Department of Health & Social Care

NHS-funded Nursing Care Practice Guidance

Published December 2018

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

Published December 2018

DH ID box
Title: NHS-funded Nursing Care Practice Guidance
Author: SCLGCP-SCP 25370
Document Purpose: Guidance
Publication date: December 2018
Target audience: Health and social care professionals Public
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Published to gov.uk, in PDF format only.

www.gov.uk/dh

Published November 2018

Contents

Executive Summary

1. The NHS-funded Nursing Care Practice guidance sets out the principles and processes of NHS-funded Nursing Care. It should be read alongside the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care October 2018 (Revised) (referred to as the National Framework).
2. This 2018 guidance replaces the previous version of the NHS-funded Nursing Care Practice Guidance July 2013 (Revised), and will be implemented from 1 December 2018.
3. At the heart of the NHS-funded Nursing Care Practice guidance is the process for determining whether an individual is eligible for NHS-funded Nursing Care.
4. 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.
5. Prior to any decision on eligibility for NHS-funded Nursing Care, a decision on eligibility for NHS Continuing Healthcare must be made and recorded.
6. Both the National Framework and NHS-funded Nursing Care Practice guidance are underpinned by Standing Rules Regulations, issued under the National Health Service Act 2006. These regulations, referred to henceforth as the Standing Rules, require Clinical Commissioning Groups (CCGs) to have regard to the National Framework.
7. 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.
8. This revised NHS-funded Nursing Care Practice guidance and National Framework both take into account legislative changes brought about by the Care Act 2014, which preserves the existing boundary and limits of local authority responsibility in relation to the provision of nursing and/or healthcare.
9. 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.
10. CCGs, the National Health Service Commissioning Board (referred to throughout this guidance as NHS England) and local authorities have legal duties and responsibilities in relation to NHS Continuing Healthcare and NHS-funded Nursing Care.
11. Those eligible for NHS-funded Nursing Care continue to be entitled to access the full range of primary, community, secondary and other health services.

12. There are special circumstances where an individual can qualify for an urgent nursing care payment to meet an urgent or temporary need for registered nursing care in a care home with nursing (see paras 28-31 below)

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 the 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.

Introduction

13. This practice guidance replaces the NHS-funded Nursing Care Practice Guide July 2013 (Revised). It includes information and links to other guidance, and sets out the process for the consideration of eligibility for NHS-funded Nursing Care from 1st December 2018. This guidance should be read alongside the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care October 2018 (Revised). There is a public information leaflet which sets out information on NHS Continuing Healthcare and NHS-funded Nursing Care for individuals and their families.

Roles and Responsibilities

14. NHS England, Clinical Commissioning Groups (CCGs) and local authorities must comply with their responsibilities, as set out in the National Framework, Standing Rules, and Care Act regulations , as appropriate, in relation to NHS Continuing Healthcare and NHS-funded Nursing Care.
15. CCGs are responsible and accountable for NHS-funded Nursing Care.
16. It is important that local authorities and CCGs work in partnership to ensure that the delivery of NHS-funded Nursing Care is integrated within local systems.
17. 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, both the NHS-funded Nursing Care Practice Guidance and National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, will apply. Throughout the National Framework, where reference is made to a CCG, the relevant responsibilities will also apply to NHS England in these limited circumstances.

Core values and principles

18. Individuals being assessed for NHS-funded Nursing Care 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. The National Framework describes the person-centred approach in more detail.
19. 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, marital status, gender reassignment 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.
20. Assessments of eligibility for NHS Continuing Healthcare and NHS-funded Nursing Care should be organised so that the individual being assessed and their representative 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 of the National Framework).

What is NHS-funded Nursing Care?

21. 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.

22. 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). Local authorities may arrange for the provision of accommodation together with the provision of nursing care by a registered nurse if (a) the authority has obtained consent for it to arrange for the provision of the nursing care from whichever CCG regulations require, or (b) the case is urgent and the arrangements for accommodation are only temporary.

23. 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.

24. The registered nurse input is defined in the following terms (R v Cardiff and Vale University Health Board):

    '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'.

25. '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.

26. 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.
27. Consideration of eligibility for NHS Continuing Healthcare and NHS-funded Nursing Care is not an alternative to discussions between providers and commissioners about the appropriate level of fees payable to care homes for accommodation and other non-nursing services. These discussions will take place locally, taking account of local circumstances.

Short periods in residential care, including in emergencies, for respite care and for trial periods

28. There may be occasions when, using locally agreed procedures, individuals need to go into a care home with nursing for short periods of time such as:
    - in an emergency or crisis, e.g. where a carer is suddenly taken ill and is unable to look after the individual;
    - when those placed in a care home with nursing are awaiting the completion of an NHS funded nursing care determination of care by a registered nurse;
    - for a trial period – to explore whether they would prefer to move into a care home on a permanent basis, (this would not apply to permanent residents of care homes who wanted to find another home); or
    - for respite care, recuperative care or a short break.
29. Such short periods in a care home providing nursing care of less than six weeks can qualify for urgent nursing care. There is no need to carry out a nursing assessment if it is known at the outset that the stay will be less than six weeks and the individual has already been assessed as requiring nursing care (for example, they are an existing client of the community nursing service). Periods of less than a week can also qualify for urgent nursing care on a pro rata basis.
30. CCGs that arrange short-term care for their residents out of their area (and in other circumstances where they continue to be the responsible commissioner as set out in the relevant legislation) should pay the care home directly for urgent nursing care. Where they are doing this they will need to inform the CCG where the care home is located, to avoid duplicate payments.
31. Someone who chooses to pay privately for nursing care at home may qualify for NHS-funded nursing care or urgent nursing care for any periods of care in a care home providing nursing care.

When should NHS-funded Nursing Care be considered?

32. In all cases, individuals should be considered for eligibility for NHS Continuing Healthcare **before** a decision is reached about the need for on-going NHS-funded Nursing Care (NHS-funded Nursing Care provided by registered nurses) in care home accommodation (registered to provide nursing care).
33. In most cases, therefore, the individual will already have been considered for NHS Continuing Healthcare and will have had an associated assessment, which should provide sufficient information to gauge the need for nursing care in care home accommodation.
34. In certain circumstances, an individual who has been found not to be eligible for NHS Continuing Healthcare 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.
35. Whilst assessment of eligibility for NHS Continuing Healthcare or for NHS-funded Nursing Care can take place in either a hospital or non-hospital setting, in the majority of cases, it is preferable for eligibility 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 or NHS-funded Nursing Care 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.
36. In order to address this issue and 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. In such situations, assessment of eligibility for NHS Continuing Healthcare or NHS-funded Nursing Care, 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 or NHS-funded Nursing Care. There must be no gap in the provision of appropriate support to meet the individual's needs.

37. CCGs should commission services using models that maximise personalisation and individual control and that reflect the individual's preferences, as far as practicable. Alternative ways of providing care and support, other than admission to a care home with nursing, should always be considered as part of the care planning process. These types of services are subject to local variation to meet local need and it is important that assessors are fully aware of the services that are available.
38. CCGs should work closely with their local partners and develop agreed protocols so that they can refer individuals via the appropriate local process to arrange for an assessment of needs for health and social care to be undertaken. This is particularly important for self-funders. Local authorities and NHS bodies should consider how collaborative arrangements between agencies can ensure that individuals accessing care home provision receive appropriate and timely assessment and care; including continuity of care, should funding arrangements need to change.
39. Where an individual is receiving services under Section 117 of the Mental Health Act 1983 they will nonetheless be eligible for NHS-funded nursing care as a universal service, discrete from any Section 117 provision, if they meet the relevant criteria.

Consent and NHS-funded Nursing Care

40. While health and social care professionals can rely on a lawful basis other than consent to lawfully process personal data, consent is required to satisfy the common law duty of confidentiality. Where the individual concerned has capacity, their informed consent should be obtained before undertaking an assessment of eligibility for NHS Continuing Healthcare or NHS-funded Nursing Care .This consent needs to cover both the completion of relevant assessments, including a nursing assessment, and the sharing of relevant information between the professionals involved. Please see paragraphs 72-73 of the National Framework which gives detailed guidance on what is required for consent to be valid. Where an individual is being considered for NHS-funded Nursing Care and there is not already a suitable nursing assessment the template in Annex A can be used.
41. If there is a concern that the individual may not have capacity to give consent to the assessment process or to the sharing of information, this should be determined in accordance with the Mental Capacity Act 2005 and the associated Code of Practice. It may be necessary for best interest's decisions to be made, bearing in mind the expectation that all who are potentially eligible for NHS Continuing Healthcare or NHS-funded Nursing Care should have the opportunity to be considered for eligibility. Guidance on the application of the Mental Capacity Act in such situations is provided in paragraphs 74-81 of the National Framework.
42. The fact that an individual may have significant difficulties in expressing their views does not of itself mean that they lack capacity to make a decision. Appropriate support and adjustments should be made available in compliance with the Mental Capacity Act and with equalities legislation.
43. Robust data-sharing protocols, both within an organisation and between organisations, will help to ensure that confidentiality is respected but that all necessary information is available to complete the necessary assessments. The duty to share information (for the purposes of providing an individual with health or adult social care) as set out in Section 251B of the Health and Social Care Act 2012 applies equally to assessments for NHS-funded Nursing Care and NHS Continuing Healthcare as it does to other health and/or care and support assessments.

Who assesses the need for NHS-funded Nursing Care?

44. An assessment by a registered nurse is required to inform eligibility for NHS-funded Nursing Care, irrespective of the setting in which the individual is currently placed. Consideration of NHS-funded Nursing Care must be undertaken by a registered nurse, following a decision that the individual is not eligible for NHS Continuing Healthcare.

45. An individual is eligible for NHS-funded Nursing Care if:

    - they do not qualify for NHS Continuing Healthcare but have been assessed as requiring the services of a registered nurse.

    and

    - they are resident in a care home that is registered to provide nursing care

46. CCGs, working in partnership with local authorities, are responsible for eligibility assessments and decisions for both NHS Continuing Healthcare and NHS-funded Nursing Care and the commissioning of care to meet the identified needs. Decisions on NHS Continuing Healthcare will be based on a multidisciplinary assessment of need, preferably involving both CCGs and local authorities so that an individual's health and social care needs can be identified and met appropriately by each organisation. The multidisciplinary assessment for NHS Continuing Healthcare will often suffice for decisions regarding NHS-funded Nursing Care (if the individual is not eligible for NHS Continuing Healthcare).

47. Whether the decision about NHS-funded Nursing Care is made subsequent to a full assessment of eligibility for NHS Continuing Healthcare (using the Decision Support Tool (DST)) or following use of the NHS Continuing Healthcare Checklist, a registered nurse should be involved in identifying and documenting the registered nursing needs.

48. The registered nurse who undertakes this role should be familiar with the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care as set out in the National Framework.

The NHS-funded Nursing Care rate

49. 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.

50. Individuals who are in receipt of NHS-funded Nursing Care are entitled to continue to receive it 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.

51. 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.

52. 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 in the National Framework. 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.

53. 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.

54. 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.

Making a decision about NHS-funded Nursing Care

55. CCGs are reminded that a decision about the need for NHS-funded Nursing Care should only be made after a decision that the individual is not eligible for NHS Continuing Healthcare. However, see page 9 in relation to emergency, respite and short-stay placements.

56. The assessment of registered nursing needs should help the individual, their carer and/or representative understand the extent and nature of the nursing care required to meet their care needs and find the most appropriate environment in which to meet those needs.

57. The decision about whether support should be provided in the form of a care home with nursing should take into account all the individual's nursing and other needs based on what is known about the individual's condition and how this usually presents over a period of time. Consideration should be given to the potential outcomes if support were not to be provided, or was provided in different ways. In making their evaluation, the registered nurse should also focus on the individual's preferences, the impact of any decisions on the individual's independence, and risks involved for the individual, their family and others close to them.

58. A care plan should be developed, clearly setting out how the individual's identified needs should be met including the provision of care by a registered nurse. This, therefore, includes not only direct input from a registered nurse, but also time spent in the planning, supervising and monitoring of care delivered by someone else, who may or may not be a registered nurse. 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 DST. A care plan developed as part of the NHS Continuing Healthcare assessment of eligibility process may already identify the needs for care from a registered nurse.

59. Using all available evidence, and their professional skill and judgement, the registered nurse should record the level and quantity of nursing need and any specific risk factors against each care domain. A recommendation on the nature of the nursing care needed should be made.

60. If the decision about registered nursing care is being reached subsequent to a full assessment of eligibility for NHS Continuing Healthcare, there is a space in the DST to record the outcome of that process. In the absence of an existing DST or nursing needs assessment the assessor may want to use the template in Annex A to summarise the necessary care.

61. Only the needs of the individual should be recorded, and this should not be influenced by the restrictions placed on the delivery of care by the hospital or care home environment. For example, an individual who is physically and mentally competent to self-medicate will, in a hospital or care home environment, nonetheless have their medication dispensed by a registered nurse in order to comply with registration requirements. In such a situation the individual concerned would not normally have a need for registered nursing in relation to their medication, unless there was a complexity around administering the medication.

62. The registered nurse involved in this decision should consider the following questions:

- Does the individual have registered nursing needs that can be met in their own home by community nursing services?
- Does the individual have registered nursing needs of a type or level where they require a care home providing a nursing care environment?
- Do they want to/need to be in a residential setting or is another option preferred or more appropriate?
- Are there any safeguarding concerns relating to the individual or the proposed care placement that should be considered or addressed in the decision-making process?

What are the possible outcomes of an NHS-funded Nursing Care assessment?

63. The registered nurse, working with the multi-disciplinary team (MDT) as appropriate, will make a decision that the individual is either:

- Eligible for NHS-funded Nursing Care, or
- Not eligible for NHS-funded Nursing Care

64. In either outcome, the individual 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.

What happens next when an individual is eligible for NHS-funded Nursing Care?

65. Once it has been agreed with the individual, or a best interest decision has been made that a care home providing nursing offers the best environment in which their needs can be met, the next phase is to set goals within the care plan. This process should usually be completed before a long-term admission to a care home takes place and should be used to inform the identification of an appropriate care home.

66. Where a local authority is involved, the relevant professionals should be working closely together to identify the care required which, in turn, will inform the selection of a care home able to meet those needs. In all cases, unless the person lacks mental capacity and a best interest decision has been made, the individual is responsible for making the choice of care home providing nursing care, supported and advised by the relevant professionals. Where a local authority is funding some or all of the non-nursing care needs, they will advise on funding or other factors that will need to be taken into account in making this choice, including reference to the Care and Support and After-Care (Choice of Accommodation) Regulations 2014.

Communicating the NHS-funded Nursing Care eligibility decision to the individual

67. Once an eligibility decision with regard to NHS-funded Nursing Care has been made the individual should be informed as soon as possible.

68. In many situations the decision that the individual is eligible for NHS-funded Nursing Care may be communicated at the same time as the decision that they are not eligible for NHS Continuing Healthcare. In such cases, the content of the letter to the individual should follow the guidance set out in para 159 – 161 of the National Framework.

Equipment

69. Where individuals in a care home require equipment to meet their care needs, there are several routes by which it may be provided:

a) The care home may be required to provide certain equipment as part of 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 website at www.cqc.org.uk.

b) Individuals who are entitled to NHS-funded Nursing Care have an entitlement – on the same basis as other people – to joint equipment services. CCGs and local authorities should ensure that the availability to those in receipt of NHS-funded Nursing Care is taken into account in the planning, commissioning and funding arrangements for these services.

c) Some individuals will require bespoke equipment (or non-bespoke equipment that is not available through routes (a) and (b) above) to meet specific assessed needs identified in their care plan. CCGs and (where relevant) local authorities should make appropriate arrangements to meet these needs.

Entitlement to Other Services

70. Those in receipt of NHS-funded Nursing Care continue to be entitled to access to the full range of primary, community, secondary and other health services.
71. 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 community nursing services, respectively. No gap in service provision should arise between the two sectors.
72. Services provided/funded by the NHS (e.g. NHS-funded Nursing Care, NHS Continuing Healthcare, primary care services) are not subject to a financial assessment and contribution by the individual. Services provided/funded by the local authority may be subject to a financial contribution, following a financial assessment. Where an individual has resources above the relevant capital threshold they may be a 'self-funder' and may be responsible for arranging and funding their own care arrangements. Local authorities also have a power under the Care Act to meet the needs of individuals in residential care who are self-funders and request this.
73. Services commissioned by CCGs (which could, for example, include podiatry, physiotherapy, occupational therapy, speech and language therapy services, tissue viability nursing and palliative care services) should be made available to residents of care homes providing nursing care on the same basis as they are to those in other settings, whether in care homes or at home.
74. Residents of care homes are entitled to be registered with a GP on the same basis as anyone else, so that they can have access to the full range of NHS services that are available for patients.
75. 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 or health related equipment;

- specialist nursing services
- specialist support for healthcare needs; and
- palliative care and end-of-life healthcare.

76. Joint funding arrangements between the CCG and local authority can be implemented within the care home setting if needs indicate that this is necessary.
77. The CCG responsible for the individual should be determined in accordance with the principles set out in current 'responsible commissioner' legislation and guidance.
78. Local authority provision of care and support under the Care Act 2014 is based on national eligibility criteria.

Continence Services

79. Residents of care homes, including those providing nursing care, should have access to professional advice about the promotion of continence. See Good Practice in Continence Services.
80. As well as prevention and advice services, the continence service should also include the provision of continence products, subject to a full assessment of an individual's needs. Continence products or payments should be made available by the CCG to care home residents, including those who are also receiving NHS-funded nursing care, if required.

3 and 12 month Reviews of NHS-funded Nursing Care

81. Where an individual has been found eligible for NHS-funded Nursing Care, a review should be undertaken within 3 months of the eligibility decision being made. After this, further reviews should normally be undertaken on at least an annual basis.

82. 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.

83. 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.

84. 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.

85. In order to determine whether there has been a material change in need, the annotated 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.

86. 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 previously completed 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.

87. Where:

a) there has not been a previous DST completed by an MDT

or

b) the NHS-funded Nursing Care review indicates a possible change in eligibility,

then a positive Checklist should always be followed by an MDT completing a DST and making a recommendation on eligibility regarding NHS Continuing Healthcare.

88. Where there has been a material change in need such that the individual no-longer meets the criteria for NHS-funded Nursing Care, then the individual will no-longer be eligible for NHS-funded Nursing Care and payments will cease.

89. After the initial 3 month reviews, further reviews should normally take place annually, as a minimum. Some cases may require a more frequent review, in line with clinical judgement, anticipated changing needs or if there is a significant change in the healthcare needs of the individual. The care provider should notify the CCG if there is a significant change in needs that may indicate that an early review is necessary.

90. If the local authority is also 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. Where the review is not carried out jointly it is important for both parties to share relevant information with each other that may have an impact on their respective commissioning responsibilities e.g. relating to a change in need or safeguarding concerns.

Additional Information

Transition between hospital and care home placements

91. When a care home resident is admitted to hospital, payments for their care by a registered nurse should not be duplicated for the duration of their stay but should resume on their return to the care home. These terms, and any variations to them, should be reflected in local NHS contracts with care homes. Local authorities and individuals will need to agree separately with care homes the level of fees necessary to retain the place in the care home providing nursing care in the event of such temporary absences.
92. In order to guarantee the place in the care home on return from hospital and to avoid individuals being asked to pay any shortfall for the time they are in hospital, CCGs should consider the payment of an equivalent sum as a retainer. This should be in accordance with the practice of their local authority partners. Where someone has been placed in residential care under a local authority contract, it has been customary practice for local authorities to continue to pay care homes the full fee for a set period (e.g. four / six weeks), followed by a reduced payment thereafter.
93. In these circumstances, the NHS may need to pay a sum equal to the amount that was being paid towards NHS-funded Nursing Care immediately prior to the admission to hospital in order to retain accommodation there.
94. Separate contracts that the NHS has with providers to pay for nursing care (for self-funders) should also provide for a retainer to be paid on admission to hospital in order to safeguard the care home bed when the individual is ready for discharge from hospital

Special Circumstances

95. There are a few care homes where the normal arrangements for NHS-funded Nursing Care do not apply. Please see Annexes B and C with reference particularly to Vitalise, War Pensioners and Ilford Park, and other charitable/voluntary organisations.

Death of a care home resident

96. In their contracts with providers, local authorities often pay a full fee for a certain period following death, in recognition of the fact that rooms need to be prepared for new residents. CCGs will need to agree a similar payment in these circumstances to cover the period after death in line with any agreements reached with providers and local authorities.-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 resident dies.

Complaints

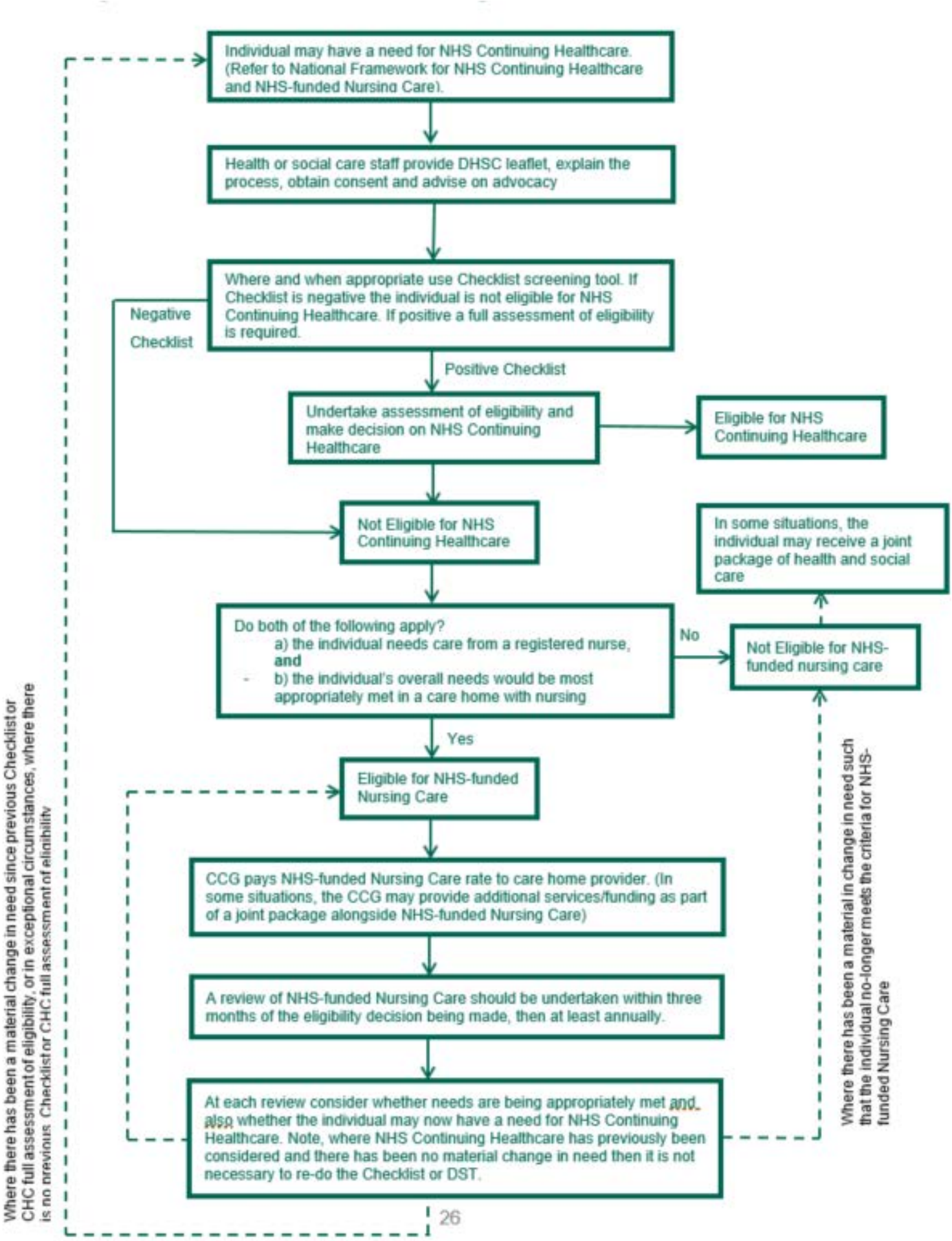
97. If the individual is dissatisfied with the outcome of a decision relating to their eligibility for NHS-funded Nursing Care, they are entitled to ask their CCG for a review of that decision. If they remain dissatisfied following this they can pursue the matter through the NHS complaints procedure

98. Where appropriate advice should be given to the individual (and/or their representative) regarding Healthwatch, local Independent Complaints Advocacy Services (ICAS) and/or other local advocacy providers who can support them through the process.

Monitoring and Assurance

99. In addition to the responsibilities for governance set out in the National Framework, which relate mainly to NHS Continuing Healthcare eligibility considerations, CCGs will find it helpful to carry out routine audits of the award of NHS-funded Nursing Care. This should enable the CCG to monitor capacity issues, to monitor the consistency of decision making, to inform the commissioning process and to take action accordingly.

Figure 1 Flow chart for NHS-Funded Nursing Care



Annex A: Record of registered nursing care needs

Template for local adaptation

NHS-funded Nursing Care Documentation:

Patients Name	
NHS Number	
Date of Birth	
GP GP surgery	Dr.
Local Authority Funding (if applicable)	
Family/Carer Representative	
Nursing Home	
Date of admission	

Reviews completed	
Next review due	
Comments	
Name of Assessor, Place of Work, email address & Tel. No	

Care Domains	Registered Nursing Care Needs	CHC Check-List Score
Breathing		
Nutrition		
Continence		
Skin Integrity		
Mobility		
Communication		
Psychological & Emotional needs		
Cognition		
Behaviour		
Drug therapies & Medication		
Altered States of Consciousness		

Summary of Needs & Recommendation: Registered Nursing Care Needs – Does the individual require the provision, planning, supervision or delegation of nursing care by a registered nursing in a care home with nursing? **Yes/No**. If yes, please specify:

Total CHC Checklist score – A: ☐ **B:** ☐ **C:** ☐

Referral for full consideration of NHS Continuing Healthcare IS / IS NOT necessary at this time (please circle as appropriate)

Annex B: Vitalise care homes

Vitalise

1. Vitalise (formerly known as the Winged Fellowship) runs care homes specialising in short-term respite care for severely disabled people. Nursing care for periods of short-term respite care in the care homes listed below will be funded by the CCG where the care home is physically located, rather than by the CCG where the person is GP registered.
2. To ease administrative burdens, allocations to the host CCGs were increased to reflect the additional administrative burden placed on them for making payments and for monitoring care on behalf of other CCGs and, where partnership arrangements are in place, local authorities.

Vitalise care homes/centres

- Jubilee Lodge, Epping
- Netley, Eastleigh
- Sandpipers, Southport

Annex C: Some special cases

War pensioners and Ilford Park

1. A very small number of residents of care homes receive nursing care and the whole of their care costs, including care from a registered nurse, funded by the state through Veterans UK (including the Ilford Park Polish Home).
2. Although not self-funders, they continue to receive funding for their care from Veterans UK and so are not eligible for NHS-funded Nursing Care. The NHS will, however, be involved in ensuring that they are receiving other appropriate NHS services and care that they may need, as well as continence advice.
3. For the vast majority of war pensioners who live in care homes the situation is the same as for any other resident. Local Authorities will need to take account of the receipt of a war pension as set out in the Care and Support (Charging and assessment of Resources) Regulations 2014 (as amended) when carrying out financial assessments. In these circumstances, eligibility for NHS-funded Nursing Care would be unaffected by whether or not they qualify for any support from a local authority.

Charitable and voluntary organisations

4. The policy of a number of charities and voluntary organisations has been for them to subsidise all the costs of care provided by a registered nurse for the residents of their care homes. In the majority of cases, those charitable and voluntary sector bodies are also the providers of care. The individual is usually asked to pay for all the other costs of their care, other than registered nurse care. In these circumstances, the residents may be eligible for NHS-funded Nursing Care, as a self-funder, subject to this guidance.

5. In order for the charity/organisation to benefit from NHS-funded Nursing Care, they would need to increase the fee level by an equivalent amount of the NHS-funded Nursing Care payment to include care provided by a registered nurse. The charity/organisation would then be able to collect and retain the full NHS-funded Nursing Care payment.

6. Alternatively, the charity/organisation could amend their policy or status so that the care from a registered nurse is no longer subsidised at all and it would then be entitled to receive the NHS funded Nursing Care payment. With this option the resident may pay more than their current fee level if the NHS-funded Nursing Care payment does not fully cover the cost of registered nurse care provided.

7. Whatever option is chosen, individual residents, or their representatives, would need to be informed and the position explained to them, in particular if and how this is likely to affect the level of fee they will be expected to pay to the care home.

Independent hospitals

8. Some care homes – mainly providing care for those with mental health problems – that used to be registered as a care home providing nursing care under the Registered Homes Act have opted to register as independent hospitals under the Care Standards Act.

9. Residents and patients of independent hospitals are entitled to NHS-funded Nursing Care and so should first be considered for NHS Continuing Healthcare.