NHS continuing healthcare and NHS-funded nursing care in Wales

About this factsheet

This new factsheet for Wales explains what NHS continuing healthcare is, the process for deciding whether you are eligible to receive it and what to do if you are unhappy with the decision reached. It also explains NHS-funded nursing care – the financial contribution towards the cost of meeting nursing care needs of residents of nursing homes.

This factsheet should be read in conjunction with Age Cymru’s other factsheets: 10w Paying for permanent residential care in Wales; 38w Treatment of property in the means test for permanent care home provision in Wales. Age UK factsheets may also be relevant: 39 Paying for care in a care home if you have a partner and 41 Local authority assessment for community care services.

The information given in this factsheet is applicable in Wales. Different rules apply in England, Northern Ireland and Scotland. Readers in England should read Age UK’s Factsheet 20 NHS continuing healthcare and NHS-funded nursing care. Readers in Northern Ireland and Scotland should contact Age NI and Age Scotland respectively – see section 8 for details.

For details of how to order other Age Cymru and Age UK factsheets and information materials go to section 8.

Note: The Age UK family works nationally and locally as Age UK, Age Cymru, Age NI and Age Scotland.
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1 Recent developments

- The Welsh Assembly Government issued its **Continuing NHS Healthcare: the National Framework for implementation in Wales** in May 2010, with an implementation date of 16th August 2010. This included an Independent Review Panel checklist and a Decision Support Tool, as well as information on ‘fast-track’ assessments, where appropriate. The Welsh Assembly Government gave a commitment to review the Framework after one year of implementation.

- The revised rate for NHS-funded nursing care in a care home from April 2010 is given in section 6.3.

2 Continuing care

Health and social care professionals may use the following terms when describing support from the NHS or local authority.

**Continuing care** is a general term describing care provided over a period of time to meet physical and mental health needs that have arisen as a result of disability, an accident or illness.

**Continuing NHS and social care** is care available in a range of settings that may involve services from the NHS and social services. It may also be described as a ‘joint package of continuing care’.

**NHS continuing healthcare** – a complete package of ongoing care arranged and funded by the NHS. See sections 3 and 4.

**Note:** Although these are not the terms used by the Care and Social Services Inspectorate Wales (CSSIW) for different types of care home, for ease of reading we will use the shorter terms: residential home or nursing home, or care home if it can be either.
3 NHS continuing healthcare

3.1 Background to NHS continuing healthcare

When you have long-term care needs it is usually obvious whether the help you need is the responsibility of the NHS or of social services. However, if you have complex needs, the boundaries between health and social care may not always be clear. As services provided by the NHS are free whereas those arranged by social services are means tested, the outcome of any decision as to who has overall responsibility for your care can have significant financial consequences.

Since the early 1990’s, the Parliamentary and Health Service Ombudsman in England and the Public Services Ombudsman in Wales have investigated a large number of complaints about local criteria developed using government guidance and about processes followed when making decisions about eligibility for NHS continuing healthcare. The legality of some eligibility decisions was challenged in the courts.

It is against this background that the National Framework for NHS continuing healthcare and NHS-funded nursing care was developed and first introduced in England in October 2007 and the National Framework for implementation in Wales was introduced in August 2010.

Further information about the Ombudsman’s investigations and court decisions can be found in the appendix to this factsheet (see page 27).

3.2 What is NHS continuing healthcare?

NHS continuing healthcare is a package of care arranged and funded solely by the NHS to meet physical and/or mental health needs that have arisen because of disability, accident or illness. It can be provided in any setting including, but not limited to a care home, a hospice or your own home.

If you live in your own home, the NHS arranges and funds an appropriate care package to meet your assessed health and personal care needs. If you live in a care home, the NHS makes a contract with the home to pay fees covering your accommodation and assessed health and personal care needs.
3.3 **Who arranges and funds NHS continuing care?**

If you are found eligible for NHS continuing healthcare in Wales, the Local Health Board that holds the contract with your GP practice at the time of your assessment is responsible for arranging and funding a suitable care package.

**Note:** There will be a manager at each Local Health Board with responsibility for NHS continuing healthcare. NHS Direct can tell you which Local Health Board you need to contact (see section 7).

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3.4 **What is the National Framework?**

The National Framework for Implementation in Wales is the Welsh Assembly Government guidance document that:

- sets out clear principles and processes to be followed throughout Wales for establishing eligibility for NHS continuing healthcare (see section 4)
- clarifies the interaction between the assessment for NHS continuing healthcare and NHS-funded nursing care (see section 6).

It aims to put in place a sound national Framework, good decision tools, training and review arrangements to ensure speed, consistency and fairness in decisions by providing:

- guidance that must be followed by all Local Health Boards in Wales in conjunction with their local authorities and by hospital staff involved in the assessment process
- a national assessment process supported by a single tool – the Decision Support Tool
- common paperwork to record evidence that will inform decision-making

The Framework and the tool were implemented on 16th August 2010. The Welsh Assembly Government gave a commitment to review the Framework after one year of implementation.
3.5 **Who is eligible for NHS continuing healthcare?**

Eligibility for NHS continuing healthcare does not depend on who provides your care or where care is provided or on having a particular condition or diagnosis.

Eligibility decisions should be independent of budgetary constraints and rest on whether your need for care is primarily due to your health needs. This is referred to as having a ‘**primary health need**’.

Certain characteristics of your needs, in combination or alone, may demonstrate a ‘primary health need’ because of the quality and/or quantity of care needed to manage them. So when assessing your needs, staff consider them in relation to these characteristics:

- **nature**: the type of needs, and the overall effect of those needs, including the type (quality) of interventions required to manage them

- **intensity**: both the extent (quantity) and severity (degree) of the needs and the support required to meet them, including the need for sustained/ongoing care (continuity)

- **complexity**: how the different needs present and interact to increase the skill needed to monitor and manage care. This can arise with a single condition or can also include the presence of multiple conditions or the interactions between two or more conditions

- **unpredictability**: this describes the degree to which needs fluctuate, creating 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, or unstable or rapidly deteriorating condition.

These characteristics are reflected in the descriptions of the different levels of need that feature in the Decision Support Tool. This tool helps inform staff making a recommendation about your likely or actual eligibility for NHS continuing healthcare. See section 4.4.

These characteristics are also considered by staff deciding whether to recommend ‘fast tracking’ a patient so they can receive an urgent package of NHS continuing healthcare in an appropriate location. See section 4.5.
3.6 When should eligibility be considered?

A Local Health Board must take reasonable steps to ensure that an assessment for eligibility for NHS continuing healthcare is carried out in all cases where it appears necessary and regardless of where you are living at the time.

Not everyone with ongoing health needs is likely to be eligible but there are times to make sure your eligibility is considered. You should ask hospital staff, or speak to your GP or social services:

- when you are ready to be discharged from hospital and are not being offered rehabilitations or other NHS-funded services that may lead to an improvement in your condition. Your eligibility must be considered before a decision to find a permanent place in a nursing home is made
- whenever your health and social care needs are being reviewed as part of a community care assessment.
- if your physical or mental health deteriorates significantly and your current level of care – at home or in a care home – seems inadequate
- when, as a resident of a nursing home, your nursing care needs are being reviewed. This should be undertaken at least annually (see section 6)
- if you have a rapidly deteriorating condition with an increasing level of dependency and may be approaching the end of your life.

3.7 How is eligibility decided?

Staff should follow the Framework guidance using the Decision Support Tool.

Note: You may find it helpful to see a copy of the Decision Support Tool in advance. It should be available from staff who will be using it (for example, hospital or care home staff) and can be found on the Welsh Assembly Government’s website at http://wales.gov.uk/docs/dhss/publications/100614chcframeworken.pdf (see Annex 6)

The process for deciding eligibility is described in the following section.
4 National Framework principles and process

4.1 Involving you and your carers

Staff should ensure that you and your family understand at the outset how they will decide if you are eligible for NHS continuing healthcare. At each stage, decisions made and their rationale should be transparent and communicated clearly in writing.

Where possible, when a full assessment is taking place or the Decision Support Tool is completed, you and, where appropriate, a family member or representative should be enabled to play a central role.

If you are found eligible for NHS continuing healthcare, the final decision about your care plan and location of care rests with the funding Local Health Board. However, when your care plan is drawn up, your wishes and expectations of how and where you might be cared for should be recorded and taken into account and considered, along with any risks that may be associated with where you are cared for and fair access to Local Health Board resources.

Giving consent

You should be told if staff consider you may be eligible for NHS continuing healthcare. Your informed consent should be explicitly sought and staff should let you know whether they are seeking your consent to complete a full assessment of your needs or completion of the Decision Support Tool. You can withdraw your consent at any stage in the process if you wish.

If you decide not to give consent, the local authority cannot take responsibility for meeting needs that would be the responsibility of the NHS. The consequences of not giving consent should be explained to you.

When you lack capacity to give consent

If it is agreed that you lack capacity to give consent, staff should check whether, under the Mental Capacity Act 2005, you have appointed someone to have Lasting Power of Attorney (LPA) to act on your behalf on health and welfare matters or whether someone has been appointed a Welfare Deputy by the Court of Protection. A partner, family member or other ‘third party’ cannot give or refuse consent on your behalf unless this is the case.
If no one has been appointed to act in one of these ways, staff will be responsible for making decisions on your behalf and must act in your ‘best interests’, having consulted with those who have a genuine interest in your welfare. This will usually include your family and friends. The expectation is that everyone who is potentially eligible should have the opportunity to be considered. The outcome of a ‘best interests’ decision should be recorded.

**Advocacy**

If the Local Health Board (or local authority) ultimately has to make a ‘best interests’ decision that involves a change of residence – it may be considering a move to a care home when drawing up your care plan – it has a duty under the Mental Capacity Act to instruct and consult an Independent Mental Capacity Advocate (IMCA).

The IMCA’s role is to seek information about what would be in their client’s ‘best interests’, represent their interests and challenge any decision that does not appear to be in their ‘best interests’.

Even when you have capacity to make your own decisions, you can ask a family member to act as an advocate and help you make your views known. You can ask the person co-ordinating your assessment for details of local advocacy services that you could approach for advice and support.

**Note:** You can find out more about LPAs, IMCAs and the Mental Capacity Act 2005 from the Office of the Public Guardian. See section 7.

### 4.2 Routes to reaching a decision

Times when you should ensure your eligibility is considered are raised in section 3.6.

There is an option to ‘fast-track’ the assessment so that you can move quickly onto NHS continuing healthcare. It can be used if you have a rapidly deteriorating condition with an increasing level of dependency and appear to be reaching the end of your life. See section 4.5.

However, this is not the usual route. For most people the type and level of their needs should prompt a multi-disciplinary team assessment, using the Framework guidance and the ‘Decision Support Tool’ and ultimately making a recommendation about your eligibility.
4.3 **Multi-disciplinary assessment**

Once you are referred for a full assessment, the Local Health Board is responsible for co-ordinating the whole process until a decision about your eligibility and the funding of your care has been reached and a care plan agreed. The Local Health Board should appoint someone employed by them, or by mutual agreement by another organisation, to co-ordinate this process.

An appropriate range of health and social care professionals, which may include those not currently caring for you but who have a direct knowledge of you and your needs, should be invited to contribute to your assessment so that all your physical and mental health and social care needs can be looked at and evaluated individually and together – including ways in which they interact with each other – to give an accurate reflection of your current needs and likely changes in the near future.

A good quality assessment is crucial both to determining your eligibility for NHS continuing healthcare and addressing how your needs can best be met – whether you are eligible for NHS continuing healthcare or not.

4.4 **Decision-support tool**

Information collected during your assessment is used to complete the decision-support tool that helps inform the eligibility decision.

The tool features 12 ‘domains’ or areas of need – 11 specific domains and a twelfth which is an open domain for needs that don’t readily fit into the other 11.

Each domain is broken down into between four and six levels of need:

‘No need’ ‘low’ ‘moderate’ ‘high’ ‘severe’ ‘priority’. However, the domains do not always include all these levels.

The descriptions given for the levels in each domain minimise the use of medical terms so that they can be understood by you and your family.

The domains are:

1. **Behaviour**
2. Cognition
3. Psychological and emotional needs
4. Communication
The Decision Support Tool (DST) is completed by a Multi-Disciplinary Team (MDT) identified by the co-ordinator. The team should have at least two professionals, usually from both health and social care professions. Other professionals who have an up-to-date knowledge of your needs and potential capacity may also be included.

When the DST is completed you should be invited to be present or represented where possible. You should be given sufficient notice of the date, for you to arrange for a family member or advocate to be present if you wish. If this is not possible, your views or those of your representative should be obtained and actively considered when completing the DST. Those completing the tool should note within it whether you or your representative were present and/or represented and, if not, the reason why.

The completed tool should give an overall picture of your needs.

When completing the tool, the following points are important:

● all care domains should be completed, ideally on the same day
● the team should use the assessment evidence and their professional judgement to select the level that most closely describes your needs
● your needs should not be placed between levels. If it proves difficult to choose between two levels, the higher level should be selected and the reasons for the differences of opinion recorded
● interactions between needs should be considered as appropriate
● needs not covered by one of the 11 domains should be recorded in the twelfth domain and taken into account when making an eligibility decision
needs should not be marginalised because they are successfully managed. Well-managed needs are still needs and should be recorded appropriately.

If it can reasonably be anticipated that your condition will deteriorate and that needs in certain domains will increase in the near future, this should be recorded and taken into account when the final recommendation is made. Such knowledge may also influence the time when a review of your needs should be undertaken.

**Reaching a decision**

The multi-disciplinary team uses evidence from the completed DST, along with relevant risk assessments and their experience and expertise, to make a recommendation to the Local Health Board as to whether or not your needs have characteristics that demonstrate a ‘primary health need’ and hence eligibility for NHS continuing healthcare. The DST has space for their recommendation and for your views or those of your representative.

A clear recommendation of eligibility would be expected if you have:

- priority level of need in any of the three domains with that level
- two or more instances of severe needs across all domains.

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

- one domain recorded as severe together with needs in a number of other domains, or
- a number of domains with high and/or moderate needs.

In this case the judgement whether you have a ‘primary health need’ must be based on what the evidence indicates about the **nature** and/or **complexity** and/or **intensity** and/or **unpredictability** of your needs.

If needs in all domains are ‘no need’, this would indicate ineligibility and if all are ‘low’ needs, this is unlikely to indicate eligibility.

Only in exceptional circumstances should the Local Health Board disagree with the recommendations of the multi-disciplinary team.

**Note:** Having taken into account any likely deterioration in your condition that could affect your needs, a recommendation for you to be ‘fast tracked’ on to NHS continuing healthcare may be appropriate. See sections 5.49 to 5.56.
The multi-disciplinary team is also asked to indicate whether they expect your needs to improve or deteriorate before the three-month review and whether they would recommend an earlier review.

A decision that you are eligible for NHS continuing healthcare can be overturned at a later date if a review of your condition shows your condition has improved and your needs changed.

If the recommendation is that you are not eligible but that you may need care in a care home the team should indicate, with reasons, whether this should be a nursing home.

4.5 **Fast-track assessments**

When you have a rapidly deteriorating condition with an increasing level of dependency and may be approaching the end of your life, urgent consideration of your eligibility would allow an appropriate care package to be arranged as quickly as possible.

Such changes in your condition could be observed while you are in hospital or by staff caring for you at home or in a care home. If this happens, they should contact an ‘appropriate clinician’ and ask them whether it would be appropriate to consider completion of a ‘fast-track assessment’.

4.6 **What happens if you are eligible?**

The Local Health Board should tell you their decision verbally and in writing, giving clear reasons and the basis on which the decision was made. A copy of the completed Decision Support Tool should also be available to you. This is not necessarily a permanent decision as your condition and needs may change. Ongoing reviews are built into the process. See section 4.9.

The Local Health Board must provide a care package it thinks appropriate to meet your needs. When drawing up and agreeing your care plan, your preferences and those of your relatives or advocate on how and where your care is provided should be taken into account, together with any risks associated with different types of care and fairness of access to resources of the Local Health Board. The final decision rests with the Local Health Board.
Note: If you are dissatisfied with the care package proposed by the Local Health Board and cannot resolve your concerns informally, you should be told how to access and use the NHS complaints procedure.

Your care can be provided in a range of settings.

In a care home

If it is agreed that you should move into a care home, you do not have the right to choose either the location, ie the town, or actual care home but you can express preferences. Care will usually be provided in a nursing home, but does not have to be, particularly if you have been awarded NHS continuing healthcare through the ‘fast-track assessment’, having been living in a residential home and if you have expressed a preference for remaining there.

The Local Health Board may have a contract with one or more nursing homes but your assessed needs will determine whether they are suitable.

It may seem more appropriate for you to move to a home closer to relatives who live in a different Local Health Board area. You may propose this but cannot assume it will be acceptable to the funding Health Board.

If it is agreed you can live in a care home in a different Local Health Board area, your care home fees continue to be the responsibility of the Local Health Board that initially agreed your placement. Once you move into the care home, you need to register with a local GP practice. Once registered, any NHS services or treatment unrelated to the reason for your placement in the care home become the responsibility of your GP practice’s Local Health Board.

If you are living in a care home when the decision to grant NHS continuing healthcare is made, you need to discuss whether you can stay there with your Local Health Board. This is particularly relevant if your home is more expensive than the Local Health Board would normally pay to meet needs such as yours. The risks and benefits of moving you, including the effect on your physical and mental health, would need to be assessed before a decision were made.

If your current care home cannot meet your needs you would need to discuss this with the Local Health Board.
In a hospice

This may be appropriate if you are reaching the end of your life. However, the Welsh Assembly Government’s Framework recognises that there will be circumstances in which you may wish to remain at home at this time.

In your own home

The Local Health Board package you receive should meet all your eligible needs, including personal and social care needs. This is often a more complex care package to arrange and local resources may influence whether care can be provided at home.

If you were living at home prior to being eligible for NHS continuing healthcare, you may have been receiving Direct Payments from your local authority. Although NHS continuing healthcare cannot be provided through Direct Payments, Local Health Boards can arrange services to maintain a similar package of care to that already in place, to replicate as far as possible the personalisation and control you enjoyed with Direct Payments.

Note: If you have a partner who is providing, or will in future provide, a substantial amount of care as part of your care package, the Local Health Board should let them know of their right to ask the local authority for a carer’s assessment.

Moves within the UK

If you wish, regardless of setting, to receive care in England, Scotland or Northern Ireland, there would need to be a discussion between your funding Local Health Board and the relevant health body in your chosen country, for example, the Primary Care Trust in England.

Other NHS services

You should receive GP, dental and other NHS services as needed.
4.7 What happens if you wish to challenge a decision?

You or your family can approach the relevant Local Health Board for an independent review of the Local Health Board’s decision if you have been unable to resolve the matter through the Local Health Board’s local dispute resolution process and you are dissatisfied with:

- the procedure followed in reaching their eligibility decision
- application of the criteria for eligibility, that is the ‘primary health need’ test.

There are two stages in the review process:

- a local review process at Local Health Board level
- a request to the Local Health Board, which may refer the matter to an Independent Review Panel.

If using the local review process would cause undue delay, the Local Health Board has the discretion to put your case straight to the Independent Review Panel.

Each Local Health Board should agree a local review process, including timescales, which should be made publicly available and sent to anyone who requests a review of a decision. It may involve referring your case to another Local Health Board for consideration or advice.

Once local procedures are exhausted your case should be referred to the Independent Review Panel. The Local Health Board can decide not to convene a panel but before doing this should seek the advice of one of the individuals who can chair a panel. If the Local Health Board decides not to convene a panel, you, your family or representative should have a full written explanation explaining why and be told of your rights to use the NHS complaints procedure to take it further.

The Independent Review Panel has a scrutiny and reviewing role and is required to make a recommendation to the Local Health Board in light of its findings. It is therefore not generally appropriate for you to be legally represented at an Independent Review Panel hearing, although you may wish to be represented by a family member, advocate or advice worker. If you wish the support of an advocate, your Local Health Board should have details of local advocacy services. Or you could ask your local advice agency, such as Age Concern or Citizens Advice.
**Note:** Details of Independent Review Panels are in Chapter 12 of the Welsh Assembly Government’s National Framework.

However, both the Independent Review Panel and local procedures should follow the key principles for dispute resolution that are outlined in the National Framework. They include:

- the full consideration of the case by the appropriate officer of the NHS organisation and Social Services, together with the members of the multi-disciplinary teams, most likely in the form of a case conference. The formal recording of the outcome of discussions, which are to be made available to all relevant persons. The consideration of all relevant comprehensive assessments.

- the aim for any disputes to be resolved in the minimum time. All stages of disputes procedures will normally be completed within two weeks. All stages will be appropriately documented.

- involvement of the individual or their representative as far as possible, including the opportunity for them to contribute to and comment on information at all stages.

- clear and evidenced written conclusions on the process followed by the NHS body and on the individual’s eligibility for NHS continuing healthcare, together with appropriate recommendations and action to be taken in the light of the Framework rationale.

The role of the Independent Review Panel is advisory but its recommendations should be accepted by the Local Health Board in all but exceptional circumstances.

In all cases the Local Health Board should communicate the outcome of the Review, with its reasons, to the individual.

If the original decision is upheld and you still wish to challenge it, you can ask for it to be referred to the Public Services Ombudsman for Wales.
Note: The Panel arrangements make no difference to your rights to pursue a complaint through the ordinary procedures of the NHS. This is normally by complaining initially to the Chief Executive of the NHS organisation concerned.

### 4.8 Effect on state benefits of NHS continuing healthcare

#### Attendance Allowance

If you are self-funding your care in a care home and receiving Attendance Allowance (AA) or Disability Living Allowance (DLA) and will receive NHS continuing healthcare in a care home, you should notify the Disability Benefits and Attendance Allowance helpline (see section 7). Your benefit will cease on the twenty-ninth day after the Local Health Boards begins to fund your care, or sooner if you have recently been in hospital.

If you are living at home and claiming AA or DLA but will receive NHS continuing healthcare in a care home, you should notify the helpline. Your benefit will cease on the twenty-ninth day after the Local Health Board begins to fund your care or sooner if you have recently been in hospital.

If you are currently living in a care home and claiming AA or DLA and will be returning to live in your own home with an NHS continuing healthcare package, you can continue to receive AA or DLA.

#### Other benefits

Your State Pension is not affected by your eligibility for NHS continuing healthcare.

You lose the severe disability element of your Pension Credit award when you are no longer entitled to AA or DLA (care component), and this may affect the amount of Pension Credit you receive.

### 4.9 Reviewing eligibility decisions

If you have been considered for NHS continuing healthcare and the NHS is providing or funding any part of your care package, a case review should be undertaken no later than three months after the initial eligibility decision. Reviews should take place annually after that, as a minimum.
The multi-disciplinary team making the original recommendation after a full determination of your eligibility for NHS continuing healthcare may have made a specific recommendation about the timing of your next review. See section 4.4.

If you are receiving NHS continuing healthcare as a result of ‘fast-tracking’ and it is appropriate to consider your longer terms needs, your review should include completion of the Decision Support Tool by a multi-disciplinary team along with their subsequent recommendation on future eligibility.

The review will determine whether your needs have changed and consequently whether your care plan needs to be revised.

4.10 Your care package, if you are not eligible

If it is agreed that you are not eligible for a full consideration of your eligibility, a joint health and social care assessment will identify your needs. When your care package is agreed, your Local Health Board and local authority will need to decide where their responsibilities lie. You will be means-tested for services that are the responsibility of social services.

If you are found not eligible following a full consideration for NHS continuing healthcare, needs identified during your assessment and your views on how your needs can best be met will form the basis of your agreed care plan and care package which may include the provision of equipment. It is likely you will have needs for services from both the NHS and social services. You will be means-tested for services that are the responsibility of social services.

NHS services that may be provided in their own right, regularly or on an occasional basis, alongside social care services include:

- care provided in a nursing home by a registered nurse
- rehabilitation and recovery services, such as speech therapy
- assessment and/or support from community-based NHS staff, such as district nurses, continence nurses or specialist diabetic nurses
- palliative care services.
Note: For more information about care assessments and charging procedures when care services are provided by a local authority, see the other Factsheets produced by Age Cymru and Age UK which are listed on page 1.

5 Challenging NHS continuing healthcare decisions

5.1 Decisions made before 31st March 2003

The Welsh Assembly Government announced in August 2009 that “no further claims for financial compensation arising from eligibility for Continuing NHS Health Care which relate to the period 1 April 1996 to 31 March 2003 will be considered if they are submitted after 4 December 2009.” A deadline for earlier claims has also expired.

5.2 Later decisions

In view of the complexity of the issues and the sums of money that could be involved, you may wish to seek legal support for your claim. You will need to discuss fees with any solicitor you approach. You will also need to find a solicitor with experience in this field. One way is to find a solicitor who is a member of Solicitors for the Elderly and to ask them what experience they have in this specific area. Further details are given in section 7. Cases can still be pursued after the death of the person concerned, but subject to the limit in section 5.1 and any later announcements by the Welsh Assembly Government.

6 NHS-funded nursing care

NHS-funded nursing care is funding paid directly to nursing homes for care provided by registered nurses employed by the homes. Services provided on a regular basis by a registered nurse are likely to involve:

- provision of nursing care
- supervision or monitoring of care provided by a non-registered nurse
- planning and reviewing a care plan
monitoring and reviewing medication needs
identifying and addressing potential health problems.

6.1 **How is eligibility for NHS-funded nursing care decided?**

It is not appropriate to consider your need for NHS-funded nursing care in a nursing home until it has been agreed that you are not eligible for **NHS continuing healthcare** and that a place in a nursing home is the best option for meeting your needs.

The decision about your eligibility for NHS continuing healthcare could have been made following a full consideration of your eligibility for NHS continuing healthcare with completion of the Decision Support Tool, or as part of a joint NHS and social care assessment at home or in a residential home.

As when determining your eligibility for NHS continuing healthcare, staff should consider whether you have the potential to recover further in the near future if you receive additional NHS-funded services, before agreeing that a place in a nursing home is your best option. This is particularly relevant if you have been living at home and are about to be discharged from hospital following an unplanned admission.

When you have a full consideration of your eligibility for NHS continuing healthcare, as described in section 3.5, and the multi-disciplinary team recommendation is that you are not eligible for NHS continuing healthcare, the multi-disciplinary team should indicate your need for registered nursing care based on information provided by the assessments. This information should be used when drawing up your care plan.

If a joint health and social care assessment is conducted, it should identify your nursing needs. It may be useful to consider and document your needs based on the ‘domains’ featured in the Decision Support Tool.

Once it is agreed that a place in a nursing home is appropriate, the Local Health Board establishes a contract for NHS-funded nursing care with your nursing home and pays the home directly, based on information provided by the assessment.
6.2 **Review of NHS-funded nursing care needs**

Your nursing needs should be reviewed no later than three months after the decision was first made that you are not eligible for NHS continuing healthcare and at least annually as a minimum after that.

As part of each review, your potential eligibility for NHS continuing healthcare should always be considered.

If you fund your own place in a nursing home, you need to ensure you have a review of your needs three months after you first move in and annually thereafter. The care home manager should be aware of the Local Health Board’s arrangements for nursing care reviews.

6.3 **NHS-funded nursing care payments**

Local Health Boards in Wales have agreed a rate of £120.55 per week from April 2010 as the contribution from the NHS towards the cost of providing nursing care in a care home.

6.4 **If you are admitted to hospital**

If you are admitted to hospital, the Local Health Board does not pay nursing care costs to the care home during your hospital stay. You could ask the Local Health Board to consider paying a retainer to help safeguard your care home places while you are in hospital. You could argue that any arrangements the Local Health Board makes should not disadvantage residents who fund their own care home place.

6.5 **Short stays in a nursing home**

If you go into a nursing home on a temporary basis for a period of less than six weeks you will qualify for NHS funding. There is no need to carry out an assessment of nursing needs if it is known at the outset that the stay is for less than six weeks and you have already been assessed for nursing care in the community.

This might apply if you are having a trial period in the home, you are admitted to the home in an emergency because your carer is ill or for respite care.
7 Useful organisations

● Disability Benefits and Attendance Allowance helpline
   Contact this helpline if you need to give notification of your eligibility for NHS continuing healthcare.
   Tel: 08457 123456

● Healthcare Inspectorate Wales
   Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
   Tel: 029 2092 8850
   Email: hiw@wales.gsi.gov.uk

● NHS Direct
   NHS Direct is a 24-hour NHS helpline. It has details of areas covered by each Community Health Council and Local Health Board in Wales.
   Tel: 0845 46 47

● Office of the Public Guardian
   The Office of the Public Guardian supports and promotes decision-making for those who lack capacity or would like to plan for their future under the Mental Capacity Act 2005.
   Tel: 0845 330 2900
   Website: www.publicguardian.gov.uk

● Public Services Ombudsman for Wales
   The Ombudsman looks to see whether people have been treated unfairly or inconsiderately, or have received a bad service through some fault on the part of the public body providing it.
   Tel: 01656 641150
   Email: ask@ombudsman-wales.org.uk
   Web: www.ombudsman-wales.org.uk
Solicitors for the Elderly

Solicitors for the Elderly (SFE) is an independent, national organisation of lawyers, including solicitors, barristers and legal executives who are committed to providing the highest quality of legal advice for older and vulnerable people, their families and carers. Tel: 0844 567 6173 (to find a lawyer)
Email: admin@solicitorsfortheelderly.com
Web: www.solicitorsfortheelderly.com

8 Further information about Age Cymru and local Age Concern organisations

Age Cymru is the new force combining Age Concern Cymru and Help the Aged in Wales. For information visit the Age Cymru website at www.agecymru.org.uk or call Age UK Advice on 0800 169 65 65 (freephone). Age UK and Age Cymru are working together to provide Age UK Advice. Age Cymru is working in partnership with local Age Concerns.

Call Age UK Advice on 0800 169 65 65 if you would like:

● to order copies of any of the Age Cymru and Age UK information materials mentioned in this factsheet
● to request information in large print
● further information about our full range of information products
● contact details for your nearest Age Cymru/Age Concern organisation.

Books from Age UK

Age UK publishes a wide range of books for older people and those who care for and work with them. The following title may be of particular interest:

Your rights to money benefits 2010/11. All you need to know about the full range of benefits for the over 60’s. £5.99.

To order this book, or to view our full range of books, please visit our website at www.agecymru.org.uk/bookshop or call our book order line on 0870 442 2120.
The Age UK family works nationally and locally as Age UK, Age Cymru, Age NI and Age Scotland’. Age UK and Age Cymru are working together to provided Age UK Advice.

Contacts

Age Cymru
Age UK Advice: 0800 169 65 65
Website: www.agecymru.org.uk

Age UK
Age UK Advice: 0800 169 65 65
Website: www.ageuk.org.uk

Age NI
Age NI Advice: 0808 808 75 75
Website: www.ageni.org

Age Scotland
Tel: 0845 125 9732
Websites: www.olderpeoplescotland.org.uk
www.agescotland.org.uk

Support Age Cymru

Age Cymru needs your support to enable us to remain the best informed and most influential national charity for older people in Wales.

If you would like to support our work in Wales to enable us to continue distributing our free information and advice, please call 029 2043 1555 to make a donation (national call rate, Monday to Friday 9.15am – 5pm), or donate online at www.agecymru.org.uk/donate

Legal statement

Age Cymru is the new force combining Age Concern Cymru and Help the Aged in Wales
Registered address: Tŷ John Pathy, 13/14 Neptune Court, Vanguard Way, Cardiff CF24 5PJ. Company number 06837284. Registered charity number 1128436.

Age Cymru is working in partnership with local Age Concerns in Wales.

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Appendix: Eligibility criteria for NHS continuing healthcare in Wales - a brief history (1998-2010)

Since the Government of Wales Act 1998, health is an issue that is devolved to the Welsh Assembly Government. The UK Government’s Department of Health has no jurisdiction in Wales. However, the issue of NHS continuing healthcare in Wales has developed against the background of developments in England and both similarities and differences can be seen. In addition, cases in England that have been taken to the higher courts are seen as relevant to the situation in Wales.


In 1999, an important Court of Appeal judgement – known as the Coughlan judgement – ruled that eligibility criteria used by the health authority concerned in the case were far too restrictive.

The Court found social services had been asked to take on healthcare responsibilities for a nursing home resident that went far beyond the duties imposed upon them by law under section 21 of the 1948 National Assistance Act.

The judge said social services can only be asked to provide nursing care that is:

- merely incidental or ancillary to the provision of accommodation which a local authority is under a duty to provide or
- of a nature which it can be expected to provide under section 21 of the National Assistance Act 1948.

This is often referred to as the quantity/quality test. The over-riding factor is whether a person’s need is primarily for healthcare – which is fully funded by the NHS – or social care – which is means tested and so charges may be applied.

In November 2003, the Health Service Ombudsman (in England) upheld a complaint made on behalf of Mr Pointon, a man with dementia cared for at home by his wife. This complex case, which can be read in full on the Health Service Ombudsman’s website, raised a number of issues around eligibility criteria and the assessment of individuals:
The need to ensure criteria for funding NHS continuing healthcare at home are clearly defined.

The need to ensure assessment takes account of mental health and psychological as well as physical needs of patients with illnesses like dementia.

Recognition that it is possible for the standard of care provided and co-ordinated by a carer to reach that which a nurse could provide.

The Health Service Ombudsman said that this ruling should not be seen as implying that all patients with dementia should be eligible for fully funded care.

**On 1st April 2004 the 5 Health Authorities in Wales were reorganised into 22 Local Health Boards.**

In 2004, the Welsh Assembly Government issued a Welsh Health Circular (2004) 54 called Continuing NHS Health Care Guidance. This sought to address the issues raised by the Coughlan judgment and the subsequent Ombudsman’s reports.

In 2005, Powys Local Health Board issued their Advice for LHBs on managing requests for retrospective review of continuing care status following the Ombudsman’s report on long term care. This clarified that responsibility for claims relating to the period from April 1996 to April 2003 rested with Powys Local Health Board for claims in Wales.

**March 2006 – Grogan case**

The High Court heard a challenge, on behalf of Mrs Grogan, who argued that she had been wrongly denied fully funded care.

In his judgement, the judge criticised the lack of clarity in the 2001 guidance from the Department of Health in England (see first paragraph of this appendix). He also criticised the local criteria which effectively gave no guidance on the test to apply to assess and weigh the nature or complexity or intensity or unpredictability and the impact of an individual’s health needs in order to decide if they were eligible for fully funded care.
The Department of Health issued further guidance in England following the Grogan judgement.1

In 2006 the Welsh Assembly Government issued the Welsh Health Circular (2006) 046 entitled Further Advice to the NHS and Local Authorities on Continuing NHS Health Care. This indicated that reassessments of individuals should now take place where there is a potential for a different decision. The Circular also directed Local Health Boards to adopt the ‘Primary health need approach’.

In May 2007, solicitors acting for Mrs Eileen Puc, who had been denied NHS Continuing Healthcare by Cardiff Local Health Board, complained to the Public Services Ombudsman for Wales, who upheld the complaint. The Ombudsman published his report in June 2008 because it was in the public interest.

In January 2008, in response to a Freedom of Information Request, the Welsh Assembly Government gave details of the number of Continuing NHS Health Care criteria used by the 5 Health Authorities and subsequently by the 22 Local Health Boards in Wales.

On the 1st October 2009, the 22 Local Health Boards and 7 of the NHS Trusts in Wales were reorganised to form 7 new Local Health Boards, working together with the three NHS Trusts in Wales.

In May 2010, the Welsh Assembly Government issued its Continuing NHS Healthcare: the National Framework for Implementation in Wales [on 16th August 2010]. The Framework stated that Welsh Ministers’ policy included “For those who may be eligible for [NHS Continuing Healthcare] to put in place a sound national Framework, good decision tools, training and review arrangements to ensure speed, consistency and fairness in decisions”.

1 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139934