



Department
of Health

NHS-funded Nursing Care

Practice Guide July 2013 (Revised)

August 2013

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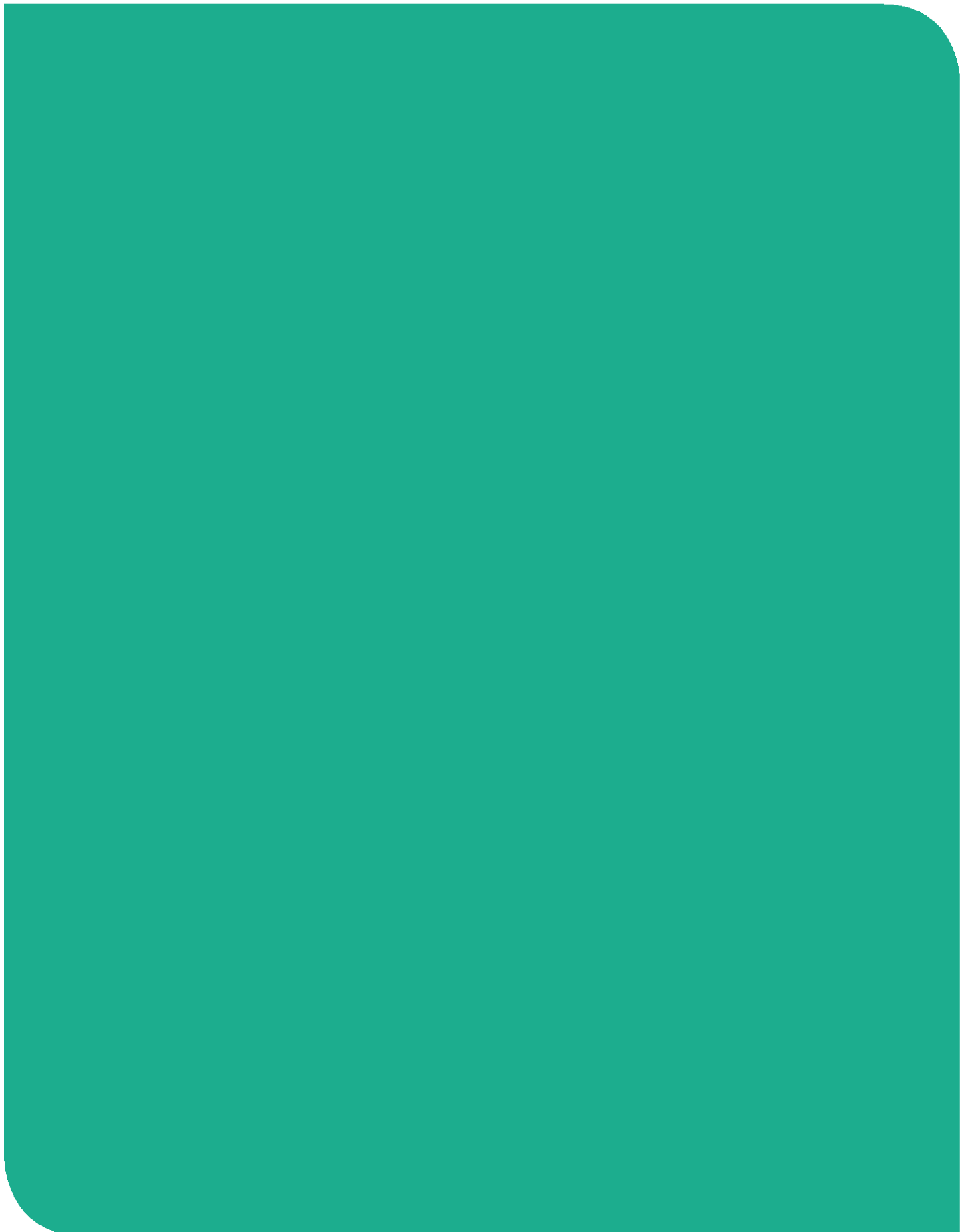
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NHS-funded Nursing Care

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Contents

Background.....	6
Key principles.....	8
Who assesses the need for NHS-funded nursing care?	10
Determining eligibility	11
Making a decision about NHS-funded nursing care.....	14
Entitlement to other services.....	17
Reviewing and monitoring.....	19
Special circumstances and changes in circumstances	21
Annex A: Record of nursing care needs	23
Annex B: Vitalise care homes	25
Annex C: Some special cases	26



Background

1. This practice guidance replaces the *NHS-funded Nursing Care Practice Guide (Revised) 2009*¹ from 1st April 2013. 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 April 2013. This guidance should be read in conjunction with the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)*². There is a public information leaflet³ which sets out information on NHS continuing healthcare and NHS-funded nursing care for individuals and their families.
2. Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board (the Board) assumed responsibilities for NHS continuing healthcare and NHS-funded nursing care from 1st April 2013. CCGs will have the same responsibilities as were previously held by Primary Care Trusts (PCTs), except in relation to specific groups as outlined below.
3. The Board will assume commissioning responsibilities for some specified groups of people, for example for prisoners and military personnel. It therefore follows that the Board will have statutory responsibility for commissioning NHS Continuing Healthcare and NHS-funded nursing care, where necessary, for those groups for whom it has commissioning responsibility. Throughout this guidance, therefore, where a CCG is referred to, the responsibilities will also apply to the Board in these limited circumstances.
4. **'NHS Continuing Healthcare'** means a package of ongoing care, for an individual aged 18 or over, that is arranged and funded solely by the NHS. This applies where the individual has been found to have a 'primary health need' as set out in the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)*.
5. **'NHS-funded Nursing Care'**, introduced in October 2001, is the funding provided by the NHS to care homes providing nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible. If an individual does not qualify for NHS Continuing Healthcare, the need for care from a registered nurse should be determined. 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 providing nursing care, then this would consequently lead to eligibility for NHS-funded nursing care. Once the need for such care is agreed, the CCG's responsibility to pay a flat rate contribution to the care home towards registered nursing care costs arises.
6. The registered nurse input is defined in the following terms:

'services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse'.

¹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106225.pdf

² <https://www.wp.dh.gov.uk/publications/files/2012/11/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf>

³ <https://www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet>

7. 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.
8. 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.

Key principles

9. 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 (NHS-funded nursing care provided by registered nurses) in care home accommodation (where registered to provide nursing care). 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. In certain circumstances, an individual who has been found not to be eligible for NHS continuing healthcare at the Checklist⁴ stage may still need an assessment of needs for NHS-funded nursing care. In such cases, an appropriate assessment should be completed.
10. This process should always take place before an individual enters a care home providing nursing care on a long-term basis, although there will be circumstances where people need to be admitted under locally agreed arrangements in emergencies or short notice.
11. 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.
12. The single band of NHS-funded nursing care⁵ was introduced on 1 October 2007 and replaced the previous low, medium and high bands of nursing care. The single band is a contribution towards the cost of services provided by a registered nurse, involving either the provision of care or the planning, supervision or delegation of the provision of care, but it does not cover services which do not need to be provided or supervised by a registered nurse. All individuals newly eligible for NHS-funded nursing care since 1st October 2007 have been placed on the standard rate / single band. The NHS is responsible for this funding. Accommodation and social care costs are the responsibility of either the LA and/or the individual (subject to the outcome of a community care assessment and financial assessment).
13. 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 until:
 - a) on review, it is determined that they no longer have any need for nursing care;
 - b) 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. In this situation, the individual should be moved onto the standard rate / single band;
 - c) they are no longer resident in a care home that provides nursing care;

⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127200/NHS-CHC-Checklist-FINAL.pdf

⁵ <http://www.dh.gov.uk/health/2012/03/care-bands/>

- d) they become eligible for NHS continuing healthcare; or
- e) they die.

Where paragraph (b) applies, the CCG should ensure that all parties concerned (including the LA if applicable) are aware of the proposed change. The CCG should then give at least 14 days notice of the change to both the individual and the care home.

14. CCGs must continue to make NHS-funded nursing care contributions in respect of those individuals who were deemed eligible for this funding prior to 1st April 2013, until such time as any of the circumstances listed in paragraph 13 above apply.

Who assesses the need for NHS-funded nursing care?

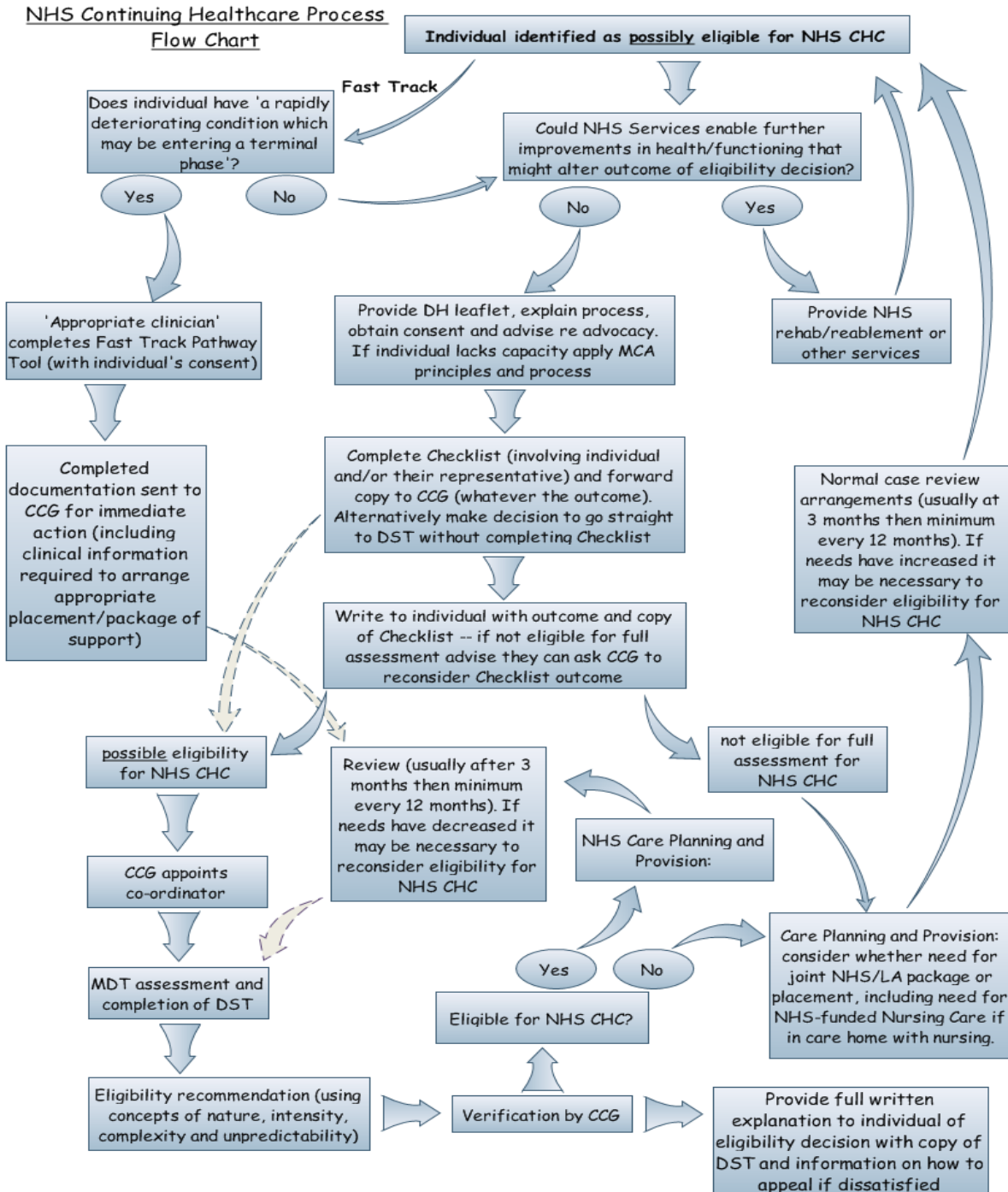
15. CCGs, working in partnership with LAs, are responsible for eligibility assessments and decisions for both NHS continuing healthcare and NHS-funded nursing care and the commissioning of care to meet the identified needs. This should be based on a multidisciplinary assessment of need, preferably involving both CCGs and LAs so that an individual's health and social care needs can be identified and met appropriately by each organisation.
16. 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 Tool⁶ (DST)) or following use of the NHS continuing healthcare Checklist, a registered nurse should be involved in identifying and documenting the registered nursing needs.
17. The nurse who undertakes this role should be familiar with recognised models of nursing, have experience relevant to the needs of the individual, and be familiar with the care domains of the Decision Support Tool. They should use their professional judgement to advise the multidisciplinary team (MDT) that is responsible for making recommendations about eligibility for NHS continuing healthcare. A registered nurse should be able to account for any decision they have made, and is personally and professionally accountable for their own practice.

⁶ www.gov.uk/government/uploads/system/uploads/attachment_data/file/127201/Decision-Support-Tool-for-NHS-Continuing-Healthcare.pdf

Determining eligibility

18. 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. 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. However, see page 21 in relation to emergency, respite and short-stay placements.
19. Figure 1 on page 12 illustrates the process of determining eligibility for NHS continuing healthcare and NHS-funded nursing care. The National Framework guidance sets out Core Values and Principles, and more detail about the process.

Figure 1. The process of determining eligibility for NHS continuing healthcare (NHS CHC) and NHS-funded nursing care



20. Assessment of eligibility for NHS continuing healthcare and for NHS-funded nursing care can take place in either hospital or non-hospital settings. It should always be borne in mind that assessment of eligibility that takes place in an acute hospital may not always reflect an individual's capacity to maximise their potential. This could be because, with appropriate support, that individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment. Anyone who carries out an assessment of eligibility should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs.
21. 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;
 - rapid response support;
 - hospital at home;
 - supported discharge;
 - intermediate care/health reablement; or
 - an interim package of support in an individual's own home or in a care home.
22. In such situations, assessment of eligibility for NHS continuing healthcare and for NHS-funded nursing care should usually be deferred until an accurate assessment of future needs can be made. The interim services should continue in place until the determination of eligibility has taken place. There must be no gap in the provision of appropriate support to meet the individual's needs. Where the NHS receives a positive checklist completed as part of hospital discharge planning, but defers or delays the completion of a full NHS CHC or FNC assessment any interim services should be provided or commissioned by the NHS (see paras 62 – 67 of Framework)
23. 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. Relevant options may include:
- ongoing support in the person's own home or elsewhere in the community with a package of healthcare and/or social care (with the LA social care services provided on the basis of an assessment of the individual's care needs in line with the LA's eligibility criteria);
 - longer-term rehabilitation/health reablement that is likely to continue for more than six weeks; or
 - admission to a care home that does not provide nursing care (usually referred to as a 'residential care home').

Making a decision about NHS-funded nursing care

24. The process of assessment and decision making should be person-centred. This means placing the individual, their perception of their support needs, and their preferred models of support at the heart of the assessment and care-planning process. When deciding on how their needs are met, the individual's wishes and expectations of how and where the care is delivered should be documented and taken into account, along with the risks of different types of provision and fairness of access to resources.
25. Access to assessment, decision making and provision should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, or type of health need (for example, whether the need is physical, mental or psychological). CCGs are responsible for ensuring that discrimination does not occur and should use effective auditing to monitor this matter.
26. 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 informed decision making about their future care. Decisions and rationales that relate to eligibility should be transparent from the outset, for individuals, carers, family and staff alike.
27. As with any examination or treatment, the individual's informed consent should be obtained before the start of the process to determine eligibility for NHS continuing healthcare and for NHS-funded nursing care. If there is a concern that the individual may not have the mental capacity to give consent, this should be established in accordance with the Mental Capacity Act 2005 and the associated code of practice.
28. The Mental Capacity Act 2005 created a new statutory service: the Independent Mental Capacity Advocate (IMCA) service.⁷ Its purpose is to represent and support vulnerable people who lack mental capacity and who are facing important decisions made by the NHS or LAs about a change of residence – for example, moving to a hospital or care home or regarding a serious medical treatment decision. NHS bodies and LAs have a duty under the Act to instruct and consult the IMCA if the relevant person lacks mental capacity in relation to the relevant decision and there is no person, other than someone acting in a professional or paid capacity that are appropriate to be consulted regarding the best interests of the person relating to such decisions.
29. Even if an individual does not meet the criteria for the appointment of an IMCA, and regardless of whether or not they lack capacity, they may wish to be supported by an advocate. CCGs should ensure that individuals are made aware of local advocacy and other services that may be able to offer advice and support, and should also consider whether any strategic action is needed to ensure that adequate advocacy services are available to support those who are eligible and potentially eligible for NHS continuing healthcare. In addition, any person may choose to have a family member or other person (who should operate independently of LAs and NHS bodies) to act as advocate on their behalf.

⁷ www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/IMCA/index.htm

30. 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.
31. 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 their usual behaviour 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.
32. 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 Decision Support Tool. A care plan developed as part of the NHS continuing healthcare eligibility process may already identify the needs for care from a registered nurse.
33. 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.
34. 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 Decision Support Tool to record the outcome of that process. The assessor may want in addition to attach the completed table from Annex A to provide more detail about the care necessary.
35. 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.
36. 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?
37. 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.
38. Where an LA 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 an LA 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 Choice of Accommodation Directions (LAC 2004 (20))⁸.

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http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/AllLocalAuthority/DH_4091152

Entitlement to other services

39. 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.
40. 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.
41. 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 LA may be subject to a financial contribution, following a financial assessment. Where an individual has resources above the relevant income/capital threshold they may be a 'self-funder' and be responsible for funding their own care arrangements. However, LAs have a responsibility for assisting 'self-funders' in arranging a care home placement where the individual is unable to do this themselves and has no other person willing and able to do this for them.
42. Services commissioned by CCGs (which could, for example, include podiatry, physiotherapy, occupational therapy, speech and language therapy services, tissue viability nursing, 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.
43. 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.
44. Apart from NHS-funded nursing care, additional health services may also be 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;
 - Intermediate care, rehabilitation and reablement
 - 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.

Joint funding arrangements between the CCG and LA can be implemented within the care home setting if needs indicate that this is necessary.

45. The CCG responsible for the individual should be determined in accordance with the principles set out in 'responsible commissioner' guidance (currently *Who Pays? Determining responsibility for payments to providers*⁹).
46. Each LA, according to its eligibility criteria and financial assessment provisions, will be responsible for providing such social care, including personal care, as can lawfully be provided.

Equipment

47. Where individuals in a care home require equipment to meet their care needs, there are several routes by which this 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 LAs 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 other 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) LAs should make appropriate arrangements to meet these needs.

Continence services

48. 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*.¹⁰
49. 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.

⁹ <http://www.england.nhs.uk/wp-content/uploads/2012/12/who-pays.pdf>

¹⁰ http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005851

Review and monitoring

Review of care needs

50. If the NHS is commissioning funding or providing any part of an individual's care, a case review should be undertaken no later than three months after the initial eligibility decision, in order to reassess care needs and to ensure that those needs are being met. The review plays a critical role in ensuring that the needs of the individual are being appropriately met and provides an opportunity to review the goals set in the care plan. It may be pertinent to consider whether the individual's level of independence has improved to the point where permanent admission to a care home providing nursing is no longer appropriate and, if so, whether other models of care and support should be considered.
51. When reviewing the need for NHS-funded nursing care, potential eligibility for NHS continuing healthcare must always be considered (using the Checklist), and full consideration should be carried out, where indicated. Where the Checklist indicates that a full DST should be completed then an MDT should complete a full DST with the following exception. A DST will not be required where:
- the person has previously had a positive checklist and full DST completed by an MDT
- and**
- there has been no material change in their needs that might lead to a different eligibility decision regarding NHS continuing healthcare and (by implication) NHS-funded nursing care
52. In order to determine this, the previously completed DST must be available at the NHS – funded nursing care review and each of the domains and previously assessed need levels considered as part of the review by the reviewer, in consultation with the person being reviewed and any other relevant people who know the person who are present at the review. The reviewer should annotate and sign each domain to indicate they have been considered, indicating any changes in need levels.
53. When notifying the person of the outcome of the review they should be advised that they have been assessed as meeting the Checklist threshold but that a full DST has not been completed because there has been no significant change in their need levels. A copy of the annotated DST should be given to the person concerned with information as to how they can request a review of the outcome of the NHS-funded nursing care review.
54. Where there has not been a previous DST completed by an MDT or where the NHS-funded nursing care review indicates a possible change in eligibility, a positive Checklist should always be followed by an MDT completed DST and a recommendation on eligibility regarding NHS continuing healthcare.
55. Reviews should then take place annually, as a minimum. Some cases will 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.

56. If the LA is also responsible for any part of the care, both the CCG and the LA 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.

Complaints

57. 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 for a review of that decision. If they remain dissatisfied following local re-consideration they can pursue the matter through the NHS complaints procedure (rather than through NHS continuing healthcare appeals mechanisms). Advice should be given to the person regarding Healthwatch, local Independent Complaints Advocacy Services (ICAS) and/or other local advocacy providers who can support them through the process.

Governance

58. 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.

Special circumstances and changes in circumstances

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

59. There may be occasions when individuals need to go into a care home 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 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, though 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.
60. Such short periods in a care home providing nursing care of less than six weeks qualify for NHS-funded nursing care. However, there is no need to carry out an 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 will also qualify for NHS - funded nursing care on a pro rata basis.
61. 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 with reference to current 'responsible commissioner' guidance) should pay the care home directly for NHS-funded nursing care. They will need to inform the CCG where the care home is located of the period of care for which they are paying, to avoid duplicate payments.
62. Someone who chooses to pay privately for nursing care at home may qualify for NHS-funded nursing care for any periods of care in a care home providing nursing care.
63. 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 S117 provision, if they meet the relevant criteria.

Vitalise

64. 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 in Annex B will be funded by the CCG where the care home is physically located, rather than by the CCG where the person is GP registered.

64. 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, LAs.

Hospital admissions

65. 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. LAs 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. It is clear that in these circumstances the NHS should not continue to pay for NHS-funded nursing care.
66. However, 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 LA partners. Where someone has been placed in residential care under an LA contract, it has been customary practice for LAs to continue to pay care homes the full fee for a set period (e.g four / six weeks), followed by a reduced payment thereafter.
67. 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 their accommodation there.
68. Separate contracts that the NHS has with providers to pay for the 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.

Death of a care home resident

69. In their contracts with providers, LAs 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 LAs.

Annex A: Record of nursing care needs

Template for local adaptation

Name			
Home address			
DOB			
ID No			
Current location			
Date completed			
Name and address of care home placement			
Registration category of home			
Relevant dates	Placement	First review	Subsequent reviews
Name of assessor (printed) and signature			
Contact details of assessor(s)			
Other relevant information such as carer or representative			

Care domains	Registered nursing care needs and details of nursing provision or supervision necessary to help meet them
Behaviour	
Cognition	
Psychological and emotional needs	
Communication	
Mobility	
Nutrition – food and drink	
Continence	
Skin	
Breathing	
Drug therapies and medication	
Altered states of consciousness	
Other significant care needs	
Summary of needs and recommendation	

Annex B: Vitalise care homes

Vitalise care homes/centres

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

Annex C: Some special cases

War pensioners and Ilford Park

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 the Veterans Agency (including the Ilford Park Polish Home).

Although not self-funders, they continue to receive funding for their care from the Agency 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.

For the vast majority of war pensioners who live in care homes the situation is the same as for any other resident. LAs will need to take account of the receipt of a war pension as they would for any other social security benefit 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 an LA.

Charitable and voluntary organisations

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.

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.

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.

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

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.¹¹

Residents and patients of independent hospitals are entitled to NHS-funded nursing care and so should first be considered for NHS continuing healthcare.

¹¹ <http://www.legislation.gov.uk/ukpga/2000/14/contents>

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