that she or he can take up the offer of assistance at any time.

PG 6 What are the rules around sharing information in the NHS Continuing Healthcare assessment process?

6.1 The rules governing information sharing are the same for NHS Continuing Healthcare as elsewhere and derive from several acts of Parliament, (including the Data Protection Act 1998, the Access to Health Records Act 1990 and the Mental Capacity Act 2005), the common law duty of confidence, and from a range of national guidance, including the Caldicott Principles. What information can, and should, be shared depends on a number of factors, including:

- Whether the individual concerned is alive or dead, bearing in mind that the records of deceased individuals are still confidential, even after death.
- If alive, whether the individual has capacity to consent to the information being shared. If they do then they should be asked for their consent to share the information and their answer recorded.
- If alive but lacking capacity, whether someone else has legal authority to make welfare decisions on their behalf (e.g. under health and welfare lasting power of attorney or health and welfare court deputy arrangements). If so the person with legal authority can give consent to sharing information on their behalf.
- If alive, lacking capacity and no-one else has authority to make decisions on their behalf, whether sharing information is properly considered to be in the individual's best interests (under the Mental Capacity Act). In the context of NHS Continuing Healthcare it may well be in their best interests for relevant

information to be shared. This may include disclosing information to a property and financial affairs deputy or attorney in order for them to carry out their responsibilities, or indeed any other third party who is acting as an advocate for them.

- If the individual concerned is deceased, whether the person requesting information has the proper authority to do so (e.g. the executor of the person's estate or someone who has grant of probate etc.).
- Whether the individual concerned now or in the past has expressly stated that certain information should not be shared
- Whether disclosure of information could lead to any person being put at serious risk of significant harm.
- Whether the records to be shared contain information about a third party (who isn't a professional), in which case this part of the record cannot be shared without some lawful basis for doing so.
- If information has been supplied by a third party (who is not part of the organisation holding the records) then it belongs to that third party and can only be shared by them or with their permission.

6.2 A guiding principle is that where decisions are being made in relation to any person's package of health or social care all pertinent information should be made available, wherever it is possible to do so having regard to the relevant law and guidance.

Capacity

PG 7 What happens if an individual with mental capacity refuses to give consent to being considered for NHS Continuing Healthcare eligibility?

7.1 Apart from the guidance given in this National Framework, The Reference guide¹ to consent for examination or treatment (second edition 2009), although focused on examination and treatment issues contains principles that should also be taken into account when considering a situation where the individual refuses consent to being considered for NHS Continuing Healthcare eligibility.

7.2 If an individual refuses to consent to the completion of a Checklist or NHS Continuing Healthcare assessment it should be clearly explained that this could potentially affect the ability of the NHS and the local authority to provide appropriate services. The reasons for their refusal should be explored. It should be explained that, if they were to consent and if the result was that they were found to be eligible for NHS Continuing Healthcare, the NHS has responsibility for funding the support necessary to meet their assessed health and social care needs. It is important to clearly document the efforts made to resolve the situation, including information and explanations given to the individual and/or their representative (where applicable).

7.3 Every effort should be made to encourage the individual to be considered for eligibility for NHS Continuing Healthcare, dealing with any concerns that they may have about this. For example, their reason for refusing consent could be a concern about losing an existing or potential direct payment arrangement, or that the level of funding available to support them might be reduced. The individual should be advised on what the CCG can do to personalise care/support and give them as much control as possible. Fuller details of approaches on this are in paragraphs 296-300 of the National Framework.

7.4 If a local authority decides that the refusal to consent to an assessment for NHS continuing healthcare means that local authority services can no longer be provided, they should give reasonable notice and clear reasons to the person concerned and give them the opportunity to request a review of the decision or to take it through the complaints process.

7.5 Although refusal of consent only occurs in a minority of cases, CCGs and local authorities should consider developing jointly agreed protocols on the processes to be followed. These should provide clarity regarding approaches such as the use of existing assessments and other information to determine each organisation's responsibilities and the most appropriate way forward. The aim should be for practitioners to be clear on their responsibilities and how to escalate the case if

¹ [Reference guide to consent for examination or treatment \(second edition\)](#)

necessary, and that the individual affected can make an informed decision on future support options as quickly as possible.

PG 8 What if there are concerns that the individual may lack capacity to consent to the completion of a Checklist/DST?

8.1 Where the third party is unable or unwilling to provide evidence of their delegated authority then decision-making responsibility remains with the assessor (although, dependent upon the urgency of the situation, the third party should be given reasonable opportunity to provide the order or LPA if they do not have it with them when requested). It is important to ensure that the assessment and support planning process is not delayed whilst awaiting confirmation of any legal authority that may be in place. Where a person has been appointed as attorney or deputy in relation to the person's property and financial affairs only, they do not have authority to make decisions about health and welfare. If they do have the appropriate authority then the assessment cannot continue if the personal welfare attorney or deputy refuses consent. Under these circumstances if the assessor believes that the deputy/attorney's decision is contrary to the best interests of the person, or would seriously compromise them, consideration should be given to raising this concern through the local Safeguarding Adults procedure. In appropriate circumstances the Court of Protection can overrule the decision or withdraw the welfare decision-making authority from the person.

PG 9 When is it appropriate to involve an Independent Mental Capacity Advocate (IMCA)?

9.1 An IMCA does not routinely need to be appointed in the context of an NHS Continuing Healthcare assessment. However, NHS bodies and LAs have a duty under the Mental Capacity Act 2005 to instruct and consult an IMCA if an individual lacks capacity in relation to, serious medical treatment or a change of accommodation for a certain period (at least 28 calendar days for a hospital admission or a stay of eight weeks in a care home), and has no family or friends that are available (or appropriate) for consultation on their behalf.

9.2 Where an IMCA has been appointed a permanent decision should not be made on the issue (for which they have been appointed) until the IMCA report has been submitted and considered by the decision-maker.

PG 10 Dealing openly with issues of risk

10.1 Assessment of risk is central to providing a holistic multidisciplinary assessment of need. A good risk assessment will include listening and observation, talking to the individual and their carers to identify what risks they see and their proposed response to them in the context of their personal and family circumstances, talking to other agencies and providers of services and then listing the key risk factors, for

example isolation, self-neglect, self-harm or aggression. In considering 'risk' it is important to establish what particular adverse occurrence might happen and to evaluate both the likelihood and the potential impact of this occurrence.

10.2 So long as an individual has mental capacity they are entitled to choose to take risks, even if professionals or other parties consider the decision to be unwise. It is important to work with the person to explain any risks involved and not to make generalised assumptions about these. 'Independence, choice and risk: a guide to best practice in supported decision-making'¹ sets out wider best practice on this issue. The governing principle it states for dealing with independence, choice and risk for all activities surrounding a person's choices about their daily living is: 'People have the right to live their lives to the full as long as that doesn't stop others from doing the same.'

10.3 To put this principle into practice, those supporting individuals have to:

- help people have choice and control over their lives
- recognise that making a choice can involve some risk
- respect people's rights and those of their family carers
- help people understand their responsibilities and the implications of their choices, including any risks
- acknowledge that there will always be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for the person
- continue existing arrangements for safeguarding people.

10.4 The guidance also includes best practice approaches to decision-making on risk issues, including a supported decision tool.

10.5 Where someone lacks the mental capacity to make a decision about a course of action, including one involving any level of risk, they will not be able to give consent. In these circumstances, any decision or action should be made on the basis of what is in the person's best interests, following the requirements in the Mental Capacity Act 2005 and its associated Code of Practice. In some circumstances, the Court of Protection may need to be involved in certain decisions. It should also be borne in mind that just because a person wishes to make an unwise decision, this does not mean in itself that they lack capacity to make the decision.

¹ [Independence, choice and risk: a guide to best practice in supported decision-making](#)

Screening for NHS Continuing Healthcare using the Checklist Tool

PG 11 Who needs to be present when a Checklist is completed?

11.1 The individual should be given reasonable notice of the need to undertake the Checklist. What constitutes reasonable notice depends upon the circumstances of the individual case. In an acute hospital setting or where an urgent decision is needed, notice may only be a day or two days. In a community setting, especially where needs are gradually changing over time, more notice may be appropriate. The amount of notice given should take into account whether the individual wishes to have someone present to act as an advocate for them or represent or support them, and the reasonable notice required by the person providing that support. It is the responsibility of the person completing the Checklist or coordinating the discharge process to make the individual aware that they can have an advocate or other support (such as a family member, friend or carer) present and of the local arrangements for advocacy support.

11.2 The individual themselves should normally be given the opportunity to be present at the completion of the Checklist, together with any representative in accordance with the above.

PG 12 What information needs to be given to the individual when completing a Checklist?

12.1 The individual and/or their representative should be advised in advance of the need to complete the Checklist and the reasons for this. The Department of Health and Social Care (DHSC) patient information leaflet on NHS Continuing Healthcare should be given to the individual. Opportunity should be given for an explanation of the NHS Continuing Healthcare process to the patient and for dealing with any questions about it. It should be made clear that completion of the Checklist does not indicate likelihood that they will be eligible for NHS Continuing Healthcare. Whatever the outcome of the Checklist, the individual should be provided with confirmation of this decision as soon as reasonably practicable. The written decision should include the contact details and the complaints process of the CCG in case the individual wishes to challenge the Checklist decision (including any review processes available through the CCG as an alternative to making a complaint). The National Framework sets out how the outcome of the Checklist must be communicated clearly and in writing to the individual or their representative as soon as reasonably practicable, this should include the reasons why the Checklist outcome was reached. Normally this will be achieved by providing a copy of the Checklist (refer to National Framework paragraph 100).

12.2 A copy of the completed Checklist, together with a covering letter giving the appropriate details for challenging the decision, will be sufficient to constitute a

written decision in many circumstances, provided that the completed Checklist or other documentation includes sufficient detail for the individual to understand the reasons why the decision was made. CCGs should consider making the decision available in alternative formats where this is appropriate to the individual's needs.

PG 13 Can registered nurses in care home settings complete a Checklist Tool?

13.1 The care home should contact the relevant CCG NHS Continuing Healthcare team to arrange for a Checklist to be completed. However, where a CCG has an agreed protocol in place with a care home then other arrangements for completion of checklists may apply.

PG 14 Can someone self-refer by completing a Checklist themselves?

14.1 No. If the individual is known to a health or social care practitioner, they could ask that practitioner to complete a Checklist. Alternatively, they should contact their CCG NHS continuing healthcare team to ask for someone to visit to complete the Checklist, or if they already have a care home or support provider, they could ask them to contact the CCG on their behalf. Where the need for a Checklist is brought to the attention of the CCG through these routes it should respond in a timely manner, having regard to the nature of the needs identified. In most circumstances it would be appropriate to complete a Checklist within 14 calendar days of such a request.

PG 15 What should happen once the Checklist has been completed?

15.1 If full assessment of eligibility for NHS Continuing Healthcare is required the Checklist should be sent to the CCG where the individual's GP is registered unless alternative arrangements have been made by the CCG. If the individual does not have a GP, the responsible CCG should be identified using the approaches set out in the relevant legislation. Checklists should be sent in the fastest, but most appropriate and secure way. The use of either internal or external postal systems can delay the receipt of the Checklist and should only be used if no other referral mechanism is available. Each CCG should have appropriate secure arrangements for the receipt of Checklists and these should be publicised to all relevant partners. The CCG will then arrange for a case coordinator to be appointed who will ensure that an MDT (including professionals currently treating or supporting the individual) carries out an assessment and uses this to complete a DST.

15.2 CCGs have the responsibility for ensuring that arrangements are in place so that individuals who are screened out at the Checklist stage are informed of the outcome, are given a copy of the Checklist, are given details of how to seek a review of the outcome by the CCG and are offered the opportunity for their case to be referred to the LA for consideration for social care support. This could be delegated

by agreement to other organisations that have staff completing Checklists but CCGs have the ultimate responsibility.

15.3 Where a Checklist indicates that a referral for assessment of eligibility for NHS Continuing Healthcare is not necessary, it is good practice for the Checklist to still be sent to the relevant CCG for information, as the individual may wish to request the CCG to reconsider the Checklist outcome and the CCG will need a copy of the Checklist in order to do this.

PG 16 Where an individual has been screened using the Checklist and has been found not to require full assessment for NHS Continuing Healthcare, is there a requirement to review this Checklist after 3 months and, following this, on an annual basis?

16.1 No, there is no requirement to review 'negative' Checklists. However, where an individual has been 'screened out' using the Checklist but their needs subsequently change it may, depending on the nature of the changes, be necessary to consider completing a new Checklist to see whether they now require full assessment for NHS Continuing Healthcare. Alternatively a decision could be made to undertake a full assessment for NHS Continuing Healthcare without doing a Checklist if the change in needs clearly warrants this.

16.2 Where an individual has been screened using the Checklist but has been found not to require a full assessment for NHS Continuing Healthcare they should be given a copy of the completed Checklist and informed that if they disagree with the decision not to proceed to full assessment for NHS Continuing Healthcare they may ask the CCG to reconsider this.

16.3 Where an individual who does not require full assessment for NHS Continuing Healthcare nonetheless requires ongoing care and support from health or social care agencies, normal arrangements for such support will apply. However, when undertaking a review of an individual who is currently in receipt of NHS-funded Nursing Care, potential eligibility for NHS Continuing Healthcare must always be considered, by completing a Checklist (unless this has been done before and needs have not changed) and, where necessary, carrying out full consideration using the Decision Support Tool.

When and where to screen and assess eligibility for NHS Continuing Healthcare

PG 17 When should the Checklist be completed if the individual is in the community or in a care setting other than hospital?

17.1 In a community setting or a care setting other than hospital it may be appropriate to complete a Checklist:

- as part of a community care assessment
- at a review of a support package or placement
- when a clinician such as a community nurse, GP or therapist is reviewing a patient's needs
- where there has been a reported change in an individual's care needs, or
- in any circumstance that would suggest potential eligibility for NHS continuing healthcare.

PG 18 When should a Checklist be completed if the individual is in hospital?

18.1 In a hospital setting the Checklist should only be completed (if required) once an individual's acute care and treatment has reached the stage where their needs on discharge are clear. Paragraphs 109-117 of the National Framework highlight the need for practitioners to consider whether the individual would benefit from other NHS-funded care in order to maximise their abilities and provide a clearer view of their likely longer-term needs before consideration of NHS Continuing Healthcare eligibility. This should be considered before completion of the Checklist as well as before completion of the DST.

18.2 In the minority of cases it might be appropriate for both the Checklist and the DST to be completed within the hospital setting but this should only be where it is possible to accurately identify a person's longer-term support needs at that time and there is sufficient time to identify an appropriate placement/ package of care/support that, where practicable, fully takes into account the individual's views and preferences.

18.3 CCGs should ensure that NHS Continuing Healthcare is clearly built into local agreed discharge pathways. This should include identification of the circumstances when NHS Continuing Healthcare assessments and care planning will be carried out in the hospital setting, bearing in mind the guidance set out in paragraphs 109-117 of the National Framework.

18.4 Checklists should not be completed too early in an individual's hospital stay; this could provide an inaccurate portrayal of their needs as the individual could potentially make a further recovery. As far as possible the individual should be ready for safe discharge at the point that a Checklist (if required) is undertaken. It should therefore be completed at the point where wider post-discharge needs are also being assessed. If at any point after a Checklist has been sent to the CCG the individual's needs change such that he/she requires further treatment, the completed Checklist will no longer be relevant and a new Checklist should be undertaken once the treatment has been completed. In some situations an individual's needs might reduce whilst they are still receiving NHS funded care to the extent that a further Checklist indicates that they no longer 'screen in' for a full assessment of eligibility for NHS Continuing Healthcare. The CCG and the individual should be kept fully informed of the changed position. This process will enable the CCG to redirect their resources to where they are most urgently required.

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

PG 19 Can the national tools be changed?

19.1 No, these are national tools and the content should not be changed, added to or abbreviated in any way. However, CCGs may attach their logo and additional patient identification details if necessary (e.g. adding NHS number, etc.).

19.2 The national tools for NHS Continuing Healthcare include: the Checklist Tool, the Decision Support Tool and the Fast Track Pathway Tool.

PG 20 What is the role of the NHS Continuing Healthcare coordinator(s)?

20.1 The coordination role includes:

- receiving and acting upon a referral for assessment of eligibility for NHS Continuing Healthcare, ensuring appropriate consent has been given
- identifying and securing the involvement of the MDT which will assess the individual's needs and will then use this information to complete the DST. The MDT should usually comprise health and social care staff presently or recently involved in assessing, reviewing, treating or supporting the individual (refer to paragraphs 119-123 of the National Framework)
- supporting MDT members to understand the role they will need to undertake in participating in a multidisciplinary assessment and completing the DST
- helping MDT members to identify whether they will need to undertake an updated or specialist assessment to inform completion of the multidisciplinary assessment
- supporting the person (and those who may be representing them) to play a full role in the eligibility consideration process, including ensuring that they understand the process, they have access to advocacy or other support where required, and organising the overall process in a manner that maximises their ability to participate
- ensuring that there is a clear timetable for the decision-making process, having regard to the expectation that decisions should usually be made within 28 calendar days of the CCG being notified of the need for a full assessment of eligibility for NHS Continuing Healthcare.
- ensuring that the assessment and DST processes are completed in accordance with the requirements in the National Framework and relevant standing rules/regulations.
- acting as an impartial resource to the MDT and the individual on any policy or procedure questions that arise

- ensuring that the MDT's recommendation on eligibility is sent for approval through the relevant local decision-making processes in a timely manner

20.2 Care should be taken by CCGs to ensure an appropriate separation between the coordinator function and those responsible for making a final decision on eligibility for NHS Continuing Healthcare.

PG 21 What are the elements of a good multidisciplinary assessment of needs?

21.1 Assessment in this context is essentially the process of gathering relevant, accurate and up-to-date information about an individual's health and social care needs, and applying professional judgement to decide what this information signifies in relation to those needs. Both information and judgement are required. Simply gathering information will not provide the rationale for any eligibility recommendation; a recommendation that simply provides a judgement without the necessary information will not provide the evidence for any subsequent decision. Assessment documentation should be obtained from any professional involved in the individual's care and should be clear, well-recorded, factually accurate, up to date, signed and dated.

21.2 As a minimum a good quality multidisciplinary assessment of an individual's health and social care needs will be:

- person-centred, making sure that the individual and their representative(s) are fully involved, that their views and aspirations are reflected and that their abilities as well as their difficulties are considered
- proportionate to the situation, i.e. in sufficient depth to enable well-informed judgements to be made but not collecting extraneous information which is unnecessary to these judgements. If appropriate this may simply entail updating existing assessments
- include information from those directly caring for the individual (whether paid or unpaid)
- holistic, looking at the range of their needs from different professional and personal viewpoints, and considering how different needs interact
- taking into account differing professional views and reaching a commonly agreed conclusion if possible
- considerate of the impact of the individual's needs on others
- focused on improved outcomes for the individual
- evidence-based – providing objective evidence for any subjective judgements made

- clear about needs requiring support in order to inform the commissioning of an appropriate care package
- clear about the degree and nature of any risks to the individual (or others), the individual's view on these, and how best to manage the risks.

21.3 Effective assessment processes and documentation are key to making decisions on eligibility for NHS Continuing Healthcare and for commissioning the right care package at the right time and in the right place, so that the individual can move to their preferred place of choice as quickly and safely as possible.

21.4 CCGs and local authorities should consider agreeing joint models of assessment documentation and having regular training or awareness events to support them.

21.5 This will require the gathering and scrutiny of all available and appropriate evidence, whether written or oral, including that from the GP, hospital (nursing, medical, mental health, therapies, etc.), professionals with relevant skills, knowledge and expertise, community nursing services, care home provider, local authority records, assessments, Checklists, DSTs, records of deliberations of MDTs, panels, etc., as well as any information submitted by the individual concerned; compilation of a robust and accurate identification of the care needs; audit of attempts to gather any records said not to be available; involvement of the individual or their representative as far as possible, including the opportunity for them to contribute and to comment on information:

PG 22 What are the potential sources of information/evidence? (NB: this is not an exhaustive list)

- Health needs assessment
- Needs assessment (under the Care Act 2014)
- Nursing assessment
- Individual's own views of their needs and desired outcomes
- Person-centred plan
- Carer's views
- Physiotherapy assessment
- Behavioural assessment
- Speech and Language Therapy (SALT) assessment
- Occupational Therapy assessment

- Care home/home support records
- Current care plan
- 24-hour/48-hour diary indicating needs and interventions (may need to be 'good day' and 'bad day' if fluctuating needs)
- GP information
- Specialist medical/nursing assessments (e.g. tissue viability nurse, respiratory nurse, dementia nurse, etc.)
- Falls risk assessment
- Standard scales (such as the Waterlow score)
- Psychiatric/community psychiatric nurse assessments

PG 23 How should the well-managed need principle be applied?

23.1 Care should be taken when applying the well-managed need principle. Sometimes needs may appear to be exacerbated because the individual is currently in an inappropriate environment rather than because they require a particular type or level of support – if they move to a different environment and their needs reduce this does not necessarily mean that the need is now 'well-managed', the need may actually be reduced or no longer exist. For example, in an acute hospital setting, an individual might feel disoriented or have difficulty sleeping and consequently exhibit more challenging behaviour, but as soon as they are in a care home environment, or their own home, their behaviour may improve without requiring any particular support around these issues.

23.2 Where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain. Similarly, where an individual's skin condition is not aggravated by their incontinence because they are receiving good continence care, it would not be appropriate to weight the Skin domain as if the continence care was not being provided.

PG 24 What is the role of the individual during the multidisciplinary team process?

24.1 The individual or their representative cannot be members of the MDT. However, they should be fully involved in the process and be given every opportunity to contribute to the MDT discussion.

24.2 Once all the information has been gathered (and depending on agreed local protocols) it is acceptable for the MDT to have a discussion without the individual

and/or their representative present in order to come to an agreed recommendation. MDTs should be aware that the DST contains a section at the end of the domain tables for the individual and/or the representative to give their views on the completion of the DST that have not already been recorded elsewhere in the document, including whether they agree with the domain levels selected. It also asks for reasons for any disagreement to be recorded. Therefore the MDT meeting should be arranged in a way that enables that individual to give his/her views on the completed domain levels before they leave the meeting.

24.3 If the individual and/or their representative are not present for the part of the meeting where the MDT agrees the recommendation regarding primary health need, the outcome should be communicated to them as soon as possible.

24.4 Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs and, where possible, have recently been involved in the assessment, treatment or care of the individual. MDT members could potentially include:

- nurse assessors
- social care practitioners
- physiotherapists
- occupational therapists
- dietitians/nutritionists
- GPs/consultants/other medical practitioners
- community psychiatric nurses
- ward nurses
- care home/support provider staff
- community nurses
- specialist nurses
- community matrons
- discharge nurses.

This list is not exhaustive but illustrates who may need to be invited to provide evidence regarding an individual's needs so that as accurate and comprehensive

picture as possible can be made. It also illustrates the variety of disciplines from which members of the MDT can be drawn.

PG 25 Is the coordinator also a member of the MDT and involved with other members in agreeing the appropriate recommendation regarding eligibility for NHS Continuing Healthcare?

25.1 The role of the 'co-ordinator' in the context of NHS Continuing Healthcare is set out in Practice Guidance note 20. All aspects of the co-ordinator's role are important and part of the role includes 'acting as an impartial resource to the MDT and the individual on any policy or procedure questions that arise'. Some have asked whether this means that the 'co-ordinator' cannot actually be a member of the MDT. If this were the case it would always be necessary to have a minimum of two professionals from different healthcare professions, or one from healthcare and one from social care, in addition to the co-ordinator. It is recognised that in many situations this would raise significant practical difficulties in convening a properly constituted MDT.

25.2 The intention in the National Framework is not to exclude the possibility of a member of the MDT also undertaking the role of co-ordinator, but where the professional concerned has this dual role they should be very clear about their two different functions. The fact that they should, amongst other things, act as an 'impartial resource' relates specifically to advising the MDT on matters of policy and procedure. They can contribute to decision-making on the correct recommendation so long as they encourage debate within the MDT and so long as they record a recommendation which genuinely reflects the view of the whole MDT, not just their own view.

PG 26 What happens if the coordinator is unable to engage relevant professionals to attend an MDT meeting?

26.1 CCGs should not make decisions on eligibility in the absence of an MDT recommendation, unless exceptional circumstances require an urgent decision to be made.

26.2 Apart from ensuring that all the relevant information is collated, it is crucial to have a genuine and meaningful multidisciplinary discussion about the correct recommendation to be made. This should normally involve a face-to-face MDT meeting (including the individual and/or their representative). If a situation arises where a relevant professional is unable or unwilling to attend an MDT meeting every possible effort should be made to ensure their input to the process in another way, such as participating in the MDT meeting as a teleconference call. Where this is not possible then submission of a written assessment or other documentation of views could be used but this should be the least favoured option. Where professionals use this route, the CCG should explain to them that, whilst their views will be taken into

account, the eligibility recommendation will by necessity be made by MDT members physically present or participating by teleconference.

26.3 Care should be taken to ensure that alternative approaches for MDT participation still enable the individual being assessed to fully participate in the process.

26.4 If, even after having followed the above processes, there are still difficulties with the participation of, or obtaining assessment information from, a specific professional, CCGs should consider (in liaison with the individual) whether they have sufficient wider assessment information to reach a full picture of the individual's needs, having regard to the minimum MDT membership set out above. CCGs should record the attempts to secure participation.

26.5 In order to ensure effective MDT decision-making, CCGs should:

- have arrangements in place for coordinators to obtain senior support to secure participation of other practitioners where necessary
- consider agreeing protocols on MDT participation with organisations that frequently have staff who participate in MDTs.

PG 27 Where should an MDT meeting take place?

27.1 An MDT meeting can take place in any setting but should be as near to the individual's location as possible so that they are enabled to be actively involved in the process. Although the acute hospital setting is not an ideal place for MDTs to make a recommendation about eligibility, it may, in some circumstances where the person is an in-patient, be the only available opportunity to have everyone involved in the process. However, wherever possible, it should still be held in a suitable room for the nature of the meeting. Alternatives to the acute hospital setting should be used for MDT meetings wherever possible, e.g. community hospitals, hospices, care homes or the individual's own home may provide suitable settings, depending on the individual's circumstances.

PG 28 What process should be used by MDTs to ensure consistency when completing the DST?

28.1 Whilst local conditions and therefore local processes will vary, the following elements are recommended as being core to achieving consistency:

- The coordinator should gather as much information as possible from professionals involved prior to the MDT meeting taking place, including agreeing where any new/updated specialist assessments are required prior to the meeting.

- The coordinator (or someone nominated by them) should explain the role of the MDT to the individual in advance of the meeting, together with details of the ways that the individual can participate. Where an individual requests copies of the documentation to be used this should be supplied.
- Information from the process above and any additional evidence should be discussed within the MDT meeting to try to achieve a common understanding of the individual's needs. Where copies of assessments are circulated to MDT members at the meeting, copies should also be made available to the individual if they are present.
- Relevant evidence (and sources) should be recorded in the text boxes preceding each of the domain levels within the DST and this information should be used to identify the level of need within that domain, having regard to the user notes of the DST.
- Depending upon local arrangements the MDT members may decide to reach the final recommendation on eligibility after the individual and/or their representative have left the meeting. However, the National Framework gives clear expectations on the individual's involvement in the wider process. If the MDT is to reach its final recommendation privately it is best practice to give the individual/representative an opportunity before they leave the meeting to state their views.
- Having completed the care domains, the MDT should consider what this information signifies in terms of the nature, complexity, intensity and unpredictability of the individual's needs. It should then agree and record its recommendation, based on these characteristics, providing a rationale which explains why the individual does or does not have a primary health need. It is important that MDT members approach the completion of the DST objectively without any preconceptions that specific conditions or diagnoses do or do not indicate eligibility or fit a particular domain level without reference to the actual needs of the individual (refer to paragraphs 147-152 of the National Framework relating to the completion of the DST and making eligibility recommendations).
- The recommendation should then be presented to the CCG, who should accept this, except in exceptional circumstances. These circumstances could for example include insufficient evidence to make a recommendation or incomplete domains.
- If the CCG does not accept the MDT recommendation (refer to Practice Guidance note 39 for circumstances when this can happen) it should refer the DST back to the MDT identifying the issues to be addressed. The coordinator for the individual case has a critical role in ensuring that any deficiencies in the MDT assessment and recommendation are fully addressed in order to avoid further delay in decision-making. The

coordinator should be satisfied that there is sufficient evidence and a clear rationale to support the recommendation before re-submitting the DST. Once the completed DST has been re-presented to the CCG, the CCG should then accept the recommendation (except in exceptional circumstances). The CCG remains responsible, and accountable for, the final eligibility decision and should avoid repeatedly returning a DST to the MDT.

- The decision should be communicated in writing as soon as possible in an accessible format and language to the individual or their representative so that it is meaningful to them. They should also be sent a copy of the DST and information on how to ask for a review of the decision if the individual is dissatisfied with the outcome.

28.2 This whole process should usually be completed within 28 calendar days. This timescale is measured from the date the CCG receives the completed Checklist indicating the need for full consideration of eligibility (or receives a referral for full consideration in some other acceptable format) to the date that the eligibility decision is made. However, wherever practicable, the process should be completed in a shorter time than this.

PG 29 Are there particular drugs, interventions or conditions which, for consistency, should always translate into a particular scoring or outcome when completing the DST?

29.1 No. For any given domain within the DST, MDT members are required to use their professional judgement to determine the closest fit between what is known about an individual's needs and the relevant domain level descriptors. There is no nationally prescribed set of 'sub-rules' to steer MDT members into allocating particular domain weightings beyond the wording provided in the domain level descriptors. Similarly, because the eligibility criteria for NHS Continuing Healthcare are needs based rather than condition-based, there are no rules which state that an individual with a particular condition must be found eligible (or not) for NHS Continuing Healthcare on the basis of their diagnosis/condition alone.

PG 30 Can associated needs be recorded in more than one domain on the DST?

30.1 Yes, needs associated with a single condition can be reflected in more than one domain. The belief that there is a 'no double-scoring rule' is a common misconception. Paragraph 24 of the user notes of the DST makes it clear that the DST is a record of needs and a single condition might give rise to separate needs in a number of domains. For example an individual with cognitive impairment will have a weighting in the cognition domain and as a result may have associated needs in other domains, all of which should be recorded and weighted in their own right. An

individual with a severe cognitive impairment might or might not also exhibit associated challenging behaviour. Therefore, if challenging behaviour exists, recording this in the behaviour domain is necessary in order to give an accurate picture of needs, even though this behaviour might be linked to their cognitive impairment.

PG 31 What is proportionate and reasonable in terms of evidence required to support domain levels and the recommendation in a DST?

31.1 Much will depend on the particular circumstances of the case in question. However, the following points should be born in mind:

The purpose of evidence in this context is to ensure that there is an accurate picture of the individual's needs, not to convince a court of law that those providing the evidence are telling the truth. Any requirement for additional evidence in support of levels of need should be proportionate and reasonable.

31.2 Having sufficient evidence is not about volume but about how pertinent it is – more is not necessarily better. For example, a précis of incident forms or a chart showing the number of times a particular type of incident/intervention occurred may be more helpful than requiring all the original incident forms or daily records.

31.3 It may be necessary to ask the provider to complete a detailed diary over a suitable period of time to demonstrate the nature and frequency of the needs and interventions, and their effectiveness.

31.4 Oral evidence from carers or relevant professionals should be taken into account where it is pertinent to establishing the levels of need. This should be recorded on the DST by the co-ordinator or other MDT members and given due consideration, bearing in mind other evidence available.

PG 32 Why is it important to complete the equality monitoring forms with the tools?

32.1 The equality monitoring form is for completion by the individual being assessed, although staff should offer to help them complete it where support is required. The purpose of the equality monitoring form is to help CCGs identify whether individuals from different groups (in terms of disability, ethnicity, etc.) are accessing NHS Continuing Healthcare on an equitable basis, including whether they are being properly identified for potential eligibility at Checklist stage and are being identified for the Fast Track process where appropriate. The equality form should be forwarded to the relevant CCG to enable it to monitor whether the National Framework is being applied equitably in its area. If the CCG identifies any issues for particular groups or communities it should take steps to address these.

32.2 The national tools for NHS Continuing Healthcare include: the Checklist Tool, the Decision Support Tool and the Fast Track Pathway Tool.

PG 33 What happens if MDT members cannot agree on the levels within the domains of the DST?

33.1 The DST (paragraph 21 of the user notes) advises practitioners to move to the higher level of a domain where agreement cannot be reached but there should be clear reasoned evidence to support this. If practitioners find themselves in this situation they should review the evidence provided around that specific area of need and carefully examine the wording of the relevant DST levels to cross-match the information and see if this provides further clarity. Additional evidence may be sought, although this should not prolong the process unduly. If this does not resolve the situation, the disagreement about the level should be recorded on the DST along with the reasons for choosing each level and by which practitioner. This information should also be summarised within the recommendation so that the CCG can note this when verifying recommendations.

33.2 The practice of moving to the higher level where there is disagreement should not be used by practitioners to artificially steer individuals towards a decision that they have a primary health need where this is not justified. It is important that this is monitored during the CCG audits of recommendations and processes so that individual practitioners found to be using the 'higher level' practice incorrectly can be identified. Discussion may need to take place with these practitioners and further training may be offered.

33.3 If practitioners are unable to reach agreement, the higher level should be accepted and a note outlining the position included within the recommendation on eligibility. As part of CCGs' governance responsibilities, they should monitor occurrences of this issue. Where regular patterns are identified involving individual teams or practitioners this should be discussed with them and where necessary their organisations to address any practice issues.

PG 34 What happens if the individual or their representative disagrees with any domain level when the DST is completed?

34.1 Whilst the individual and/or their representative should be fully involved in the process and be given every opportunity to contribute to the MDT discussion, the membership of the MDT consists of the practitioners involved (refer to paragraphs 119-123 of the National Framework regarding the composition of the MDT). The approach described in Practice Guidance note 33 applies to disagreements between practitioners and not when an individual or their representative disagrees with individual domain levels chosen in the completion of the DST. However, concerns expressed by individuals and representatives should be fully considered by

reviewing the evidence provided. If areas of disagreement remain these should be recorded in the relevant parts of the DST.

PG 35 What does the DST recommendation need to cover?

35.1 The recommendation should:

- provide a summary of the individual's needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs.
- provide statements about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these characteristics provided in paragraphs 58-66 of the National Framework.
- give an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability.
- in the light of the above, give a recommendation as to whether or not the individual has a primary health need (refer to paragraphs 58-66 of the National Framework). It should be remembered that, whilst the recommendation should make reference to all four characteristics of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

35.2 Although the core responsibility of MDTs is to make a recommendation on eligibility for NHS Continuing Healthcare, the recommendation could also indicate any particular factors to be considered when commissioning/securing the placement or care/support package required to meet the individual's needs (whether or not the individual has a primary health need).

35.3 Where the outcomes of the individual care domains do not obviously indicate a primary health need (e.g. a priority level in one domain or severe levels in two domains being found), but the MDT is using professional judgement to recommend that the individual does nonetheless have a primary health need, it is important to ensure that the rationale for this is clear in the recommendation.

35.4 Where an individual has a deteriorating condition, practitioners need to take this into account in reaching their conclusion on primary health need, considering the approaches set out in paragraphs 229 - 230 of the National Framework, and being mindful of how that condition and the associated needs are going to progress before the next planned review. Where an individual has a deteriorating condition but eligibility for NHS Continuing Healthcare is not presently recommended, consideration should be given to setting an early review date. This should be clearly

highlighted in the recommendation to the CCG who should ensure that the review is arranged at the appropriate time.

35.5 The recommendation for eligibility for NHS Continuing Healthcare should not be based upon an individual's specific condition or disease (e.g. stroke, cancer, Alzheimer's disease, dementia, etc.) but on the needs that are identified. Needs that give rise to eligibility can be from any condition or disease. Just because individuals with a particular condition or disease have previously been found to be eligible for NHS continuing healthcare does not mean that every individual with a similar condition or disease will be eligible. Each individual should be assessed in their own right and evidence provided around the range of their needs; the identification of a primary health need should not be prejudged without going through the proper process in each individual case.

35.6 All of the above information should be provided even if the recommendation is that the individual does not have a primary health need. The CCG is responsible for care planning and commissioning all services that are required to meet the needs of all individuals who qualify for NHS Continuing Healthcare, and for the healthcare part of any joint care package. However, it is beneficial if the MDT makes recommendations on the care package to be provided, based on the assessment and any care plan already developed, whether the CCG, LA or both will have responsibilities.

35.7 The written recommendation needs to provide as sufficient detail, but should be clear and concise, to enable the CCG and the individual to understand the rationale behind the recommendation.

35.8 As the individual or their nominated representative should receive a copy of the DST it is important that it is legible, and free from jargon and abbreviations.

35.9 A copy of the completed assessment, DST and other documents should be forwarded to the CCG.

PG 36 How does the DST and primary health need eligibility test apply to people with learning disabilities?

36.1 The DST should be used for all adults who require assessment for NHS Continuing Healthcare, irrespective of their client group/diagnosis. The tool focuses on the individual's needs, not on their diagnosis. Directions require that the DST is used to inform the decision as to whether an individual has a primary health need, and if the CCG concludes that they do they must be found eligible for NHS Continuing Healthcare.

36.2 In all cases eligibility for NHS Continuing Healthcare should be informed by good quality multidisciplinary assessment. Where the individual has a learning

disability it will be important to involve professionals with expertise in learning disability in the assessment process as well as those with expertise in NHS Continuing Healthcare. It will also be important to ensure that the assessment process is person-centred and that family members/carers are fully and appropriately involved.

36.3 The Standing Rules set out how 'primary health need' should be considered in the context of considering eligibility for NHS Continuing Healthcare. Paragraph 58 of the National Framework explains the primary health need test in some detail. It is important to understand that this test is about the balance of needs once all needs have been mapped onto the DST.

36.4 The reasons given for a decision on eligibility should not be based on the:

- a) individual's diagnosis;
- b) setting of care;
- c) ability of the care provider to manage care;
- d) use (or not) of NHS-employed staff to provide care;
- e) need for/presence of 'specialist staff' in care delivery;
- f) the fact that a need is well-managed;
- g) the existence of other NHS-funded care; or
- h) any other input-related (rather than needs-related) rationale.

36.5 The question is not whether learning disability is a health need, but rather whether the individual concerned, whatever client group he or she may come from, has a 'primary health need'.

36.6 The indicative NHS Continuing Healthcare eligibility threshold levels of need as set out in the user notes apply equally to all individuals irrespective of their condition or diagnosis.

36.7 Previous or current pooled budget, joint funding, Section 75 agreements or legacy funding arrangements and the funding transfer to local authorities in April 2009 do not alter the underlying principles of NHS Continuing Healthcare entitlement.

36.8 The Department made it clear that the funding transfer to local authorities in 2009 was for social care and did not include those eligible for NHS Continuing Healthcare. However this National Framework points out that some historic local agreements relating to particular groups of clients with learning disabilities (for example following hospital/campus closures) can mean that these individuals are not required to be considered separately for NHS Continuing Healthcare.

36.9 It is crucial that the detail of these local agreements are examined in order to clarify whether or not the National Framework applies. It is important to ensure that all adults are treated equitably under the National Framework.

36.10 Some people have concerns about the potential loss of personalisation/control for people with learning disabilities (and other client groups) if their care is commissioned/provided/funded by the NHS. However, CCGs have considerable existing legal powers to maximise choice and control, including the provision of 'personal health budgets'. Anyone in receipt of NHS Continuing Healthcare has the right to have a personal health budget which could potentially include a 'direct payment for healthcare'. These arrangements include individuals with a learning disability and CCGs should ensure that they are aware of current legislation and guidance on this matter.

36.11 Whatever the outcome of the eligibility decision regarding NHS Continuing Healthcare, commissioning should be person-centred and needs-led. Where an individual is eligible for NHS Continuing Healthcare, CCGs have responsibility to ensure that effective case management is commissioned. Consideration should be given as to who is best placed to provide this function, and clear responsibilities agreed. Amongst other options it may be appropriate to secure this from the local authority who may have previous knowledge of the individual concerned or have staff with particular skills and experience to undertake this function on behalf of the CCG.

Decision-making on eligibility for NHS Continuing Healthcare by the CCG

PG 37 What is the role of the CCG in the decision-making process?

37.1 CCGs are responsible for making the eligibility decision for NHS Continuing Healthcare, based on the recommendation made by the MDT in accordance with the processes set out in this National Framework.

37.2 The role of the CCG decision-making processes, whether by use of a panel or other processes should include:

- verifying and confirming recommendations on eligibility made by the MDT, having regard to the issues in PG41 below;
- agreeing required actions where issues or concerns arise.

37.3 CCG decision-making processes should not have the function of:

- financial gatekeeping
- completing/altering DSTs
- overturning recommendations (although they can refer cases back to an MDT for further work in certain circumstances – refer to Practice Guidance note 39 below).

PG 38 If the CCG uses a panel as part of the overall decision-making process what should its function be and how should it operate?

38.1 Once an MDT has made a recommendation regarding eligibility it is for the CCG to make the final eligibility decision. There is no requirement for CCGs to use a panel as part of their decision-making processes. Where a CCG does use a panel this should not replace the function of the MDT, whose role it is to assess the individual, complete the DST and make a recommendation regarding eligibility. Close working with local authorities is a central part of this National Framework, for example in terms of membership of MDTs and in having local joint processes for resolving disputes. It would be consistent with this overall approach for CCGs to have mechanisms for seeking the views of LA colleagues before making final decisions on NHS Continuing Healthcare eligibility and this could be by the use of a panel. However the formal decision-making responsibility rests with the CCG. Annex F (Local NHS Continuing Healthcare Protocols) contains details of the recommended content of local protocols, including decision-making processes.

38.2 Panels may be used in a selective way to support consistent decision-making. For example this could include panels considering:

- cases which are not recommended as eligible for NHS Continuing Healthcare (for audit purposes or for consideration of possible joint funding)
- cases where there is a disagreement between the CCG and the LA over the recommendation – this could form part of the formal disputes process
- cases where the individual or his/her representative is appealing against the eligibility decision
- a sample of cases where eligibility has been recommended for auditing and learning purposes to improve practice (refer to paragraph 69 of the National Framework and Practice Guidance note 1).

38.3 If a CCG chooses to use a panel arrangement as part of the decision-making process this should not be allowed to delay decision-making. Where relevant expertise is considered essential to the panel the CCG should ensure that staff with such expertise are made available in a timely manner.

PG 39 What are the 'exceptional circumstances' under which a CCG or panel might not accept an MDT recommendation regarding eligibility for NHS continuing healthcare?

39.1 Eligibility recommendations must be led by the practitioners who have met and assessed the individual. Exceptional circumstances where these recommendations may not be accepted by a CCG include:

- where the DST is not completed fully (including where there is no recommendation)
- where there are significant gaps in evidence to support the recommendation
- where there is an obvious mismatch between evidence provided and the recommendation made
- where the recommendation would result in either authority acting unlawfully.

39.2 In such cases the matter should be sent back to the MDT with a full explanation of the relevant matters to be addressed. Where there is an urgent need for care/support to be provided, the CCG (and LA where relevant) should make appropriate interim arrangements.

PG 40 How should CCGs fulfil their duty to make final eligibility decisions for NHS Continuing Healthcare?

40.1 The National Framework and Standing Rules¹ make it clear that CCGs cannot delegate their final decision-making function in relation to eligibility for NHS Continuing Healthcare. CCGs remain legally responsible for all such decisions even where they have authorised another body (such as a Commissioning Support Unit,

social enterprise or local authority) to carry out assessment functions on their behalf. CCGs have a number of options as to how to fulfil this responsibility. For example, they might choose to use one, or a combination of, the following:

- appoint (or jointly appoint) an employee (or employees) to work within the organisation carrying out the assessment functions such that this member of staff has authority to make eligibility decisions as an employee of the CCG with clear lines of authority and accountability within the CCG for undertaking this role
- identify an employee (or employees), or Governing Body Member(s), within the CCG to make eligibility decisions regarding NHS Continuing Healthcare having received the completed assessments and recommendations from the organisation carrying out the NHS Continuing Healthcare assessment function on behalf of the CCG
- bearing in mind the guidance in Practice Guidance, use a verification committee or 'panel' as a formal sub-committee of the CCG with delegated responsibility for decision making in relation to NHS Continuing Healthcare eligibility

40.2 Whatever arrangements the CCG chooses it must be remembered that the National Framework places a strong emphasis on the MDT recommendation regarding eligibility for NHS Continuing Healthcare and states that 'Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed. A decision not to accept the recommendation should never be made by one person acting unilaterally (refer to paragraph 156 of the National Framework). Any model for final ratification must respect this requirement and also the requirement that 'the final eligibility decision should be independent of budgetary constraints' (refer to paragraph 156 of the National Framework). It is vital that all arrangements for verifying recommendations and for making the final eligibility decisions are timely and efficient and do not result in delays, particularly where the individual concerned is awaiting transfer of care from an acute hospital setting.

PG 41 Can 'commissioners' sit on panels which scrutinise and ratify eligibility recommendations for NHS Continuing Healthcare?

41.1 The National Framework (paragraph 156) makes it clear that the final decision regarding eligibility for NHS Continuing Healthcare should be independent of budgetary constraints and that 'finance officers' should not be part of a decision-making panel. The purpose of excluding finance officers is to avoid any perception that eligibility has been influenced by funding considerations.

41.2 CCGs do not have to use a panel arrangement as part of their process for ratifying eligibility recommendations, but if they do the panel should not be used for financial gatekeeping (refer to Practice Guidance note 40).

41.3 Being a budget holder does not automatically mean that a person is a finance officer. Almost everyone working in the NHS or in social care has some responsibility for the proper use of public money. This does not make them 'finance officers'. The term 'finance officer' refers to individuals whose primary role is financial management rather than managing, commissioning or providing services. In a CCG, for example, the Director of Finance is a finance officer and it is probable that most staff who report directly to that Director are also 'finance officers'.

41.4 The National Framework does not state that 'commissioners' should not be panel members and it is recognised that in many cases it will be commissioning staff (whether from health or social care) who will bring relevant expertise to the decision-making process. However, where panel members, or any officers involved in the ratification process, also have budgetary responsibilities it is very important to be clear that decision-making is based on whether the individual has a 'primary health need', not on financial considerations.

41.5 As a matter of best practice, and in order to ensure objectivity, where a professional has been involved in making an eligibility recommendation they should not also be involved in ratifying that recommendation.

PG 42 If a person dies whilst awaiting a decision on NHS Continuing Healthcare eligibility, should a decision still be made in respect of eligibility for the period before their death?

42.1 Where an individual received services prior to their death that could have been funded through NHS Continuing Healthcare then the eligibility decision-making process should be completed. Where no such services were provided it is not necessary to continue with the eligibility decision-making process.

42.2 Where a decision is made that the individual would have been eligible for NHS Continuing Healthcare funding then payments should be made in accordance with the guidance on refunds in Annex E of this National Framework.

Care Planning and Delivery

PG 43 How should commissioning be approached for a person eligible for NHS Continuing Healthcare?

43.1 This National Framework sets out a number of responsibilities of CCGs in relation to NHS Continuing Healthcare commissioning, including:

- NHS Continuing Healthcare commissioning involves actions at both strategic and individual levels.
- NHS Continuing Healthcare commissioning actions by CCGs should include strategic planning, specifying outcomes, procuring services, and managing demand and provider performance (including monitoring quality, access and the experience of those in receipt of NHS Continuing Healthcare). In managing the quality and performance of providers and the experiences of those using their services, CCGs should take into account the role and areas of focus of the Care Quality Commission and, where relevant, local authority commissioners of the relevant provider's services in order to avoid duplication and to support the mutual development of an overall picture of each provider's performance.
- There should be clarity on the roles of commissioners and providers. The services commissioned should include an ongoing case management role as well as the assessment and review of individual needs.
- CCGs should consider commissioning from a wide range of providers in order to secure high quality, value for money services. In exercising this responsibility, CCGs should have regard to the case management role set out in the National Framework 167-170 of ensuring that the care/support package meets the individual's assessed needs and agreed outcomes and is appropriate to achieve the identified intended outcomes in the care plan. To help inform this approach, CCGs should have an understanding of the market costs for care and support within the relevant local area.
- CCGs should commission in partnership with local authorities wherever appropriate.
- CCGs should ensure clarity regarding the services being commissioned from providers, bearing in mind that those in receipt of NHS Continuing Healthcare continue to be entitled to access the full range of primary, community, secondary and other health services. The services that a provider of NHS Continuing Healthcare-funded services is expected to supply should be clearly set out in the contract between the provider and the CCG. CCGs should commission services using models that maximise personalisation and individual control and that reflect the individual's preferences as far as possible. It is particularly important that this approach should be taken when an individual who was previously in receipt of a local authority direct payment begins to receive NHS continuing healthcare; otherwise they may experience a loss of the control they had previously exercised over their care.

- CCGs are reminded that people in receipt of NHS Continuing Healthcare have a right to have a personal health budget (PHB). For more information please visit the NHS England PHB pages at <https://www.england.nhs.uk/personal-health-budgets/>
- CCGs and local authorities should operate person-centred commissioning and procurement arrangements, so that unnecessary changes of provider or of care package do not take place purely because the responsible commissioner has changed.
- CCGs should take into account other policies and guidance relevant to the individual's needs.

PG 44 Can a CCG use an external agency to carry out the commissioning of NHS Continuing Healthcare services or for negotiation with providers?

44.1 CCGs hold the statutory responsibility for commissioning NHS services for their populations, including NHS Continuing Healthcare. CCGs may reach arrangements with other organisations to carry out functions on their behalf, they retain statutory responsibility. CCGs can make arrangements with local authorities or other bodies/organisations in relation to NHS Continuing Healthcare commissioning. In order for the local authority to commission NHS Continuing Healthcare on the CCG's behalf, this requires a transfer of appropriate powers using section 75 of the NHS Act 2006. Other arrangements, such as integrated teams of the CCG and local authority staff commissioning for individuals with high support needs in an integrated manner are also possible. In all cases, the CCGs retain ultimate responsibility for NHS Continuing Healthcare commissioning. Any such arrangements should reflect the CCG's responsibilities to fund the assessed health and social care needs of individuals eligible for NHS Continuing Healthcare and that NHS Continuing Healthcare, as with most other NHS services, is free at the point of delivery to the individual.

44.2 CCGs should ensure that there is clarity in arrangements with external organisations on the respective responsibilities of the CCG and of the external organisations in relation to the above roles. The approaches of the external organisation to the functions they carry out on behalf of the CCG should reflect the best practice set out for CCGs in this Practice Guidance and in the National Framework. The external organisation should operate within the CCG's strategic approaches and policies in relation to NHS Continuing Healthcare commissioning, including in relation to the range of providers and the choice available to individuals.

PG 45 Can CCGs take comparative costs and value for money into account when determining the model of support to be provided to an individual?

45.1 Yes, subject to the following guidance and the guidance set out in paragraphs 279-290 of the National Framework. In some situations a model of support preferred

by the individual will be more expensive than other options. CCGs can take comparative costs and value for money into account when determining the model of support to be provided, but should consider the following factors when doing so:

- The cost comparison has to be on the basis of the genuine costs of alternative models. A comparison with the cost of supporting a person in a care home should be based on the actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care home cost.
- Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual's assessed needs and agreed desired outcomes. For example, individuals can sometimes be described as needing 24-hour care when what is meant is that they need ready access to support and/or supervision. CCGs should consider whether models such as assistive technology could meet some of these needs. Where individuals are assessed as requiring nursing care, CCGs should identify whether their needs require the actual presence of a nurse at all times or whether the needs are for qualified nursing staff or specific tasks or to provide overall supervision. The willingness of family members to supplement support should also be taken into account, although no pressure should be put on them to offer such support. CCGs should not make assumptions about any individual, group or community being available to care for family members.

Cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment (see the Gunter case in Practice Guidance note 46).

PG 46 Gunter Case

46.1 In the case of *Gunter vs. South Western Staffordshire Primary Care Trust* (2005), a severely disabled woman wished to continue living with her parents whereas the PCT's preference was for her to move into a care home. Whilst not reaching a final decision on the course of action to be taken, the court found that Article 8 of the European Convention of Human Rights had considerable weight in the decision to be made, that to remove her from her family home was an obvious interference with family life and so must be justified as proportionate. Cost could be taken into account but the improvement in the young woman's condition, the quality of life in her family environment and her express view that she did not want to move were all important factors which suggested that removing her from her home would require clear justification.

Inter-agency disagreements and disputes

PG 47 What if the dispute crosses CCG/LA borders?

47.1 Where a dispute occurs between a CCG and local authority in different areas (and therefore without a shared disputes resolution agreement) it is recommended that the local process applying to the CCG involved in the case is used. Where a dispute involves two CCGs, it is recommended to use the disputes process for the CCG area where the individual is residing at the outset of the relevant decision-making process. Thus if CCG A had made a placement in CCG B's area, it is CCG A's dispute process that should be used, even if the person is now physically residing in CCG B's area. Both CCGs should be able to play a full and equal role in the dispute resolution. Consideration could be given to identifying an independent person (who is not connected with either CCG) to oversee the resolution of the dispute. CCGs and local authorities should consider agreeing and publishing local processes and timescales for responding to complaints and concerns relating to NHS Continuing Healthcare on issues that fall outside of the independent review panel (IRP) process.

PG 48 What can key agencies do to improve partnership working in relation to NHS Continuing Healthcare?

48.1 NHS Continuing Healthcare can only be delivered successfully through a partnership approach at both organisational and practitioner levels between NHS England, CCGs, LAs, local NHS bodies, and provider organisations. Local protocols covering the areas where agreement is needed on policy and processes relevant to NHS Continuing Healthcare may be helpful in ensuring consistency and developing relationships. Annex G contains guidelines on what could be included in such protocols. Trust between organisations is developed by actions that are trustworthy and transparent, and by an approach that is based on everyone seeking to accurately apply the eligibility criteria rather than seeking to move responsibility to another organisation. Amongst other things good partnership working involves:

- NHS England, CCGs and LAs, as far as possible, adopting similar approaches to the ranges and models of care or support they commission so that there is no perceived advantage or disadvantage to being funded by one agency rather than the other;
- NHS England, CCGs and LAs developing similar approaches to risk and enablement;
- NHS England, CCGs, LAs and providers supporting their staff to adopt creative, flexible approaches that reflect best practice;
- Practitioners across all sectors being supportive, open and honest with one another;

- Practitioners respecting each other's professional judgement, knowledge and experience and working together to obtain the best outcome for the individual;
- Dealing with genuine disagreements between practitioners in a professional manner without inappropriately drawing the individual concerned into the debate in order to gain support for one professional's position or the other;
- Practitioners being clear with each other what services can be commissioned by their respective organisations in order to give accurate information to the individuals concerned.

Examples of good partnership working include:

- the LA and CCG having unified commissioning/contracting arrangements, with one organisation commissioning and/or contracting on behalf of both;
- joint brokerage arrangements between the LA and CCG;
- joint preparation and delivery of training;
- joint arrangements for hospital discharge coordinators funded by the CCG based in acute hospitals to ensure good communication, correct processes and streamlined decision-making;
- reciprocal agreements around 'funding without prejudice';
- joint tendering for domiciliary care;
- Secondment/joint post arrangements whereby social care staff work alongside CCG staff to undertake NHS Continuing Healthcare assessments;
- Arrangements to jointly review those receiving NHS Continuing Healthcare;
- CCGs working with the Transition Team to ensure screening and planning occurs for young people approaching adulthood who may become eligible for NHS Continuing Healthcare;
- Appointment of a social worker within an NHS Continuing Healthcare team;
- Joint funding of advocacy services by CCGs and LAs.

Fast Track Pathway Tool

PG 49 Do individuals need to consent to a Fast Track Pathway Tool being completed?

49.1 Yes, where the individual has capacity their consent is required for the completion of the Fast Track Pathway Tool. The clinician completing the Tool should sensitively seek this, along with consent to share personal information for the purposes of arranging appropriate care. Consent in these circumstances should be in a form which complies with the requirements for explicit consent set out in para 72 of the Framework.

49.2 Where an individual lacks capacity to provide consent, the appropriate clinician should make a 'best interests' decision on whether to complete the Fast Track Pathway Tool in accordance with the Mental Capacity Act 2005. This best interests process should be carried out without delay, having regard to the intention that the tool should enable individuals to be in their preferred place of care as a matter of urgency.

PG 50 How should Fast Track care packages be put in place?

50.1 CCGs who receive significant numbers of Fast Track Pathway Tools could consider having staff dedicated to implementing Fast Track care packages as this will avoid a conflict of time priorities when dealing with non-Fast Track applications. Having dedicated staff could also facilitate close working with end of life care teams. CCGs should also consider wider arrangements that need to be in place to facilitate implementation of packages within 48 hours, such as protocols for the urgent provision of equipment. The CCG coordinator and the referrer should communicate effectively with each other to ensure well-coordinated discharge/support provision arrangements.

Joint packages of care, including NHS-funded Nursing Care

PG 51 In a joint package does the DST define which elements are the responsibility of the NHS and which are the responsibility of social services?

51.1 No. The completed DST will help to indicate the nature and levels of need of an individual, but it does not attribute responsibility for individual elements of a care package. Where a person is not eligible for full NHS Continuing Healthcare the cost of a jointly funded support package are a matter of negotiation between the CCG and the local authority based on the assessed needs of the person and the limits of what a local authority can fund.

51.2 One approach to identifying respective funding responsibilities is to analyse a 24 hour/48 diary of the tasks and interventions required to meet the individual's needs in order to identify which elements are beyond local authority powers, which are areas where both health and social care have power to provide, and which areas which are clearly social care responsibility.

51.3 CCGs and local authorities should agree protocols for dealing with jointly funded packages/placements. Local dispute resolution processes should cover both disputes over joint funding as well as NHS Continuing Healthcare eligibility.

PG 52 How does NHS-funded Nursing Care affect other funding such as from local authorities?

52.1 The fundamental issue here is about how the care home fee is shared between the NHS, the nursing home resident and/or the local authority.

53.2 NHS-funded Nursing Care is a defined contribution towards the cost of registered nursing in a care home. It is set each year at a standard rate.

52.3 The Care home provider should set an overall fee level for the 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.

PG 53 Is there a national template for assessing NHS-funded Nursing Care?

53.1 Yes, Annex A of the NHS-funded Nursing Care Practice Guide contains a template for recording nursing care needs. This template is for use in those situations where the individual has not already had a full MDT assessment with a

DST completed (i.e. the individual has had a Checklist completed but this did not indicate the need for a full assessment for NHS Continuing Healthcare).

53.2 Where a full MDT assessment and DST have been completed there should be sufficient information to determine the need for NHS-funded Nursing Care.

Further Information related to care and support arrangements

PG 54 Case study 1: Paying for additional services

54.1 Eileen lives in a care home as part of a care package funded via NHS Continuing Healthcare. She has significant difficulties in leaving the care home due to mobility needs. Her care plan identifies that she requires physiotherapy weekly which she receives from a physiotherapist employed by the CCG. Eileen considers that she wishes to purchase an additional session of physiotherapy weekly.

54.2 The CCG review her care plan and consider that one physiotherapy session a week is sufficient to meet her needs. Eileen decides that she would nevertheless like to purchase an additional session. She makes arrangements with a private physiotherapist for this purpose.

54.3 With Eileen's permission, the NHS and privately-funded physiotherapists liaise to ensure compatible approaches to the treatment that they will give, ensuring that the NHS treatment continues to be fully provided by the NHS physiotherapist. This is set out in a care plan agreed with Eileen.

PG 55 Case study 2: Paying for additional services

55.1 John receives a support package funded via NHS Continuing Healthcare in his own home. The package is delivered by care workers from a private agency engaged by the NHS who visit to provide support every four hours. John considers that support should be provided more often and asks the CCG to increase the visits to every two hours. The CCG review John's support package and agree that more frequent support is needed during the evenings. They increase the frequency to every two hours each evening. However the CCG consider that four hourly visits are still appropriate during the daytime.

55.2 John still wishes to have additional support during the day and arranges with the same care provider to purchase additional visits every two hours. The CCG liaise with John and the care provider to develop mutual clarity on the additional support to be provided in the privately-funded visits as opposed to those provided in the NHS-funded visits. This is set out in a care plan agreed between the CCG, the care provider and John. The arrangements also include a single set of daily notes completed by the care provider's staff as a record of each visit so that, regardless of whether the most recent visit was NHS funded or privately funded, there is effective communication on John's current needs for the next staff who visit.

PG 56 Who is responsible for equipment and adaptations if an individual is eligible for NHS Continuing Healthcare and is in their own home?

56.1 Where an individual is eligible for NHS Continuing Healthcare the CCG has a responsibility to meet the individual's assessed nursing, healthcare, personal care and associated social care needs. It may well be that the provision of equipment and/or adaptations is identified as being an appropriate way to meet some of these needs.

56.2 Those in receipt of NHS Continuing Healthcare should have access to local joint equipment services on the same basis as any other person. Local agreements on the funding of joint equipment services should take into account the fact that the NHS has specific responsibilities for meeting the support needs of those eligible for NHS Continuing Healthcare. Some individuals will require bespoke equipment (and/or specialist or other non-bespoke equipment that is not available through joint equipment services) to meet specific assessed needs identified in their NHS Continuing Healthcare care plan. CCGs should make appropriate arrangements to assess for and meet these needs.

56.3 Disabled Facilities Grants (DFGs)¹ may be available from local housing authorities towards the cost of housing adaptations that are necessary to enable a person to remain living in their home (or to make a new home appropriately accessible). DFGs are means-tested and are administered by the housing authority which has to decide whether the proposed adaptation is reasonable and practicable. Under the relevant legislation² the housing authority is required to consult with the Local Authority as to whether the adaptation is necessary and appropriate for the individual in question, but this does not necessarily mean that the local authority is required to undertake an occupational therapy assessment for this purpose. Because CCGs are responsible for meeting the needs of those eligible for NHS Continuing Healthcare, the local authority might reasonably rely on information from the CCG in order to provide advice rather than undertake its own separate assessment for this purpose. A duty to assess under the Care Act 2014 is not triggered in these circumstances (but the request may indicate the need for the CCG to carry out a review of the individual's NHS Continuing Healthcare support plan).

56.4 The CCG retains responsibility for deciding with the individual how their needs will be met, including in situations where property adaptation is assessed as an appropriate option. DFGs are means tested and the individual might not be entitled to a grant or the grant might not cover the full cost of the adaptation. CCGs are reminded that in such circumstances they must give consideration to the option of funding the adaptation if this is a cost effective solution. Housing authorities, CCGs and local authority social services authorities all have powers to provide additional

¹ [Disabled Facilities Grant](#)

² [The Housing Grants, Construction and Regeneration Act 1996](#)

support where appropriate. Further details can be found in the guidance *Delivering Housing Adaptations for Disabled People; A Detailed Guide to Related Legislation, Guidance and Good Practice (2013)*¹. This guidance encourages the above bodies, together with home improvement agencies and registered social landlords, to work together locally on integrated adaptations services. Whether or not such integrated services are in place, CCGs should have clear arrangements with partners setting out how the adaptation needs of those eligible for NHS Continuing Healthcare should be met, including referral processes and funding responsibilities.

56.5 CCGs should be aware of their responsibilities and powers to meet housing-related needs for those eligible for NHS Continuing Healthcare:

- a) CCGs have a general responsibility under section 3(1)(e) of the NHS Act 2006 to provide such after-care services and facilities as it considers appropriate as part of the health service for those who have suffered from illness.
- b) NHS England has responsibility for arranging, under section 3B(1) of the NHS Act 2006 and under Standing Rules Regulations, secondary care and community services for serving members of the armed forces and their families, and prisoners, as part of the health service to such an extent as it considers necessary to meet all reasonable requirements.
- c) CCGs may make payments in connection with the provision of housing to housing authorities, social landlords, voluntary organisations and certain other bodies under sections 256 and 257 of the above Act.
- d) CCGs also have a more general power to make payments to local authorities towards expenditure incurred by the local authority in connection with the performance of any local authority function that has an effect on the health of any individual, has an effect on any NHS function, is affected by any NHS function or are connected with any NHS function.
- e) Housing can form part of wider partnership arrangements under section 75 of the above Act.

56.6 Local authorities should be aware that they may continue to have responsibilities under the Care Act 2014 to those in receipt of NHS Continuing Healthcare. Local authorities cannot lawfully meet needs by providing or arranging services that are legally the responsibility of the NHS. Therefore, in deciding what

¹ [*A Detailed Guide to Related Legislation, Guidance and Good Practice \(2013\)*](#)

services to provide or arrange the local authority will need to take into account services that are the responsibility of the NHS to provide or arrange, either as NHS Continuing Healthcare or as other NHS services. They may also continue to have some responsibilities for those in their own homes eligible for NHS Continuing Healthcare where the services needed are not ones that the Secretary of State requires the NHS to provide.

56.7 When an assessment is required for a minor housing adaptation or the provision of equipment for an individual receiving NHS Continuing Healthcare funding, the CCG is responsible for ensuring that the assessment is undertaken and, where appropriate, the adaptation or equipment is provided.

56.8 Whilst local authorities and CCGs have some overlapping powers and responsibilities in relation to supporting individuals eligible for NHS Continuing Healthcare in their own home, a reasonable division of responsibility should be negotiated locally. In doing this, CCGs should be mindful that their responsibility under NHS Continuing Healthcare involves meeting both health and social care needs based on those identified through the MDT assessment. Therefore, whilst local authorities and CCGs have overlapping powers, in determining responsibilities in an individual case, CCGs should first consider whether the responsibility to meet a specific need lies with them as part of their NHS Continuing Healthcare responsibilities. Local authorities should be mindful of the types of support that they may provide in such situations as outlined in paragraphs 291-295 of the National Framework.

Advocacy

PG 57 Whose responsibility is it to provide advocacy for individuals going through the eligibility decision-making process?

57.1 Any individual is entitled to nominate a person to represent their views or speak on their behalf and this could be a family member, friend or peer, a local advocacy service or someone independent who is willing to undertake an advocacy role. It is not appropriate for either a local authority or NHS member of staff to act as a formal advocate in this sense as there could be a conflict of interest, although staff should always seek to explain the individual's views alongside their own. Local authorities and CCGs may have varying arrangements to fund advocacy services in their locality, some being jointly funded whereas others are funded by a single agency or rely on voluntary contributions.

57.2 In addition to the provision of advocacy under the Mental Health Act and the Mental Capacity Act, the Care Act 2014 introduced new responsibilities on local authorities to arrange independent advocacy for individuals undergoing certain processes including a care and support assessment and planning under the Care Act 2014 where:

- a) that individual would otherwise have substantial difficulty in understanding relevant information, retaining information, using or weighing information or communicating their views, wishes and feelings and
- b) there is currently no appropriate individual available to support and represent the person for the purpose of facilitating their involvement.

57.3 However, whilst there is no specific statutory provision for independent advocacy for people being assessed for NHS Continuing Healthcare, where an individual is being assessed by the local authority, and their needs indicate that a joint assessment is required for NHS Continuing Healthcare, the local authority is under a duty to consider the individual's need for an advocate to support their involvement in that assessment¹. These Care Act 2014 requirements do not mean that local authorities have a general responsibility for the provision or funding of independent advocacy where individuals are being assessed for NHS Continuing Healthcare.

57.4 Whilst CCGs do not have a statutory requirement to provide advocacy services, they should consider planning strategically together with their local authority partners

¹ [Paragraph 7.21, 7.22, 7.8, Care and support statutory guidance](#)

regarding statutory and non-statutory advocacy services in their locality, bearing in mind the needs of those being considered for NHS Continuing Healthcare as well as the needs of those requiring support through the care and support assessment and planning process. For advocacy in relation to independent review panels (IRPs), CCGs should ensure that there are agreed protocols as to how the provision of advocates will operate and the circumstances in which they may be made available. CCGs could link such protocols with the strategic development of advocacy services discussed above.

PG 58 Do individuals need to have legal representation during the NHS Continuing Healthcare eligibility process?

58.1 No, although individuals are free to choose whether they wish to have an advocate present, and to choose who this advocate is. This National Framework (supported by Standing Rules Regulations and Care Act 2014 Regulations) sets out a national system for determining eligibility for NHS Continuing Healthcare. The eligibility process is focused around assessing an individual's needs in the context of the National Framework rather than being a legal or adversarial process.

58.2 If the individual chooses to have a legally qualified person to act as their advocate, that person would be acting with the same status as any other advocate nominated by the individual concerned. The MDT process is fundamentally about identifying the individual's needs and how these relate to the National Framework. Health and social care practitioners should be confident of their knowledge and skill in dealing with most queries that arise about the MDT process and the appropriate completion of the DST. Where wider issues that are not connected with the question of eligibility are raised by advocates (such as legal questions) they should, if appropriate, be asked to raise these separately with the CCG outside the MDT meeting.

Annex A: Glossary

Assessment notice

A notice given by the responsible NHS body to the local authority where the NHS body considers it unsafe to discharge a hospital patient unless arrangements are made for that person's care and support needs.

Assessment of eligibility for NHS Continuing Healthcare

The assessment process used by a multidisciplinary team to make a recommendation regarding eligibility for NHS Continuing Healthcare. The assessment of eligibility requires the completion of the Decision Support Tool in order to arrive at an eligibility recommendation.

Assessment of needs

The collection and evaluation of a range of relevant information relating to an individual's needs.

Care

Support provided to individuals to enable them to live as independently as possible, including anything done to help a person live with ill health, disability, physical frailty or a learning difficulty and to participate as fully as possible in social activities. This encompasses health and social care.

Care package

A combination of care and support and other services designed to meet an individual's assessed needs.

Care plan

A document recording the reason why care and support and other services are being provided, what they are, and the intended outcomes.

Care planning

A process based on an assessment of an individual's needs that involves working with the individual to identify the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Carer

A carer is anyone who, usually unpaid, looks after a friend or family member in need of extra help or support with daily living, for example, because of illness, disability or frailty.

Clinical Commissioning Group (CCG)

CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. References to CCG in this National Framework include any person or body authorised by the CCG to exercise any of its functions on its behalf in relation to NHS Continuing Healthcare. Where a CCG delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework. The CCG cannot delegate its final decision-making function in relation to eligibility decisions, and remains legally responsible for all eligibility decisions made (in accordance with Standing Rules¹).

Commissioning

Commissioning is the process of specifying and procuring services for individuals and the local population, and involves translating their aspirations and needs into services that:

- deliver the best possible health and well-being outcomes, including promoting equality;
- provide the best possible health and social care provision; and
- achieve this with the best use of available resources and best value for the local population.

Coordinator

A person(s) who coordinates the NHS Continuing Healthcare eligibility assessment process. Refer to Practice Guidance note 20.

End-of-life care

Care that helps those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms, and provision of psychological, social, spiritual and practical support.

Local authority social services

Local authorities are statutory bodies responsible for a wide range of public services in specified geographic area, including social services. Individually and in partnership with other agencies, local authority social services departments provide a wide range of care and support for people who are in need and meet nationally specified eligibility criteria for care and support.

Long-term conditions

Those conditions that cannot, at present, be cured, but may be controlled by medication and other therapies.

Mental capacity

The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is set out in section 2 of the Mental Capacity Act 2005: *a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain*.

Mental disorder

Mental disorder is defined in section 1(2) of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) as meaning *'any disorder or disability of the mind'*.

Multidisciplinary

'Multidisciplinary' refers to when professionals from different disciplines (such as social work, nursing and occupational therapy etc) work together to assess and/or address the holistic needs of an individual, in order to improve delivery of care.

Multidisciplinary team

In the context of assessing eligibility for NHS Continuing Healthcare, a multidisciplinary team (MDT) is a team of at least two professionals, usually from both the health and the social care disciplines. It does not refer only to an existing multidisciplinary team, such as an ongoing team based in a hospital ward. It should include those who have an up-to-date knowledge of the individual's needs, potential and aspirations. Refer to paragraphs 119-123 of the National Framework.

NHS Continuing Healthcare

A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual has a 'primary health need'. It can be provided in any setting. Where a person lives in their own home, it means that the NHS funds all the care and support that is required to meet their assessed health and care needs. Such care may be provided either within or outside the person's home, as appropriate to their assessment and care plan. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the person's accommodation, board and care.

NHS England

NHS England is the name given to what is legally known as the National Health Service Commissioning Board. References to NHS England in this National Framework include any person or body authorised by NHS England to exercise any

of its functions on its behalf in relation to NHS Continuing Healthcare. Where NHS England delegates such functions it continues to have statutory responsibility and must therefore have suitable governance arrangements in place to satisfy itself that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework.

NHS-funded Nursing Care

Funding provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible. It exists because Section 22 of the Care Act 2014 prohibits local authorities from providing, or arranging for the provision of nursing care by a registered nurse, save in the very limited circumstances set out in Section 22 (4). Since 2007 NHS-funded Nursing Care has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS Continuing Healthcare before a decision is reached about the need for NHS-funded Nursing Care.

Palliative care

Palliative care is the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.

Personal health budget

A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local NHS. It isn't new money, but a different way of spending health funding to meet the needs of an individual. Personal health budgets are one way to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs.

Personalised

The term used to describe care and services received by a person that are individualised and tailored to their needs and preferences. Wherever possible, it involves the individual having choice and control over the care and support they receive.

Registered nurse

A nurse registered with the Nursing and Midwifery Council.

Rehabilitation

A programme of therapy and re-enablement designed to maximise independence and minimise the effects of disability or illness.

Representative

Any friend, carer or family member who is supporting the individual in the process as well as anyone acting in a more formal capacity (e.g. welfare deputy or power of attorney, or an organisation representing the individual).

Specialist assessment

An assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care, e.g. stroke, cardiac care, bereavement counselling.

Annex B: The Coughlan Judgment

R v North and East Devon Health Authority, ex parte Pamela Coughlan

1. Pamela Coughlan was seriously injured in a road traffic accident in 1971. Until 1993, she received NHS care in Newcourt Hospital. When the Exeter Health Authority wished to close that hospital and move Miss Coughlan and other individuals to a new NHS facility at Mardon House, the individuals were promised that Mardon House would be their home for life.
2. In October 1998, the successor health authority (North and East Devon Health Authority) decided to withdraw services from Mardon House, close that facility, and transfer the care of Miss Coughlan and other disabled individuals to the local authority (LA) social services. Miss Coughlan and the other residents did not wish to move out of Mardon House and argued that the decision to close it was a breach of the promise that it would be their home for life, and was therefore unlawful.
3. The arguments on the closure of Mardon House raised other legal points about the respective responsibilities of the health service and the social services for nursing care. The Court of Appeal's judgement on this aspect has heavily influenced the development of continuing care policies and the National Framework. The relevant law relating to NHS Continuing Healthcare has since been updated with the introduction of the Care Act 2014 (which replaced the National Assistance Act and other Acts of parliament). However, the key relevant points made in this judgement, in the context of the law at the time, were as follows:
 - The NHS does not have sole responsibility for all nursing care. LAs can provide nursing services under section 21 of the National Assistance Act 1948, so long as the nursing care services are capable of being properly classified as part of the social services' responsibilities.
 - No precise legal line can be drawn between those nursing services that can be provided by an LA and those that cannot: the distinction between those services that can and cannot be provided by an LA is one of degree, and will depend on a careful appraisal of the facts of an individual case.
 - As a very general indication as to the limit of LA provision, if the nursing services are:
 - a) merely incidental or ancillary to the provision of the accommodation that an LA is under a duty to provide, pursuant to section 21; and
 - b) of a nature that an authority whose primary responsibility is to provide social services, can be expected to provide

then such nursing services can be provided under section 21 of the National Assistance Act 1948.

- By virtue of section 21(8) of the National Assistance Act 1948, an LA is also excluded from providing services when the NHS has, in fact, decided to provide those services.
- The services that can appropriately be treated as responsibilities of an LA under section 21 may evolve with the changing standards of society.
- Where a person's primary need is a health need, the responsibility is that of the NHS, even when the individual has been placed in a home by an LA.
- An assessment of whether a person has a primary health need should involve consideration not only of the nature and quality of the services required, but also of the quantity or continuity of such services.
- The duty of clinical commissioning groups under section 3 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), is limited to providing the services identified, to the extent that they consider necessary to meet all reasonable requirements.
- In respect of Ms Coughlan, her needs were clearly of a scale beyond the scope of LA services.

Annex C: The Grogan Judgment

R v Bexley NHS Care Trust, ex parte Grogan

1. Maureen Grogan had multiple sclerosis, dependent oedema with the risk of ulcers breaking out, was doubly incontinent, a wheelchair user requiring two people for transfer, and had some cognitive impairment. After the death of her husband, her health deteriorated and she had a number of falls. Following admission to hospital with a dislocated shoulder, it was decided that she was unable to live independently and she was transferred direct to a care home that provided nursing care.
2. Subsequent assessments indicated that (under the then local criteria dated December 2002) Mrs Grogan's condition was such that she did not qualify for fully funded NHS continuing healthcare. It was initially determined that she was in the medium band of NHS-funded Nursing Care. By and large, she remained in this band, although one determination placed her in the high band from April to October 2004. Mrs Grogan argued that the decision to deny her full NHS funding was unlawful, since the eligibility criteria put in place by South East London NHS CB were contrary to the judgement in the Coughlan case (refer to Annex B). She also submitted that the level of nursing needs identified in the Registered Nursing Care Contribution (RNCC) medium and high bandings (in which she had been placed) indicated a primary need for healthcare that should be met by the NHS.
3. Key relevant points from the Grogan judgement include:
 - In assessing whether Mrs Grogan was entitled to NHS continuing healthcare, the care trust did not have in place – and did not apply – criteria which properly identified the test or approach to be followed in deciding whether her primary need was a health need.
 - The court identified the fact that there can be an overlap, or a gap, between social care and NHS provision, depending on the test, or tests, applied. The court accepted, as had been submitted by the Secretary of State, that the extent of her duties was governed by NHS legislation, not the upper limits of local authority lawful provision, and that therefore there was a potential in law for a gap between what the Secretary of State provided and those 'health services' that the local authority could 'lawfully' supply.
 - If the policy of the Secretary of State was that there should be no gap, then, when applying the primary health need approach, this should be considered against the limits of social services lawful provision, not just by reference to a 'primary health need'.
4. The trust's decision that Mrs Grogan did not qualify for NHS continuing healthcare was set aside, and the question of her entitlement to NHS continuing healthcare was remitted to the trust for further consideration.
5. There was no finding, or other indication, that Mrs Grogan in fact met the criteria for NHS continuing healthcare.

Annex D: Independent Review Panel Procedures

The purpose and scope of independent review panels

1. Standing Rules¹ require NHS England to maintain independent review panels (IRPs).
2. An IRP's key tasks are, at the request of NHS England, to conduct a review of the following:
 - a) the primary health need decision by a CCG; or
 - b) the procedure followed by a CCG in reaching a decision as to that person's eligibility for NHS continuing healthcareand to make a recommendation to NHS England in the light of its findings on the above matters.
3. An IRP should not proceed if it is discovered that the individual has not previously received a comprehensive assessment of needs and a determination of their eligibility for NHS Continuing Healthcare, including use of the Decision Support Tool or the Fast Track Pathway Tool, as appropriate. Where an IRP request is received in such circumstances, NHS England should refer the case to the relevant CCG and ask for an assessment of needs and a determination of the individual's eligibility for NHS continuing healthcare to be carried out, if it appears that there may be a need for such care.
4. The IRP procedure does not apply where individuals, their families or any carer wish to challenge:
 - the content of the eligibility criteria;
 - the type and location of any offer of NHS-funded continuing care services;
 - the content of any alternative care package that they have been offered;
 - their treatment or any other aspect of the services they are receiving or have received (this would properly be dealt with through the complaints procedure).
5. The IRP should apply the key principles for dispute resolution processes, as set out in paragraphs 196-207 of the National Framework.
6. Individuals (and their carer and/or representative, where appropriate) should be given clear information about the IRP procedure, the situations it does and does not cover, and how it operates locally. Advocates should be provided where this will support the individual through the review process. NHS England and CCGs

should ensure that there are agreed protocols as to how the provision of advocates will operate and the circumstances in which they are to be made available.

7. It is particularly important that, before an IRP is convened, all appropriate steps have been taken by the relevant CCG to resolve the case informally, in discussion with the NHS England where necessary. NHS England should have a named contact, who is the first port of call for queries from partner organisations for the relevant locality.
8. If the case cannot be resolved by local resolution (or local resolution will cause undue delay), the individual (or their representative) may ask the NHS England to arrange an IRP to review the case with regard to the matters listed in paragraph 2 above. Before doing so, NHS England should ensure that none of the circumstances listed at paragraphs 3 and 4 of this annex apply. If any of them are applicable, NHS England should contact the individual and advise them of the appropriate routes for dealing with these matters. If the case nevertheless has some issues that fall within an IRP's responsibilities, the IRP should proceed, but should only deal with the relevant matters.
9. NHS England should designate individuals to maintain the review procedure and to give advice to IRPs and to the parties involved on the content of the requirements of the National Framework and the associated tools, as well as on any procedural issues.
10. Clear and timely communication is very important. NHS England should develop and publish timescales for the hearing of IRP cases.
11. NHS England does have the right to decide in any individual case not to convene an IRP. It is expected that such a decision will be confined to those cases where the individual falls well outside the eligibility criteria, or where the case is very clearly not appropriate for the IRP to consider. Before taking such a decision, NHS England should seek the advice of the chair of the IRP, who may require independent clinical advice. In all cases where a decision not to convene an IRP is made, NHS England should give the individual, their family or carer a written explanation of the basis of its decision, together with a reminder of their rights under the NHS complaints procedure.
12. No individual should be left without appropriate support while they await the outcome of the review. The eligibility decision that has been made is effective while the independent review is awaited. This does not preclude review of eligibility in the meantime by the CCG, using the process set out in paragraphs 194-195 of the National Framework, if the individual's needs change or if the time for the next scheduled review of the individual has arrived. Please see Appendix E for guidance on responsibilities when a decision on NHS Continuing Healthcare eligibility is awaited or is disputed.

Establishment and operation of the panels

13. IRP chairs should be selected by the NHS England, following an open recruitment process. Those chosen should have a clear understanding of the IRP's purpose and be able to communicate this to the individual, their family and any carers concerned. On the basis of the evidence received and the advice given at the IRP, the chair should be able to determine, in consultation with other IRP members, whether eligibility criteria have been correctly applied. The chair should have the capacity to make balanced decisions in sometimes difficult circumstances, while taking a sympathetic view of the concerns of individuals, their family and any carers.
14. Selection of the right people as chairs – people who are capable of gaining the confidence of all parties – will be a crucial factor in the success of the IRP. Current NHS staff, board members of NHS organisations, LA staff and LA elected members should not be considered but people who have formerly held such a position are eligible. NHS England is advised to involve lay people in the selection process.
15. The appointment of representatives from CCGs and LAs will be on the basis of the nomination of those organisations. They should take account of professional and other skills that are relevant to the work of the IRP. The chair and members of an IRP should receive reasonable expenses.
16. The members of the IRP should meet to consider individual cases. A designated NHS England representative should be responsible for ensuring that the relevant information has been received from the CCG before the IRP. The IRP should also have access to the views of key parties involved in the case, including the individual, his or her family and any carer, health and social services staff, and any other relevant bodies or individuals. It will be open to key parties to put their views in writing or to attend. If parties attend, they should be given the opportunity to hear the submissions of other parties and to ask them questions.
17. An individual may have a representative present to speak on his or her behalf if they so choose, or if they are unable to, or have difficulty in presenting their own views. This role may be undertaken by a relative or carer or advocate acting on the individual's behalf. The IRP should be satisfied that any person acting on behalf of the individual accurately represents their views, and that the representative's interests or wishes do not conflict with those of the individual. The IRP should respect confidentiality at all times.
18. The IRP will require access to independent clinical advice, which should take account of the range of medical, nursing and therapy needs involved in each case. Such arrangements should avoid any obvious conflicts of interest between the individual clinician(s) giving the advice and the organisation(s) from which the individual has been receiving care. The chair of the relevant IRP should consider in advance of the hearing whether, bearing in mind the nature of the case, the evidence supplied and the role of the clinical adviser set out in paragraph 19 below, there is a need for the panel to access independent clinical advice, and

whether this should be in the form of attendance at the hearing or of the clinician supplying written advice.

19. It is the role of the clinical adviser to advise the IRP on the original clinical judgements and on how those judgements relate to the National Framework. It is not the adviser's role to provide a second opinion on the clinical diagnosis, management or prognosis of the individual.
20. An IRP may ask all parties to withdraw while it deliberates and agrees its recommendations. Where appropriate, an IRP may ask an NHS England representative and/or the clinical adviser to be present to give advice. NHS England may also be represented in order to keep a record of deliberations.
21. In reaching a view on whether the CCG followed the correct process and whether it correctly applied the eligibility criteria, the range of recommendations made by the IRP for consideration by the CCG could include:
 - a) that the case should be reconsidered by NHS England or the CCG, addressing identified deficiencies in the process used or in the application of the eligibility criteria; or
 - b) that, on the evidence submitted, when compared to the eligibility criteria, the individual should or should not be considered to have a primary health need.
22. A full record should be made of the IRP hearing, including details of those present and their role, the issues and evidence considered, the conclusions and recommendations reached by the IRP, and the reasons for them. A copy of this should be sent by NHS England to all parties.
23. The recommendations of an IRP should be accepted by NHS England in all but exceptional circumstances.
24. If NHS England decides, in exceptional circumstances, not to accept an IRP recommendation in an individual case, it should explain this in writing to the individual, the CCG and the chair of the IRP, including its reasons for not accepting it.
25. In all cases, the NHS England should communicate the outcome of the review, with its reasons, to the individual and the CCG.
26. A CCG should accept the recommendations of the IRP, as forwarded by the NHS England, in all but exceptional circumstances. If a CCG decides, in exceptional circumstances, not to accept an IRP recommendation in an individual case, it should explain this in writing to the individual and NHS England, including its reasons. If NHS England or CCG does not accept the recommendations, and if the individual is dissatisfied with this, the matter should be pursued through the NHS complaints procedure.
27. NHS England or the CCG, as appropriate, should ensure that the individual is informed in writing of their right to use the NHS complaints procedure in such circumstances.

Annex E: Guidance on responsibilities when a decision on NHS Continuing Healthcare eligibility is awaited or is disputed

1. This guidance sets out the approach to be taken by CCGs and local authorities (LAs) in three situations:
 - a) where there is a need for health or care and support to be provided to an individual during the period in which a decision on eligibility for NHS Continuing Healthcare is awaited, in a case that does not involve hospital discharge (refer to paragraphs 109-115 of the National Framework).
 - b) where a CCG has unjustifiably taken longer than 28 calendar days to reach a decision on eligibility for NHS Continuing Healthcare; or
 - c) where, as a result of an individual disputing an NHS Continuing Healthcare eligibility decision, the CCG has revised its decision.
- a) Where care needs to be provided whilst a decision on NHS continuing healthcare is awaited, in a case that does not involve hospital discharge
2. A person only becomes eligible for NHS continuing healthcare once a decision on eligibility has been made by a CCG, informed by a completed Decision Support Tool or Fast Track Pathway Tool. Prior to that decision being made, any existing arrangements for the provision and funding of care should continue, unless there is an urgent need for adjustment.
3. If, at the time of referral for an NHS Continuing Healthcare assessment, the individual is already receiving ongoing care and support funded by a CCG, or a local authority, or both, those arrangements should continue until the CCG makes its decision on eligibility for NHS Continuing Healthcare, subject to any urgent adjustments needed to meet the changed needs of the individual. In considering such adjustments, local authorities and CCGs should have regard to the limitations of their statutory powers.
4. Some health needs fall within the powers of both CCGs and local authorities to meet. However where:
 - i) a local authority is providing services during the period in which an NHS Continuing Healthcare eligibility decision is awaited; and
 - ii) it is identified that the individual has some health needs that are **not** within the power of a local authority to meet (regardless of the eventual outcome of the NHS Continuing Healthcare eligibility decision); and
 - iii) those health needs have to be met before the decision on eligibility is made;

the CCG should consider its responsibilities under the NHS Act to provide such health services to such extent as it considers necessary to meet all reasonable requirements. NHS England or the CCG should therefore consider whether the individual's health needs are such that it would be appropriate to make services available to help meet them in advance of the NHS Continuing Healthcare eligibility decision.

5. Where an individual is not already in receipt of ongoing care and support from the local authority or CCG (or both), they may have urgent health or care and support needs which need to be met during the period in which the NHS Continuing Healthcare eligibility decision is awaited, for example because previous private arrangements are no longer sustainable or there were not previously any care needs requiring support. Where there are urgent healthcare needs to be met, these should be assessed by the relevant healthcare professional.
6. Where the individual appears to be in need of care and support, the local authority should assess the individual's eligibility for these under section 9 of the Care Act 2014.
7. If, in carrying out a needs assessment (under the Care Act 2014), it appears to the local authority that the individual may be eligible for NHS Continuing Healthcare the local authority must refer the individual to the CCG. The CCG must then take steps to ensure that an assessment of eligibility for NHS Continuing Healthcare is carried out. The local authority and CCG should jointly agree actions to be taken in the light of their statutory responsibilities until the outcome of the NHS Continuing Healthcare eligibility decision making process is known. No individual should be left without appropriate support because statutory bodies are unable to agree on respective responsibilities.
- b) Where the CCG has unjustifiably taken longer than 28 calendar days to reach a decision on eligibility for NHS continuing healthcare
8. Decision-making on eligibility for NHS Continuing Healthcare should, in most cases, take no longer than 28 calendar days from the CCG (or organisation acting on behalf of the CCG) being notified of the need for assessment of eligibility for NHS Continuing Healthcare e.g. an appropriately completed positive Checklist, or other notification that an assessment of eligibility is required.
9. When
 - i) the CCG makes a decision that a person is eligible for NHS continuing healthcare; and
 - ii) it has taken more than 28 calendar days to reach this decision; and
 - iii) a local authority or the individual has funded services whilst awaiting the decision;

the CCG should, having regard to the approaches set out in paragraphs 11 to 13 below, refund directly to the individual or the local authority, the costs of the services from day 29 of the period that starts on the date of receipt of a completed Checklist (or where no Checklist is used, other notification of potential

eligibility for NHS Continuing Healthcare), and ends on the date that the decision was made. This period is referred to below as the “period of unreasonable delay”. The refund should be made unless the CCG can demonstrate that the delay is reasonable as it is due to circumstances beyond the CCG’s control, which could include:

- i) evidence (such as assessments or care records) essential for reaching a decision on eligibility has been requested from a third party and there has been delay in receiving these records from them;
 - ii) the individual or their representatives have been asked for essential information or evidence or for participation in the process and there has been a delay in receiving a response from them;
 - iii) there has been a delay in convening a multidisciplinary team due to the lack of availability of a non -CCG practitioner whose attendance is key to determining eligibility and it is not practicable for them to give their input by alternative means such as written communication or by telephone.
10. In all of the above and other circumstances, the CCG should make all reasonable efforts to ensure the required information or participation is made available in accordance with the 28 calendar days timeframe. This should include developing protocols with services likely to be regularly involved in NHS Continuing Healthcare eligibility processes that reflect the need for information in accordance with the within 28 calendar days timeframe. Where the CCG commissions the service from another organisation from which information or participation is regularly required, it may be appropriate to consider placing such expectations within the specification for the relevant service.
11. CCGs and LAs should be aware of the requirements of the Standing Rules¹ and Directions to local authorities⁵ for the CCG to consult the relevant local authority, wherever reasonably practicable, before making a decision on NHS continuing healthcare eligibility and for the local authority, wherever reasonably practicable, to provide advice and assistance to the relevant CCG.
12. Where unreasonable delay has occurred and it is an LA that has funded services during the interim period, the CCG should refund the local authority the costs of the care package that it has incurred during the period of unreasonable delay. The CCG can use its powers under section 256 of the NHS Act to make such payments. The amount to be refunded to the local authority should be based on the gross cost of the services provided. Where an individual has been required to make financial contributions to the local authority as a result of an assessment of their resources under the Care Act 2014, the above approach should be adopted rather than the CCG refunding such contributions directly to the individual as the refund of contributions is a matter between the local authority and the individual. Where a CCG makes a gross cost refund, the local authority should refund any financial contributions made to it by the individual in the light of the fact that it has been refunded on a gross basis, including interest.
13. Where a CCG has unreasonably delayed reaching its decision on eligibility for NHS Continuing Healthcare, and the individual has arranged and paid for services directly during the interim period, the CCG should make an ex-gratia

payment in respect of the period of unreasonable delay.

14. Such payments would need to be made in accordance with the guidance for ex-gratia payments set out in Managing Public Money¹. This sets out that, where public services organisations have caused injustice or hardship, they should provide remedies that, as far as reasonably possible, restore the wronged party to the position that they would have been in had matters been carried out correctly. This guidance sets out other issues to be considered and CCGs should take these into account in reaching their decision.

c) Where, as a result of an individual disputing an NHS continuing healthcare eligibility decision, a CCG has revised its decision

15. When a CCG has made a decision on NHS Continuing Healthcare eligibility, then that decision remains in effect until the CCG revises the decision. This National Framework sets out that IRPs make recommendations but that these recommendations should be accepted by NHS England and the CCG in all but exceptional circumstances. Where a CCG accepts an IRP recommendation on NHS Continuing Healthcare eligibility, it is in effect revising its previous decision in the light of that recommendation.

16. Where:

- i) a local authority has provided care and support to an individual in circumstances where a CCG has decided that the individual is not eligible for NHS continuing healthcare, and
- ii) the individual disputes the decision that they are not eligible for NHS Continuing Healthcare and the CCG's decision is later revised (including where the revised decision is as a result of an IRP recommendation),

the CCG should refund the local authority the costs of the care package. This should be based on the gross care package costs that the local authority has incurred from the date of the decision that the individual was not eligible for NHS Continuing Healthcare (or earlier, if that decision was unreasonably delayed – see the previous section) until the date that the revised decision comes into effect. The CCG can use its powers under section 256 of the NHS Act to make such payments. Where the local authority has collected an assessed charge from the individual, the refund from the CCG should include interest on that amount so that this can be reimbursed to the individual (see paragraph 17 below)

17. Where a CCG makes such a refund, the local authority should refund any financial contributions made to it by the individual (with interest) in the light of the fact that it has been refunded on this basis.

18. Where:

- i) no local authority has provided care and support to an individual in

¹ [Managing Public Money](#)

circumstances where a CCG has decided that the individual is not eligible for NHS Continuing Healthcare, and

ii) the individual has arranged and paid for such services him or herself; and

iii) the individual disputes the decision that they are not eligible for NHS Continuing Healthcare and a CCG's decision is later revised (including where the revised decision is as a result of an IRP recommendation),

the CCG should make an ex-gratia payment directly to the individual. When the CCG has revised its decision, whether as a result of an IRP process or not, this is a recognition that the original decision, or the process leading up to the decision, was incorrect. An ex-gratia payment would be to remedy any injustice or hardship suffered by the individual as a result of the incorrect decision. The CCG should take into account the Managing Public Money guidance as explained above.

Disputes

19. It is important that CCGs and LAs have clear jointly agreed local processes for resolving any disputes that arise between them on the issues covered in this guidance. The Standing Rules and Directions to local authorities require CCGs and LAs to have an agreed local process for resolving disputes between them on issues relating to eligibility for NHS continuing healthcare and for the NHS elements of joint packages. CCGs and LAs could extend the remit of their local disputes process to include disputes over refunds. Whatever disputes process is selected, it is important that it should not simply be a forum for further discussion but includes an identified mechanism for final resolution, such as referring the case to another CCG and LA and agreeing to accept their recommendation.
20. Where an individual disputes a CCG's decision on whether to provide redress to them, or disputes the amount of redress payable, this should be considered through the NHS complaints process.

Annex F: Local NHS Continuing Healthcare Protocols

The following provides a best practice guide for what to include when drawing up and updating local protocols and procedures regarding NHS Continuing Healthcare.

Referrals, Assessments and Recommendations

- A statement about the principles underlying the process to ensure that it is 'person-centred', equitable, culturally sensitive, robust, transparent and lawful. This includes ensuring equitable access to assessment for NHS Continuing Healthcare based on need (not on client group, current funding arrangements, etc.) and using the Checklist as a basis for identifying those who require full assessment to inform completion of the DST.
- Arrangements for ensuring that the individual and their family are kept informed and involved at every stage, including being informed of their right to seek a review if they have reason to believe that an eligibility decision regarding NHS Continuing Healthcare was incorrect.
- Arrangements for obtaining consent (refer to paragraphs 72-73 of the National Framework) to the different stages of the process, and to sharing information, where the individual has capacity to give such consent. Also arrangements for dealing with (probably rare) situations where an individual with capacity refuses consent to assessment of eligibility for NHS Continuing Healthcare.
- Local arrangements for dealing with situations where the individual appears to lack capacity, in order to ensure compliance with the Mental Capacity Act 2005 and the associated Code of Practice, including how to access the IMCA service where the criteria for this are met (refer to paragraphs 306-308 of the National Framework).
- Local arrangements regarding how individuals can access advocacy, advice and information.
- An explanation of who can complete the Checklist (and what training they need beforehand), bearing in mind that the aim is to allow a variety of professionals, in a variety of settings, to refer individuals for a full assessment for NHS Continuing Healthcare. It is for each organisation to decide for itself who are the most appropriate staff to participate in the completion of a Checklist, but these staff should be trained in its use.
- Arrangements to ensure that individuals and/or representatives are informed in writing about the outcome of the Checklist (whether negative or positive), which will normally be achieved by them being given a copy of the completed Checklist. The written information should include what the individual/representative should

do if they are dissatisfied with the Checklist outcome.

- How and in what situations Fast Track arrangements are to operate, including a statement that the Fast Track Pathway Tool (refer to paragraphs 216-245 of the National Framework) is to be completed by an 'appropriate clinician' as defined in the Standing Rules Regulations and is to be acted on by the CCG without delay. It is important to ensure that decision-making around NHS Continuing Healthcare does not in any way compromise the provision of good end of life care or timely discharge from acute hospital.
- Arrangements for the timely provision of care and/or support in fast-track cases, including provision of equipment where necessary.
- The referral process being clear where cases requiring full consideration of eligibility using the DST are to be directed (this may well differ depending on whether the individual concerned is currently in hospital, in a care home or in the community). Clarity on the method of delivery of paperwork is needed to minimise delay but ensure confidentiality.
- An agreement that the key agencies will make staff available to participate in the assessment and decision-making processes, including making staff available to sit on Independent review panels.
- Any specific local arrangements around appointing coordinators, identifying members of the MDT and convening MDT meetings. These arrangements need to ensure that, where appropriate and as far as possible, both NHS and social care colleagues are involved in both the needs assessment (under the Care Act 2014) and eligibility assessment process.
- Arrangements for dealing with people subject to section 117 of the Mental Health Act 1983, with reference to paragraphs 309-319 of the National Framework.
- Clarity on how the NHS Continuing Healthcare process fits with hospital discharge arrangements, with reference to paragraphs 109-115 of the National Framework. These arrangements must reflect the clear emphasis in this National Framework that in the majority of cases it is preferable for eligibility for NHS Continuing Healthcare to be assessed after discharge from hospital when the individual's ongoing needs should be clearer. The assessment process for NHS Continuing Healthcare should not be allowed to delay hospital discharge.
- Arrangements for care and/or support and funding (including 'without prejudice' funding) whilst the decision-making process is carried out, noting that if an individual is identified in the hospital discharge pathway as requiring assessment for NHS Continuing Healthcare then the CCG retains funding responsibility whilst the DST is being completed and the eligibility decision is being made, in accordance with paragraph 114 of the National Framework.
- How transfers of care are to be handled, including effective risk management.

- Arrangements for reviewing:
 - care packages or placements where an individual is in receipt of NHS Continuing Healthcare.
 - Joint packages of care
 - Individuals in receipt of NHS-funded nursing care
- Timeframes for each stage of the process.

Visual representation of the process in flow-charts can often be very helpful.

Decision-making

Arrangements must be in place to ensure that (so far as is reasonably practicable) the local authority's views regarding needs and eligibility are obtained before decisions are made regarding eligibility for NHS Continuing Healthcare. There should be robust arrangements for decision-making between the CCG and the local authority, bearing in mind that the CCG retains responsibility for making eligibility decisions regarding NHS Continuing Healthcare. This may or may not include a panel arrangement, but care should be taken to ensure that panels are not used unnecessarily (refer to Practice Guidance note 38 and 41).

- Terms of reference for panel (where these exist)– purpose of panel, which cases are to be referred, client groups covered, limitations of decision-making powers, bearing in mind that the National Framework states that '*only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed*' (refer to paragraph 155 of the National Framework and Practice Guidance note 39).
- Arrangements and process for obtaining the local authority's views where a panel process is not in place.
- Membership and chairing arrangements (some have independent chairs).
- Arrangements for panel members to have sight of case documentation in advance.
- Whether/how the individual and/or their representative is to be involved in the panel arrangements.
- What counts as a quorum.
- Frequency of meetings.
- Access to specialist input/advice.
- Paperwork expected (including DST) to inform discussion.
- Arrangements for recording main points of panel discussion and decisions.

- Clarity on decision-making, voting arrangements (if any), etc. On some panels local authority members have an equal say (which is good practice); others limit local authority involvement to advice from a social care perspective. There is a need to be clear that financial considerations do not influence the decision regarding eligibility for NHS Continuing Healthcare.
- Procedure for dealing with disagreement over eligibility within the panel meetings.
- Local resolution process (refer to paragraphs 194-195 of the National Framework) where an individual or their representative is unhappy with the eligibility decision, with reference to the guidance on local resolution provided in this National Framework.

Dispute Avoidance and Resolution between Agencies

Good communication, effective joint working and mutual respect are key to avoiding unnecessary disputes. Any local protocols should consider:

- Clarity on what counts as a disagreement and what counts as a formal dispute – some protocols include disagreements/disputes at Checklist and DST stage as well as at panel decision-making stage.
- Different levels of dispute resolution – the aim is usually to resolve disputes at practitioner level but most procedures have the option of escalating the dispute through appropriate levels to senior management level where necessary. Some dispute resolution processes include referring the case to a second panel to check the original decision; in some cases there are agreements to refer to a panel in another area. It is important that dispute resolution processes have a clear end, final resolution point.
- What types of dispute are covered – protocols should deal with disputes over NHS Continuing Healthcare eligibility, joint funding arrangements and refunds.
- What paperwork/information is needed at each stage.
- Timescales at each stage of the process.
- Arrangements to ensure individuals get the care or support they need whilst disputes are being resolved, bearing in mind the principle of ‘no unilateral withdrawal of funding’ (refer to paragraph 190 of the National Framework).
- Clarity on what happens over interim or ‘without prejudice’ funding – including over any backdating arrangements for reimbursing costs and how charging the service user will be handled in a variety of possible situations, having regard to the approaches set out in Annex E above.