A guide to continuing healthcare and funded nursing care in the NHS
This guide has been compiled by Hazel Heath, independent nurse consultant for older people and Deborah Sturdy, senior nurse adviser, older people, Department of Health. The content is drawn from Department of Health (England) published frameworks and guidance, particularly the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care July 2009 (Revised) (DH 2009a), NHS Continuing Healthcare Practice Guidance (DH 2010) and NHS-funded Nursing Care: Practice Guide (Revised) 2009 (DH 2009b). Guidance is subject to change and it is important to refer to these documents for full details of the policy on issues set out below.

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Introduction

This guide aims to support nurses in implementing the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (Department of Health (DH) 2009a) and guidance (DH 2009b, 2010). Explanations of how the framework should operate on a day-to-day basis, how the stages of decision making should progress and how the DH tools should be used in practice are offered. Each section highlights links to the main DH documents and the relevant paragraphs within these. The implications for nurses are highlighted. This guide is not a substitute for the framework and associated tools; it is essential that nurses read and understand these before using them in practice.

NHS continuing healthcare (CHC) is a major issue. It is relevant to all adult client groups and all settings in England. During the year 2010-2011, some 50,000 people in England received NHS CHC (DH 2011). Registered nurses (RNs) are central in implementing NHS CHC and NHS-funded nursing, including supporting their primary care trusts (PCTs) in:

- Promoting awareness of NHS CHC and NHS-funded nursing care.
- Implementing and maintaining good practice.
- Ensuring that clients and, where appropriate, families understand the processes and decisions involved.
- Ensuring that clients are supported in participating as fully as possible in the processes and decisions.
- Where appropriate, facilitating advocacy support for individuals and families.
- Ensuring that all the steps in assessing for, and implementing, NHS CHC and NHS-funded nursing care have been followed.
- Ensuring that tools are used appropriately.
- Ensuring that quality standards are met and sustained.
- Participating in training and development opportunities or, where appropriate, arranging training opportunities for staff.
- Striving to ensure consistency in the application of the national policy on eligibility for NHS CHC and NHS-funded nursing care.

DH guidance (DH 2009b, paragraph 16) emphasises that: ‘A registered nurse is personally and professionally accountable for their own practice. This means that the registered nurse is answerable for their actions and omissions regardless of advice or directions from another professional. Professional accountability is fundamentally concerned with weighing up the interests of the patient and clients in complex situations, while using professional knowledge, judgement and skills to make a decision; a registered nurse should be able to account for any decision they have made.’

The meaning of NHS continuing healthcare

‘Continuing care’ means care provided over an extended period of time, to a person aged 18 or over, to meet physical or mental health needs that have arisen as a result of disability, accident or illness. NHS CHC is a complete package of continuing care, or ongoing care, arranged and funded solely by...
the NHS, where it has been assessed that the individual’s primary need is a health need. Eligibility for NHS CHC places no limits on the settings in which the package of support can be offered or on the type of service delivery. The actual services provided as part of that package should be seen in the wider context of best practice and service development for each client group.

Where a person lives in their own home, NHS CHC 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 in 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.

Unlike help from social services for which a financial charge may be made depending on the person’s income and savings, NHS CHC is free of charge to the person receiving the services.

The national framework and legal responsibilities
The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH 2009a) sets out the principles and processes for NHS CHC and NHS-funded nursing care. It aims to provide for fair and consistent access to NHS funding across England, regardless of location, so that individuals with equal needs should have an equal chance of getting their care funded by the NHS. The main responsibilities for the NHS and local authorities (LAs) are in primary legislation. Case law is also relevant to NHS CHC, specifically:

- The Coughlan judgement examined the responsibilities of the NHS and LAs, particularly regarding the provision of nursing care.
- The Grogan judgement examined the interaction between NHS continuing healthcare and NHS-funded nursing care.

Core values and principles
Person-centred practice Person-centred care is vital at all stages of NHS CHC as individuals will be at a vulnerable point in their lives. There may well be difficult and significant choices to be made, so empowering individuals at this time is essential. Nurses should try to put themselves in the position of the individual by asking questions such as: ‘How would I feel if this was happening to me?’ and ‘Have I tried to understand what this person wants, what is important to them now and for the future?’

Elements of person-centred practice with NHS CHC include:

- Ensuring that the person is fully and directly involved in the assessment and the decision-making process.
- Taking full account of the individual’s views and wishes, ensuring that his or her perspective is the starting point of every part of the assessment process.
- Addressing communication and language needs.
- Obtaining informed consent to the assessment process and to sharing records, where the individual has the mental capacity to do this.
- Dealing openly with issues of risk.
- Keeping the person fully informed throughout
the process. (A public information leaflet is available: see Box 3, page 18.)
Access to assessment, decision making and provision must be fair and consistent. There should be no discrimination.
Assessment of eligibility needs to be organised so that individuals being assessed and their representatives understand the process, and receive advice and information that will maximise their ability to participate in informed decision making about their future care.
Decisions and rationales that relate to eligibility should be transparent from the outset: for individuals, carers, family and staff alike.

**Consent** The individual's informed consent should be obtained before the start of the process. It should be made explicit to the individual whether his or her consent is being sought for a specific aspect of the eligibility consideration process, such as completion of the checklist, and for every stage in the process. Consent should also be sought for the person's record to be shared.
There should be evidence that consent has been given, either by noting this in a patient's health record or by including a consent form signed by the patient. It should also be noted that individuals may withdraw their consent at any time in the process. If individuals do not consent to assessment of eligibility for NHS CHC, the potential effect this will have on the ability of the NHS and LA to provide appropriate services should be carefully explained to them.

**Capacity** If there is a concern that the individual may not have capacity to give consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice (http://tinyurl.com/63emo7).
Nurses should be particularly aware of the five principles of the act:
- A presumption of capacity: every adult has the right to make his or her own decisions and must be presumed to have capacity to do so unless it is proved otherwise.
- Individuals being supported to make their own decisions: a person must be given all practicable help before anyone treats him or her as not being able to make decisions.
- Unwise decisions: just because an individual makes what might be seen as an unwise decision, he or she should not be treated as lacking capacity to make that decision.
- Best interests: an act done or decision made under the act for or on behalf of a person who lacks capacity must be in his or her best interests.
- Least restrictive option: anything done for, or on behalf of, a person who lacks capacity should be the least restrictive of his or her basic rights and freedoms.

**Advocacy** The Mental Capacity Act 2005 created the independent mental capacity advocate (IMCA) service. NHS bodies and LAs have a duty under the act to instruct and consult the IMCA if those concerned are people who lack capacity in relation to the relevant decision and who have no family or friends who are available or appropriate for consultation on their behalf. Even if individuals do 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.

Nurses should ensure that individuals are made aware of local advocacy and other services that may be available to offer advice and support. In addition, any person may choose to have a family member or other person to act as an advocate on his or her behalf.

**Carers** Nurses should bear in mind that carers who provide, or intend to provide, substantial care on a regular basis have a right to have their needs as a carer assessed.

**Eligibility for NHS continuing healthcare** Healthcare need and social care need can be broadly defined (Box 1). To assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the National Health Service Act 2006, and to distinguish between those services that LAs may provide under section 21 of the National Assistance Act 1948, the secretary of state developed the concept of a ‘primary health need’.

Where a person’s primary need is a health need, he or she is eligible for NHS CHC. Deciding whether this is the case involves looking at the totality of the relevant needs. Where an individual has a primary health need, and is therefore eligible for NHS CHC, the NHS is responsible for providing all of that individual’s assessed needs, including accommodation if that is part of the overall need. The term ‘primary health need’ does not appear in primary legislation, although it is referred to in section 21 of the National Assistance Act 1948, which states that a person should be considered to have a primary health need when the nursing or other health services they require, when considered in their totality, are:

- Where that person is, or is to be, accommodated in a care home, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person’s means, under a duty to provide; or
- Of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide.

The LA can only meet nursing/healthcare needs when, taken as a whole, the nursing or other health services required by the individual are below this level. If the individual’s nursing/healthcare needs, when taken in their totality, are beyond the lawful power of the LA to meet, then they have a ‘primary health need’.

In simple terms – not a legal definition – individuals have a primary health need if, having taken account of all their needs (following completion of the decision support tool: see below) it can be said that the main aspects or most of the care they require is focused on addressing and/or preventing health needs or that the nursing or other health services that they need are not of a nature that a social services authority can lawfully provide. It is important to work closely with LA colleagues in making decisions on such matters.

Primary health need is not about the reason (diagnosis) why someone requires care or support, it is about their overall actual day-to-day needs.
The difference between a healthcare need and a social care need

While there is not a legal definition of a healthcare need in the context of NHS CHC, in general terms it can be said that such a need is one related to the treatment, control 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.

In general terms – not a legal definition – it can be said that a social care need is one that is focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and, in some circumstances, accessing a care home or other supported accommodation. Social care needs are directly related to the type of welfare services that local authorities have a duty or power to provide.

When a person is eligible for NHS CHC the NHS is responsible for meeting their assessed health and social care needs.

(DH 2010, paragraph 4.11.)

ESSENTIAL GUIDE

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. 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 is the impact of the need on overall health and wellbeing?
- 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?

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').

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 (as set out in the decision support tool. See below)?

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 individuals’ responses to their own conditions have an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need. It is also 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 inter-related?
- Do they impact on each other to make the needs even more difficult to address?
- How much knowledge and skill are required to address the need(s)?
- How does the individual’s response to his or her condition make it more difficult to provide appropriate support?

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. Someone with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Questions that may help to consider this include:
- Is the individual, or those who support him or 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 is not 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?

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 considered carefully.

Establishing that an individual's primary need is a health need requires a clear, reasoned decision, based on evidence of needs from a comprehensive assessment. A good quality assessment that looks at all 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 CHC.

The reasons given for a decision on eligibility should not be based on:
- The person's diagnosis.
- The setting of care.
- The ability of the care provider to manage care.
- The use (or not) of NHS-employed staff to provide care.
- The 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.

The NHS's responsibility to commission, procure or provide care, including NHS CHC, is not indefinite, as needs could change. This should be made clear to individuals and their families. Regular reviews are built into the process to ensure that the care package continues to meet the person's needs. Access to assessment, care provision and support should be fair, consistent and free from discrimination.

The assessment of an individual's need informs the assessment of whether or not they are entitled to NHS CHC. However, regardless of whether the individual is determined to be eligible for NHS CHC, PCTs and LAs should always consider whether the assessment of needs has identified issues that require action to be taken. For example, if an assessment of needs indicates that the individual has significant communication difficulties, referral to a speech and language service should be considered.

(Further details on primary health need are given in DH (2009a), paragraphs 25-32 and DH (2010), paragraphs 4.1-4.10).

Eligibility consideration

Figure 1 (page 10) illustrates the process of determining eligibility for NHS CHC and NHS-funded nursing care. In a hospital setting, staff must take all reasonable steps to ensure that an assessment for NHS CHC is carried out in all cases where it appears that the patient may have a need for such care. PCTs, other local NHS bodies and LAs should have local protocols in place to identify how responsibilities for NHS CHC are to be discharged between them. There should be processes in place to identify those individuals for whom it is appropriate to use the checklist (see below) and, where the checklist indicates that they may have needs that would make them eligible for NHS CHC, for full assessment of eligibility to then take place.

Assessment of eligibility for NHS CHC can take place in either hospital or non-hospital settings, but it should always be borne in mind that assessment of eligibility that takes place in an
FIGURE 1

The process of determining eligibility for continuing healthcare and funded nursing care in the NHS

Fast track

Discharge planning, review or other trigger

Yes

Other NHS-funded services

Could NHS services enable improvements that might alter the outcome of eligibility decision in the short term?

No

Checklist: screen for possible eligibility for NHS CHC

Possible eligibility

No eligibility

Decision support tool: full consideration for NHS CHC

Care planning: consider need for joint NHS/local authority package, including need for registered nursing care

Establish primary health need: qualify for NHS CHC

NHS-funded nursing care: NHS contribution to services of a registered nurse

Written rationale for decision - communication to individuals and representatives

Joint care package funded or provided

NHS CHC package funded

Review

Other care package: NHS and LA contributions

Review

NB. Eligibility for continuing healthcare must always be considered before any consideration of eligibility for NHS-funded nursing care.
acute hospital may not always reflect an individual’s capacity to maximise his or her potential. This could be because, with appropriate support, that 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 he or she is in an acute services department. Anyone who carries out an assessment of eligibility for NHS CHC should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs.

If it is decided that the provision of further NHS-funded services is appropriate, such as therapy and/or rehabilitation, that could make a difference to the potential of the individual in the following few months; assessment of eligibility for NHS CHC should usually be deferred until an accurate assessment of future needs can be made.

The interim services should continue in place until the determination of eligibility for NHS CHC has taken place and there must be no gap in the provision of appropriate support to meet the individual’s needs.

When considering eligibility, it is also important that deterioration in a person’s health is taken into account, including circumstances where deterioration might reasonably be regarded as likely in the near future. If individuals have a rapidly deteriorating condition that may be entering a terminal phase, they may need NHS CHC funding to enable their needs to be met urgently, for example, to allow them to go home to die or appropriate end of life support to be put in place. This would be a primary health need because of the rate of deterioration. In all cases where an individual has such needs, consideration should be given to use of the fast track pathway tool (see Box 2 and below).

Good practice in end of life care is supported through the end of life care programme. The principles of the national End of Life Care Strategy (DH 2008) should be reflected in all NHS CHC cases that involve individuals with an end of life condition.

**BOX 2**

**Tools to be used in assessing eligibility for continuing health care and funded nursing care in the NHS**


These tools can all be found at: www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/DH_073912

It is not permissible to amend or adapt these tools in any way when assessing for eligibility.
**Fast track pathway tool**
The purpose of the fast track pathway tool (DH 2009c) is to ensure that individuals with a rapidly deteriorating condition that may be entering a terminal phase, and with an increasing level of dependency, are supported to be in their preferred place of care as quickly as possible, without encountering delay as they wait for the full NHS CHC eligibility process to be completed.

The fast track pathway tool is used to gain immediate access to NHS CHC funding where an individual needs an urgent package of care/support. This tool bypasses the checklist and decision support tool (described below) and should only be used with individuals who have a primary health need through a rapidly deteriorating condition that may be entering a terminal phase, and have an increased level of dependency.

The framework makes it clear that the fast track pathway tool can only be completed by an ‘appropriate clinician’, including consultants, registrars, GPs and registered nurses. Practitioners should be knowledgeable about the individual’s health needs, diagnosis, treatment or care, and be able to provide reasons why the individual meets the conditions required for the fast-tracking decision.

Others involved in supporting an individual with end of life needs should, with the individual’s consent, contact the appropriate clinician responsible for that individual’s health care to request that a fast track pathway tool be completed.

Where it is appropriate, the fast track pathway tool replaces the need for a checklist and decision support tool to be completed, although a fast track pathway tool can also be completed after the completion of a checklist if it becomes apparent at that point that they meet the relevant criteria.

There are no time limits specified and the phrases ‘rapidly deteriorating’ and ‘may be entering a terminal phase’ should not be interpreted narrowly to situations where death is imminent. This process should reflect the best practice set out in the national End of Life Care Strategy (DH 2008).

**NHS Continuing Healthcare Checklist**
The NHS Continuing Healthcare Checklist (DH 2009d) is a screening tool to help practitioners to work out whether needs might possibly be of a level or type that might make the individual entitled to NHS CHC. The checklist does not indicate whether the individual is eligible for NHS CHC, only whether he or she requires full assessment of eligibility for NHS CHC. If the checklist suggests that there is a possibility the person might be eligible for NHS CHC, the assessor should arrange for a multidisciplinary team to carry out a needs assessment.

In a hospital setting the checklist should only be completed once an individual’s acute care and treatment have reached the stage where his or her needs on discharge are clear. Practitioners should consider whether individuals would benefit from other NHS-funded care to maximise their abilities and provide a clearer view of their likely longer-term needs before consideration of continuing healthcare eligibility.

In certain cases it can be appropriate for both the checklist and decision support tool to be completed in a hospital, but this should only be
done 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 fully takes into account the individual's views and preferences.

NHS CHC should be built into local agreed hospital discharge pathways, including identification of the circumstances when NHS CHC assessments and care planning will be carried out in a hospital.

In a community or 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 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 CHC.

Before the checklist is applied, it is necessary to ensure that the individual and, where appropriate, his or her representative understand that the checklist does not indicate a likelihood that the individual will be eligible for NHS CHC – only that he or she is entitled to consideration for eligibility.

The individuals themselves should normally be present at the completion of the checklist, together with any representative or advocate (as above).

No individual should be left without support while he or she awaits the outcome of the decision-making process.

Whatever the outcome of the checklist, the decision – including the reasons why the decision was reached – should be communicated clearly and in writing to individuals and, where appropriate, their representatives, as soon as is reasonably practicable.

Where the outcome is not to proceed to full assessment of eligibility, the written decision should also contain details of the individual's right to ask for reconsideration of the decision via the NHS complaints process.

Each local PCT and LA should identify and agree who can complete the tool but it is expected that it should, as far as possible, include all staff involved in assessing or reviewing individuals' needs as part of their day-to-day work. Such staff should be trained in the checklist's use and have completion of it as an identified part of their role.

Multidisciplinary assessment, completion of the decision support tool and making recommendations

The decision support tool (DH 2009e) is designed to help identify eligibility for NHS CHC. It should be used following a comprehensive multidisciplinary assessment of an individual's health and social care needs and his or her desired outcomes. If a multidisciplinary assessment has recently been completed, this may be used; but care should be taken to ensure that it provides an accurate reflection of current need.

The multidisciplinary assessment should draw on those who have direct knowledge of the individual and his or her needs. It should also make use of existing specialist assessments, and
should make referrals for other specialist assessments whenever that is appropriate in the light of the individual’s care needs.

A good multidisciplinary assessment may well identify care/support needs regardless of eligibility for NHS CHC. The involvement of LA colleagues, as well as health professionals in the assessment process, will streamline the process of care planning and will help decision making to be more effective and consistent.

The DST is not an assessment in itself. Rather, it is a way of bringing together and applying evidence in a single practical format, to facilitate consistent, evidence-based decision making. The evidence and the decision-making process should be accurately and fully recorded.

The DST provides practitioners with a framework to bring together and record the various needs in 12 ‘care domains’ or generic areas of need. The domains are subdivided into statements of need, representing low, moderate, high, severe or priority levels of need, depending on the domain. The care domains are:

- Behaviour.
- Cognition.
- Psychological and emotional needs.
- Communication.
- Mobility.
- Nutrition – food and drink.
- Continence.
- Skin, including tissue viability.
- Breathing.
- Altered states of consciousness.
- Drug therapies and medication: symptom control.
- Other significant care needs.

Completion of the tool should result in an overall picture of the individual’s needs that captures their nature and complexity, intensity and/or unpredictability – and thus the quality and/or quantity, including continuity, of care required to meet the individual’s needs.

Figure 2 indicates how the domains in the DST can illustrate the complexity, intensity and unpredictability of needs. The overall picture, and the descriptors in the domains, also relate to the nature of needs.

In certain cases, an individual may have particular needs that are not easily categorised by the care domains. In such circumstances, it is the responsibility of the assessors to determine the extent and type of the care need and to take that need into account (and record it in the 12th care domain) when deciding whether a person has a primary health need.

The multidisciplinary team should use the DST to set out the evidence and enable them to consider not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments.

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, 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 need are such that the individual has a primary health need.
FIGURE 2
How the domains help to build up a picture of complexity, intensity and unpredictability

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Within the 12 care domains N = no, L = low, M = moderate, H = high, S = severe, P = priority
Once the multidisciplinary team has reached agreement, it should make recommendation to the PCT on eligibility. The PCT should accept the recommendation in all but exceptional circumstances.

Access to other NHS-funded services
Entitlement to other NHS-funded care
Those in receipt of NHS CHC continue to be entitled to access the full range of primary, community, secondary and other health services.

Joint packages of health and social care services
If a person is not eligible for NHS CHC, he or she may receive a package of health and social care, rather than be fully funded by the NHS or by the LA.

Equipment
Where individuals in receipt of NHS CHC require equipment to meet his or her care needs, there are several routes by which this may be provided, such as by the local joint equipment service, the PCT or a care home. PCTs should be clear in their contract with care homes on what equipment should be provided. Care home residents should have the same rights to use joint equipment services as any other PCT patient.

Determining the need for NHS-funded nursing care
Some individuals not eligible for NHS CHC will be eligible for NHS-funded nursing care if they are assessed as requiring accommodation in a care home that includes nursing. NHS-funded nursing care is provided to homes to support the provision of nursing care by a registered nurse for those assessed as eligible. The registered nurse input is defined as ‘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 service which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse’ (DH 2009b, pages 4-5).

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 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.

In all cases, individuals should be considered for eligibility for NHS CHC before a decision is reached about the need for NHS-funded nursing care (NHS-funded nursing care provided by RNs) in residential accommodation. In most cases, therefore, the individual will already have been considered for NHS CHC and will have had an associated assessment, which should provide sufficient information to gauge the need for nursing care in residential accommodation.

In certain circumstances an individual who has been found not to be eligible for NHS CHC at the checklist stage may still need an assessment of needs for NHS-funded nursing care. In such cases, an appropriate assessment should be completed. It may be appropriate to use the single assessment process (or similar) to ensure that all needs are identified and that the decisions reached are proportionate, reasoned and recorded.
If it is agreed that a care home providing nursing offers the best environment in which the person's needs can be met, the next phase is to set goals within a care plan. The care plan should identify the need for care (or supervision of care) by a registered nurse across the same comprehensive care domains as those used in the decision support tool. (A template record of nursing care needs, which can be adapted for local use, is set out in DH (2009b), pages 26-28.)

By law, LAs cannot provide registered nursing care. For individuals in care homes with nursing, registered nurses are usually employed by the care home itself and, to fund this nursing care, the NHS makes a payment directly to the care home.

The DH guidance (2009b) emphasises that individuals in receipt of NHS-funded nursing care continue to be entitled to access the full range of primary, community, secondary and other health services.

**Review**

Regular reviews should be carried out. If the NHS is commissioning, funding or providing any part of an individual's care, a case review should be undertaken no later than three months after the initial eligibility decision to reassess care needs, ensure that those needs are being met and to consider whether a person continues to be eligible, or has now become eligible, for NHS CHC. Some people will need more frequent reviews.

When reviewing the need for NHS-funded nursing care, potential eligibility for NHS CHC must always be considered (using the checklist) and full consideration via the DST or fast track pathway tool should be carried out, where necessary.

The outcome of the case review will determine whether the individual's needs have changed, and that will determine whether the package of care may have to be revised or the funding responsibilities altered.

After the first three-monthly review, reviews should then take place annually, as a minimum. Some cases will require a more frequent case review, in line with clinical judgement, anticipated changing needs or if there is a significant change in the healthcare needs of the individual.

**Dispute resolution**

There should be a local dispute procedure setting out the process to be followed when there is disagreement between the NHS and LAs concerning an eligibility decision or on joint funding. Separate independent review panel procedures exist for when an individual disagrees with a decision or with the process used to reach it. There are key principles for dispute resolution procedures involving NHS CHC (DH 2009a, paragraph 154).

**Conclusion**

NHS CHC and NHS-funded nursing care are complex but the DH has established clear guidance and tools to facilitate implementation. It is essential that RNs working with adults in all care settings in England understand their professional responsibilities and actively fulfil these. Nurses are crucial to promoting awareness of NHS CHC and NHS-funded nursing, in ensuring fairness and consistency in the application of national policy on eligibility and in sustaining high
quality practice. The contribution of nurses is particularly vital in ensuring that patients/clients understand the decisions that are made, that they participate as fully as possible and that they are supported through the processes of decision making at a time in their lives when they may be vulnerable.

REFERENCES

BOX 3
Resources
Public information
This leaflet gives a summary of information for the public on NHS continuing healthcare and NHS-funded nursing care, including details of what individuals should do if they think they may be eligible.

Training materials
These slides have been developed to support local training. Individual groups of slides can be used for training on specific issues. Speaker notes are attached.

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