THE CHC FAMILY GUIDE — 2026 EDITION

The CHC Family Guide

How to claim NHS funding for care home fees

And what to do if you are refused

CHC FUNDING | FAST TRACK | APPEALS | BACK-CLAIMS | FNC

12 DOMAINS EXPLAINED

What assessors score, what evidence you need, and common mistakes for each domain.

WELL-MANAGED NEEDS

The argument that wins more CHC appeals than any other — and how to use it.

FAST TRACK PATHWAY

The 48-hour route for families facing hospital discharge or terminal illness.

APPEAL TEMPLATES

Four letter templates ready to adapt: assessment request, local review, FNC claim, Fast Track.

NHS FUNDED NURSING CARE

The £267.68 per week payment most families in nursing homes never claim.

RETROSPECTIVE CLAIMS

How to reclaim fees already paid when CHC should have applied.

Introduction

> *Every year, tens of thousands of families in England pay for care home fees they should never have paid. This guide is written to change that.*

NHS Continuing Healthcare (CHC) is a legal entitlement that covers 100% of care costs for people whose primary need is a health need. It is not means-tested. It does not depend on savings, income, or property. If your relative qualifies, the NHS pays everything — the nursing care, the accommodation, the food, all of it.

Around 144,000 people are currently self-funding their care in England, paying an average of £1,298 per week for residential care or £1,535 per week for nursing care. Many of them should be receiving CHC funding. They are not, because nobody told them CHC exists, or because their application was refused at the first attempt and they did not know how to challenge it.

This guide explains who qualifies for CHC, how the assessment works, what evidence you need, and exactly what to do if you are refused. It also covers NHS Funded Nursing Care (£267.68/week for people in nursing homes who do not qualify for full CHC) and the Fast Track pathway for people whose condition is rapidly deteriorating.

This is not a guide for healthcare professionals. It is written for families. The language is plain. The advice is practical. Every recommendation is grounded in the NHS National Framework and established case law.

If your relative is in a care home, or is about to move into one, read this guide before you agree to pay anything.

CHAPTER 1

Could Your Relative Qualify?

Understanding the primary health need test

CHAPTER 1

Could Your Relative Qualify?

CHC eligibility comes down to one question: is the main reason your relative needs care a health need? This is called the "primary health need" test. It does not depend on a specific diagnosis. It asks whether the overall package of care your relative needs is primarily about healthcare — or primarily about social and personal care such as help with washing and dressing.

The distinction matters because health care is free at the point of use in England. Social care is means-tested — people with assets above £23,250 pay for it themselves. If your relative's needs are primarily health needs, the NHS is legally required to fund them.

The Four Characteristics

Nature — What type of care is needed. Does it require clinical knowledge or healthcare oversight beyond what a care assistant can provide? A nurse managing a complex wound or administering controlled drugs is providing healthcare. A care assistant helping someone dress is providing social care.

Intensity — How much care is needed and how often. Medical monitoring four times a day is high-intensity. Intensity looks at frequency, duration, and continuity of care.

Complexity — How different needs interact. A person with dementia, heart failure, and diabetes does not have three separate conditions — managing them together requires clinical knowledge beyond standard care home training.

Unpredictability — How quickly a person's condition can change. A person who can have a life-threatening seizure without warning needs a level of readiness only a healthcare setting can provide.

THE FOUR CHARACTERISTICS — QUICK CHECK

Nature: Does managing their condition require a registered nurse rather than a care assistant? Intensity: Do they need healthcare input multiple times a day, or continuous monitoring? Complexity: Do they have multiple conditions that interact and are difficult to manage together? Unpredictability: Can their condition change rapidly and dangerously without warning?

What CHC Is Not

CHC is not based on diagnosis. Having dementia, Parkinson's, or cancer does not automatically qualify someone. Two people with the same diagnosis can have very different eligibility outcomes.

CHC is not based on where care is delivered. You can qualify whether your relative is in a care home, nursing home, or their own home.

CHC is not a discretionary benefit. If your relative has a primary health need, the NHS has a legal duty to fund their care — established by the NHS Act 2006.

REALISTIC EXPECTATIONS

Around 70% of first-time CHC applications fail at the initial screening stage — not because applicants don't qualify, but because families arrive without adequate evidence. The families who succeed are the ones who prepared properly.

CHAPTER 2

The 12 Domains

What assessors score, common mistakes, and evidence checklists

CHAPTER 2

The 12 Domains

When your relative is assessed for CHC, assessors work through 12 care domains using the Decision Support Tool (DST). Each domain is scored at one of several levels: No Need, Low, Moderate, High, Severe, or Priority. No single domain score automatically triggers CHC eligibility — what matters is the overall picture.

1. Behaviour

Scoring range: No Need to Priority

Assessors look for documented challenging behaviour — aggression, attempts to leave unsupervised, refusal of essential care — and whether managing it requires specialist clinical expertise.

Common Mistakes

MISTAKE 1

Good behaviour on the day

Assuming that because your relative was cooperative during the 2-hour assessment visit, there is no behavioural need.

WHAT TO DO INSTEAD

Bring 3-6 months of incident logs from the care home. The assessment should reflect the full pattern of need, not a single good day.

MISTAKE 2

Not linking behaviour to health

Describing the behaviour without connecting it to the underlying health condition causing it.

WHAT TO DO INSTEAD

State explicitly: "The aggression is caused by unmanaged pain" or "The agitation is a symptom of her dementia." The healthcare cause strengthens the case.

Evidence Checklist

- ☐ Incident logs from the care home covering the past 3-6 months
- ☐ Behaviour support plan (ask the care home for a copy)
- ☐ Psychiatric or psychology assessments if any have been done
- ☐ Written statement from the care home on what would happen if specialist support were withdrawn

2. Cognition

Scoring range: No Need to Severe

Assessors look for memory, understanding, and decision-making ability — and whether cognitive impairment interacts with other conditions to create complex care needs. Document the worst presentation, not the average.

Common Mistakes

MISTAKE 1

Diagnosis without detail

Saying "she has dementia" without specifying the impact on care.

WHAT TO DO INSTEAD

Be specific: "She fails to recognise her daughter on most visits, cannot sequence tasks like dressing, and has twice left the building believing she was going to work."

MISTAKE 2

Missing fluctuating cognition

Not noting that cognition varies — worse in evenings, during infections, after medication changes.

WHAT TO DO INSTEAD

Document the pattern. Fluctuation is itself a scoring factor — unpredictability increases the score. The National Framework requires assessment at the worst presentation.

Evidence Checklist

- ☐ Cognitive testing results (MMSE or Montreal Cognitive Assessment) with dates
- ☐ Neuropsychology reports if available
- ☐ Care home records documenting specific incidents related to cognition
- ☐ Mental Capacity Act assessments if any decisions have been made on your relative's behalf

3. Psychological & Emotional

Scoring range: No Need to High

Assessors look for mental health diagnoses, psychotropic medications, observable psychological distress, and the impact of psychological needs on other aspects of care.

Common Mistakes

MISTAKE 1

Medication means no need

Assuming that because medication is working, there is no psychological need.

WHAT TO DO INSTEAD

The medication is the management. Under National Framework paragraph 162, well-managed needs are still needs. Document what would happen if the medication were withdrawn and what ongoing monitoring is required.

MISTAKE 2

No impact shown

Saying "she's anxious" without showing what that means for care.

WHAT TO DO INSTEAD

Translate it: "She refuses personal care when anxious, requiring psychiatric nurse liaison before procedures. She has twice needed emergency sedation to allow essential wound care."

Evidence Checklist

- ☐ Psychiatric assessments or psychology reports
- ☐ Complete medication list showing psychiatric medications with dates started
- ☐ Incident reports showing episodes of emotional distress
- ☐ Care plans documenting psychological interventions

4. Communication

Scoring range: No Need to High

Assessors look at ability to communicate healthcare information — pain, distress, medication needs. They want to see formal speech and language therapy input if communication difficulties exist.

Common Mistakes

MISTAKE 1

No SLP assessment

Saying "she can't speak" without a formal speech and language therapy assessment.

WHAT TO DO INSTEAD

The same situation with a formal SLP assessment documenting the level of impairment and interventions required will score significantly higher. If no assessment has been done, request one before the CHC assessment.

Evidence Checklist

- [ ] Speech and language therapy assessment — if none exists, request one urgently
- [ ] Audiology reports if hearing loss is a factor
- [ ] Documentation of communication methods used by care staff
- [ ] Examples of where communication difficulties have caused safety issues

5. Mobility

Scoring range: No Need to Severe

Assessors look at physical ability to move and transfer, equipment required, falls history, and whether a progressive condition means needs will increase.

Common Mistakes

MISTAKE 1

Vague descriptions

Saying "can't walk much" rather than describing the actual support required.

WHAT TO DO INSTEAD

Be specific: "Requires two-person assist with hoist for all transfers, falls risk assessed as high, three documented falls in the past six months including one resulting in a bruised hip."

MISTAKE 2

Not documenting what happens without support

Describing current ability without noting what happens if support is removed.

WHAT TO DO INSTEAD

State it explicitly: "If we did not use the hoist she would fall and fracture her hip again given her osteoporosis and age." This is evidence of ongoing specialist need.

Evidence Checklist

- [ ] Physiotherapy assessments
- [ ] Occupational therapy reports
- [ ] Falls risk assessments (formal, dated)
- [ ] Equipment prescriptions (hoists, wheelchairs, sensor mats)
- [ ] Falls incident logs showing dates and outcomes

6. Nutrition

Scoring range: No Need to Severe

Assessors look at swallowing ability, choking risk, modified diet requirements, nutritional monitoring, and whether specialist input is in place. A dietitian assessment is highly weighted.

Common Mistakes

MISTAKE 1

No dietitian assessment

Presenting nutritional concerns without a formal dietitian assessment.

WHAT TO DO INSTEAD

If there is no dietitian assessment and nutritional issues exist, request one before the CHC assessment. Assessors weight these highly and their absence weakens the case significantly.

MISTAKE 2

Prescription vs actual intake

Not documenting what your relative actually eats versus what is prescribed.

WHAT TO DO INSTEAD

Be specific: "Prescribed puree diet at IDDSI Level 5; currently eating approximately 30% of meals; weight has fallen 4kg over three months." Concrete, evidenced, hard to score Low.

Evidence Checklist

- [ ] Dietitian assessment — if none exists, request one urgently
- [ ] Speech and language pathology swallowing assessment if relevant
- [ ] Food and fluid intake charts
- [ ] Weight records showing trend (weekly or monthly)
- [ ] MUST (Malnutrition Universal Screening Tool) scores
- [ ] PEG or NG tube documentation if applicable

7. Continence

Scoring range: No Need to Severe

Assessors look at type and cause of incontinence, management complexity (especially catheterisation), skin integrity risk, and whether specialist nursing input is required.

Common Mistakes

MISTAKE 1

Pads = managed = Low

Assuming that because incontinence is managed with pads, it scores Low.

WHAT TO DO INSTEAD

The score reflects complexity and clinical oversight required, not simply the presence of incontinence. A suprapubic catheter with a history of infections and urology involvement scores much higher than basic pad management.

Evidence Checklist

- [ ] Urology assessments if catheterisation is involved
- [ ] Catheter management documentation
- [ ] Skin integrity monitoring records
- [ ] Infection and UTI history
- [ ] Incontinence product prescriptions

8. Skin Integrity

Scoring range: No Need to Severe (no Priority)

Assessors look for active wounds or pressure ulcers, their stage and complexity, whether specialist tissue viability input is required, and whether wounds are healing or deteriorating.

Common Mistakes

MISTAKE 1

Descriptions without assessments

Describing a wound without formal documentation.

WHAT TO DO INSTEAD

"She has a sore on her heel" scores lower than the same situation documented by a tissue viability nurse with measurements, staging, dressing prescriptions, and a Waterlow score. If no assessment has been done, request one.

Evidence Checklist

- [ ] Tissue viability nurse assessment — if none exists, request one
- [ ] Wound care charts with measurements and healing progression
- [ ] Waterlow or Braden pressure ulcer risk score
- [ ] Infection control documentation if MRSA or other infection is present
- [ ] Dressing prescriptions

9. Breathing

Scoring range: No Need to Priority

Assessors look at respiratory conditions, oxygen and nebuliser requirements, hospital admissions for acute exacerbations, and how quickly breathing can deteriorate.

Common Mistakes

MISTAKE 1

Stable = no need

Describing breathing as "stable with treatment" without emphasising the exacerbation risk.

WHAT TO DO INSTEAD

"Has COPD and uses inhalers" scores Moderate. "Has COPD with three hospital admissions in 12 months for acute exacerbations with hypoxia, requires daily nebulisers and supplemental oxygen at rest" supports High or Severe.

Evidence Checklist

- [ ] Pulmonary function tests
- [ ] Specialist respiratory clinic letters
- [ ] Oxygen prescription (type, concentration, frequency)
- [ ] Nebuliser charts
- [ ] Hospital admission records for respiratory exacerbations
- [ ] The care home's acute deterioration escalation protocol

10. Drug Therapies

Scoring range: No Need to Priority

Assessors look at medication complexity, monitoring requirements, and whether missed doses or side effects create serious or acute risk. The number of medications matters less than the complexity of managing them.

Common Mistakes

MISTAKE 1

Listing without explaining

Providing a list of medications without explaining the complexity or the consequences of non-compliance.

WHAT TO DO INSTEAD

"On 12 medications" is not a strong submission. "On warfarin requiring weekly INR monitoring, methotrexate requiring monthly blood tests for toxicity, and three psychiatric medications recently adjusted by a consultant — missed doses have led to two hospital admissions" is.

Evidence Checklist

- ☐ Complete medication list with doses and dates started
- ☐ Specialist clinic letters detailing medication plans and monitoring requirements
- ☐ Blood test results showing monitoring (INR, FBC, drug levels)
- ☐ Hospital admission records related to medication issues
- ☐ Covert medication documentation if a Mental Capacity Act protocol is in place

11. Altered States of Consciousness

Scoring range: No Need to Priority

Assessors look at seizures, episodes of unconsciousness, and other alterations in consciousness. They want formal documentation — Glasgow Coma Scale scores or specialist assessments — not just family descriptions.

Common Mistakes

MISTAKE 1

Undocumented episodes

Mentioning episodes without formal documentation in medical or care records.

WHAT TO DO INSTEAD

Ensure seizure monitoring records are in place and up to date from the care home. A single well-documented emergency admission is stronger evidence than multiple undocumented episodes.

Evidence Checklist

- ☐ Hospital records from any episodes of altered consciousness
- ☐ Seizure diary or monitoring records if relevant
- ☐ Specialist neurology assessments
- ☐ Care home monitoring records and response protocols

12. Other Significant Needs

Scoring range: No Need to Priority

The most underused domain. It exists to capture needs that do not fit domains 1-11. It can score Priority, making it strategically important for complex cases — especially terminal illness, progressive neurological conditions, or where the interaction of multiple conditions constitutes a primary health need.

Common Mistakes

MISTAKE 1

Not using it at all

Focusing only on the 11 named domains and ignoring Domain 12 entirely.

WHAT TO DO INSTEAD

If your relative has a condition with a clear primary health need not fully captured by other domains, make the case here explicitly. Specialist consultant letters and palliative care assessments are the key evidence. The MND Association, for example, provides specific CHC guidance for motor neurone disease patients.

Evidence Checklist

- [ ] Specialist consultant letters describing the overall care need
- [ ] Palliative care assessments if relevant
- [ ] Condition-specific charity assessments (e.g. MND Association CHC guidance)
- [ ] Care plans documenting the totality of specialist input required

CHAPTER 3

The Well-Managed Needs Principle

The argument that wins more CHC appeals than any other

CHAPTER 3

The Well-Managed Needs Principle

> *"The decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs." — NHS National Framework, Paragraph 162*

This principle wins more CHC appeals than any other single argument. It is also the principle ICBs misapply most often.

If your relative's condition is being controlled by medication, specialist nursing, a behaviour support plan, or any other intervention, the condition is still a need. The fact that it is being managed does not make it disappear. The intervention is the evidence of the need.

How ICBs Misapply This Principle

"Because the antidepressant is working, she doesn't have a psychological need."

Wrong. The antidepressant is the management. Paragraph 162 is explicit: the ongoing necessity of medication is evidence of the need, not evidence that the need has gone away.

"Because she's not currently falling, her mobility is not a concern."

Wrong. The two-person assist and the hoist are why she's not currently falling. Remove the hoist and she falls. The intervention is the evidence.

"His behaviour is well-controlled, so we are scoring it Low."

Wrong. His behaviour is well-controlled because specialist staff are implementing a behaviour support plan. Without that plan, the care home has stated the behaviour would escalate beyond what they could safely manage.

The Counter-Argument: Three Steps

Step 1: Quote paragraph 162 directly. "The National Framework states that well-managed needs are still needs. The management is evidence of the need, not evidence of its absence."

Step 2: Ask what would happen if the intervention were withdrawn. Get the answer documented in writing from the care home, GP, or specialist.

Step 3: Distinguish between resolved and stabilised. A resolved condition no longer requires treatment. A stabilised condition requires ongoing intervention to prevent deterioration. Stabilised is still a need.

Checklist: Using the Well-Managed Needs Argument

- ☐ Identify every domain where the ICB has said the need is "well-managed" or "stable"
- ☐ For each one, name the specific intervention keeping it managed (medication, specialist nursing, behaviour support plan)
- ☐ Get written confirmation from the care home or GP of what would happen if the intervention were withdrawn
- ☐ In your response, quote paragraph 162 directly and cite the specific intervention as evidence of the need
- ☐ Distinguish clearly: is this condition resolved (no longer needs treatment) or stabilised (held stable by ongoing intervention)?
- ☐ Ask the ICB to define "well-managed" in writing — force them to articulate the principle they are applying

CHAPTER 4

Before the Assessment

How to prepare your evidence and what to bring

CHAPTER 4

Before the Assessment

The families who succeed at CHC assessment are not the ones with the sickest relatives. They are the ones who arrived prepared. Around 70% of families fail at the Checklist stage — not because their relative doesn't qualify, but because the evidence was not presented clearly enough. Preparation before the appointment is more valuable than any appeal after a refusal.

Evidence to Gather Before the Assessment

Start collecting these as soon as you believe your relative may qualify. Do not wait until you have been given an assessment date.

Medical Records

- ☐ GP records covering the past 12 months
- ☐ All specialist clinic letters (request from each hospital department involved)
- ☐ Hospital discharge summaries from any admissions in the past two years
- ☐ Cognitive testing or neuropsychology reports if relevant
- ☐ Mental Capacity Act assessments if decisions have been made on your relative's behalf

Medication Records

- ☐ Complete current medication list with doses and dates started
- ☐ Monitoring requirements for each medication (blood tests, drug level checks)
- ☐ Records of any recent medication changes or adjustments
- ☐ Hospital admission records related to any medication issues

Care Home Records

- ☐ Incident logs covering the past 3-6 months (request in writing from the care home)
- ☐ Current care plan
- ☐ Behaviour support plans
- ☐ Wound care charts if relevant
- ☐ Continence management records
- ☐ Food and fluid intake charts
- ☐ Any specialist assessments the care home has commissioned

Specialist Assessments

- ☐ Physiotherapy assessment
- ☐ Occupational therapy report
- ☐ Speech and language therapy assessment (critical if swallowing or communication issues exist)
- ☐ Dietitian assessment (critical if nutritional concerns exist)
- ☐ Tissue viability nurse assessment (if any wounds or pressure ulcer risk)
- ☐ Psychiatric or psychology assessment if relevant

Missing Assessments

If any of the specialist assessments above are relevant to your relative's condition and have not been completed, request them before the assessment date. Write to the GP or relevant specialist. If they cannot be completed in time, tell the assessor explicitly: "The absence of this assessment is an evidence gap, not evidence that the need does not exist."

Preparing the Care Home

Ask the care home to:

- ☐ Prepare a written summary of your relative's care needs across the 12 domains, describing what specialist input is required and what would happen if it were withdrawn
- ☐ Ensure incident logs are up to date and complete for the past six months
- ☐ Have a senior member of staff available to speak to the assessor or provide a written statement
- ☐ Articulate their interventions clearly — not just "we manage the behaviour" but "we use a specialist behaviour support plan developed by a psychiatric nurse and this is what would happen without it"

On the Day of the Assessment

- ☐ Attend — your presence matters
- ☐ Bring all documents gathered above
- ☐ If the assessor proposes a domain score you disagree with, say so and ask for your disagreement to be recorded in writing
- ☐ If evidence is missing, state explicitly that it is an evidence gap, not evidence of no need
- ☐ At the end, request a copy of the completed Checklist with all scores before you leave

YOUR RIGHT TO DISAGREE

If the assessor and you cannot agree on a domain score, the higher level must be applied — DST Guidance, paragraph 25. This is not optional. Ask the assessor to record your disagreement in writing for every disputed domain.

CHAPTER 5

Fast Track CHC

For families facing hospital discharge or rapid deterioration

CHAPTER 5

Fast Track CHC

THE 48-HOUR COMMITMENT

Once the ICB receives a completed Fast Track form, they must make a decision within 48 hours. This applies to the decision — not to care starting. Arranging the care package can take longer depending on provider availability.

If your relative's condition is rapidly deteriorating and may be entering a terminal phase, there is a separate pathway that bypasses the normal Checklist and DST process entirely. It is called the Fast Track pathway — and most families have never heard of it.

An appropriate clinician completes the Fast Track Pathway Tool and submits it to the ICB. If approved, the NHS funds care immediately. No Checklist. No multidisciplinary team assessment. The completed form is in itself sufficient evidence of CHC eligibility.

Who Qualifies

An individual qualifies if they have: (1) a rapidly deteriorating condition, AND (2) the condition may be entering a terminal phase. "Rapidly deteriorating" means changing and worsening quickly — not simply seriously ill. Conditions that commonly qualify include advanced cancer, motor neurone disease in later stages, end-stage COPD, end-stage heart failure, and advanced dementia with clear recent functional decline.

How to Request Fast Track

Identify the right clinician. The hospital consultant managing your relative's primary condition is usually best. A GP who knows your relative well is also appropriate.

Brief them on the criteria. Many GPs and consultants are not familiar with Fast Track. Write to them with the criteria from paragraphs 240-269 of the National Framework.

Prepare the evidence. A concise written summary of recent deterioration — hospitalisations, functional decline, medication changes.

Put it in writing. If the clinician declines, ask them to explain in writing why the criteria are not met.

If refused, escalate to the ICB directly and request standard CHC assessment as an alternative.

DEMENTIA AND FAST TRACK

ICBs sometimes resist Fast Track for dementia on the basis that deterioration is slow and progressive. Document specific recent changes: decline in swallowing, a recent hospital admission, increased behavioural disturbance, loss of mobility. If Fast Track is refused, request standard CHC assessment — many people with advanced dementia qualify through that pathway.

Fast Track is not permanent. At around three months, the ICB must carry out a proper CHC assessment. Paragraph 22 of the National Framework states they cannot simply stop Fast Track funding without completing this reassessment.

CHAPTER 6

The Assessment Process

Checklist, DST, and MDT step by step

CHAPTER 6

The Assessment Process

Stage 1: The CHC Checklist

The Checklist is the preliminary screening tool. It uses A, B, and C scores across 11 domains. To pass the threshold, one of three rules must be met: two or more domains scored A; five or more scored B or above; or one A in an asterisked domain (Behaviour, Breathing, Drug Therapies, Altered States, or Other Significant Needs). A negative Checklist is not the end — you can challenge it or request a full assessment directly from the ICB.

Stage 2: The Decision Support Tool

If the Checklist is positive, a multidisciplinary team carries out a full assessment using the DST. The MDT considers not just individual domain scores but the interaction between needs — whether the totality of care constitutes a primary health need. The MDT then makes a recommendation which the ICB uses to make the final decision.

Stage 3: The ICB Decision

The NHS target is 28 days from the Checklist to a decision, though delays of 2-3 months are common. If approved, the ICB takes over care fees from the date of eligibility. If refused, you have the right to appeal — see Chapter 7.

Your Rights at Every Stage

— You are entitled to attend and contribute evidence at every stage.

— You are entitled to see the completed Checklist and DST with all scores.

— You are entitled to have disagreements recorded in writing.

— If assessor and you cannot agree on a level, the higher level must be applied — DST Guidance, paragraph 25.

— If the assessment was not completed within 28 days, this is a breach of the National Framework — note it in any subsequent appeal.

CHAPTER 7

If You Are Refused

Local review, the IRP, and what actually works

CHAPTER 7

If You Are Refused

SIX-MONTH DEADLINE

You have six months from the date of the decision letter to request a local review. Act immediately — do not wait.

Around 20-30% of local reviews result in a changed decision. Around 13-25% of cases that reach the Independent Review Panel are overturned. The families who succeed are the ones who address directly what went wrong with the original assessment.

A Strong Local Review Letter

1. Opening statement

"We request a local review of the decision dated [date]. We are writing within the six-month window."

2. Core argument

"The decision failed to properly apply the primary health need test" or "The decision misapplied the well-managed needs principle in respect of [domains]."

3. Domain arguments

For each domain challenged: explain the correct score, the evidence supporting it, and why the original assessment was wrong. Cite paragraph 162 if well-managed needs were dismissed.

4. New evidence

Any specialist assessments completed since the original decision, updated care home incident logs, updated medical records.

5. Formal request

Request a written response within 28 days setting out the ICB's decision on each point raised.

The Two Key Legal Cases

R v North and East Devon Health Authority, ex parte Coughlan (1999) — The NHS cannot shift responsibility for healthcare needs to social services without lawful justification. Cite this if the ICB is classifying clearly health-related needs as social care.

R (Grogan) v Bexley NHS Care Trust (2006) — Eligibility assessment must properly apply the primary health need test. If the ICB's refusal does not engage with the four characteristics or explain why a primary health need does not exist, the decision is legally vulnerable.

The Independent Review Panel

If the local review fails, request an Independent Review Panel (IRP) through NHS England. The IRP is independent of the ICB. Around 13-25% of cases result in a changed outcome. At IRP stage, professional representation significantly improves outcomes. Beacon CHC (0345 548 0300) offers free advice on whether your case is strong enough.

CHAPTER 8

Retrospective Claims

How to claim back fees already paid

CHAPTER 8

Retrospective Claims

If your relative should have been assessed for CHC in the past but was not, or if they were assessed and the decision was wrong, you can request a retrospective review. If successful, the NHS must reimburse the care fees paid during the period of eligibility. Claims can be made for someone still alive, or on behalf of someone who has died.

What You Need

— Medical records from the relevant period: GP records, hospital discharge summaries, specialist clinic letters, medication lists as they were at the time

— Care records: care home care plans and incident logs, medication administration records

— Proof of payment: care home invoices, bank statements showing payments

— Evidence that CHC was not assessed: correspondence showing CHC was not mentioned or was dismissed without proper assessment

TIMESCALES AND SUCCESS RATES

Most ICBs apply a rolling 3-year window for retrospective claims (a guideline, not an absolute rule). Retrospective assessments typically take 28-56 weeks. Success rate for well-evidenced claims: 40-60%. Some solicitors offer no-win-no-fee arrangements — understand the cost risk before committing.

CHAPTER 9

NHS Funded Nursing Care

The £267.68 per week most families never claim

CHAPTER 9

NHS Funded Nursing Care

FNC AT A GLANCE

£267.68 per week as of April 2026 (approximately £13,900 per year). Available to anyone in a registered nursing home who requires nursing care. Not means-tested. Cannot be received simultaneously with full CHC. Backdating usually available for up to 3 years.

NHS Funded Nursing Care (FNC) is a weekly NHS payment to nursing homes to help cover the cost of registered nursing care. Most families in nursing homes are entitled to it. Many never receive it.

FNC is different from CHC. CHC covers all care costs for people whose primary need is a health need. FNC is a partial contribution for people in nursing homes who do not qualify for full CHC but still require registered nursing care.

Who Qualifies

— Placed in a registered nursing home (not a residential care home without nursing, and not home care)

— Requires nursing care input from a registered nurse

— Has been assessed by the ICB — either as part of a CHC assessment or through a standalone FNC assessment

— Not means-tested — savings, income, and property are completely irrelevant

How to Check and Back-Claim

Ask the care home: "Is NHS Funded Nursing Care being paid for my relative?" If not, request an FNC assessment from the ICB immediately. State the date your relative moved in and request backdated payment from that date. Most ICBs accept back-claims for up to three years.

REAL EXAMPLE

A family discovered in August 2024 — five months after placement — that FNC had not been applied since the March 2024 move-in date. They requested an FNC assessment immediately. FNC was approved and backdated to March 2024, resulting in a reimbursement of approximately £1,338. Always check FNC status within the first month of a nursing home placement.

Letter Templates

Adapt the following templates for your specific circumstances. Replace all text in [square brackets] before sending.

Template 1: Requesting a CHC Assessment

[Your name] | [Your address] | [Date]

The NHS Continuing Healthcare Team | [ICB name and address]

Dear Sir or Madam,

Request for NHS Continuing Healthcare Assessment
[Relative's full name] | [Date of birth]

I am writing to request a formal NHS Continuing Healthcare assessment for my [relationship], [relative's name], at [care home name and address].

[Relative's name] has been receiving care since [date]. Their care needs include [brief summary of main conditions]. I believe these needs may constitute a primary health need under the NHS National Framework for Continuing Healthcare (2022).

Please arrange for a CHC Checklist assessment at the earliest opportunity and confirm the date in writing.

Yours faithfully, [Your name] | [Telephone] | [Email]

Template 2: Requesting a Local Review After Refusal

[Your name] | [Your address] | [Date]

The NHS Continuing Healthcare Team | [ICB name and address]

Dear Sir or Madam,

Request for Local Review — [Relative's full name] | [Date of birth]
Decision dated: [date of refusal letter]

I am formally requesting a local review of the above decision. I am writing within the six-month review window.

The original decision was incorrect for the following reasons:
[The decision failed to properly apply the primary health need test. / The decision misapplied the well-managed needs principle in respect of [domains].]

[For each domain challenged:]
Domain [name]: Original score [X]. Correct score [Y].
Reason: [evidence and explanation. Cite NF paragraph 162 if applicable.]

Enclosures: [list supporting documents]

I request a written response within 28 days.
Yours faithfully, [Your name] | [Telephone] | [Email]

Template 3: Requesting an FNC Assessment or Back-Claim

[Your name] | [Your address] | [Date]

The NHS Continuing Healthcare Team | [ICB name and address]

Dear Sir or Madam,

Request for NHS Funded Nursing Care Assessment
[Relative's full name] | [Date of birth]

I am writing to request an NHS Funded Nursing Care (FNC) assessment for my [relationship], [relative's name], at [nursing home name] since [date of admission].

To my knowledge, no FNC assessment has been completed and no FNC payment is currently being made. I believe [relative's name] is entitled to FNC under the NHS-Funded Nursing Care Practice Guidance (2022).

Please complete an FNC assessment as a matter of urgency and backdate any entitlement to [date of admission].

Yours faithfully, [Your name] | [Telephone] | [Email]

Template 4: Requesting a Fast Track Referral from a Clinician

[Your name] | [Date]

Dear [Dr/Nurse/title and surname],

Request to Consider Fast Track CHC Referral
[Relative's full name] | [Date of birth]

I am writing regarding my [relationship], [relative's name], currently under your care.

I am concerned that [relative's name]'s condition is rapidly deteriorating and may be entering a terminal phase. I believe they may meet the criteria for the Fast Track CHC pathway under paragraphs 240-269 of the NHS National Framework (2022).

Specific reasons I believe the criteria may be met:
[Summary of recent deterioration — hospitalisations, functional decline, etc.]

Please review whether the Fast Track Pathway Tool should be submitted to the ICB.
If you do not believe the criteria are met, please explain in writing.
Yours sincerely, [Your name] | [Telephone] | [Email]

Glossary

CHC

NHS Continuing Healthcare. Full NHS funding for people whose primary need is a health need. Not means-tested. Covers all care costs.

Checklist

The preliminary CHC screening tool. Uses A, B, C scoring across 11 domains.

DST

Decision Support Tool. The detailed assessment used at the full MDT stage across all 12 domains.

Fast Track

Expedited CHC pathway for people with rapidly deteriorating conditions. Bypasses Checklist and DST. Decision within 48 hours.

FNC

NHS Funded Nursing Care. £267.68/week (April 2026) paid to nursing homes for people who need nursing care but don't qualify for full CHC.

ICB

Integrated Care Board. The NHS body that assesses and funds CHC in each local area. 36 ICBs in England.

IRP

Independent Review Panel. Convened by NHS England to review CHC decisions after unsuccessful local review.

MCA

Mental Capacity Act 2005. Governs decisions made for people who lack capacity.

MDT

Multidisciplinary Team. The team that carries out the full DST assessment.

MMSE

Mini Mental State Examination. Cognitive assessment tool commonly used for dementia.

National Framework

NHS National Framework for Continuing Healthcare and NHS-funded Nursing Care (2022, revised 2023). The statutory guidance governing CHC in England.

Primary health need

The legal test for CHC eligibility. Care needs are predominantly healthcare rather than social or personal care.

PUPoC

Previously Unassessed Period of Care. The formal term for a retrospective CHC claim.

Well-managed needs

National Framework paragraphs 162-164. A need held stable by ongoing intervention is still a need. Management is evidence of the need, not its absence.

Where to Get Further Help

Beacon CHC

0345 548 0300 | beaconchc.co.uk

Free independent advice on NHS Continuing Healthcare. Can advise on whether your case is strong enough to proceed, how to structure an appeal, and whether professional representation would help.

Care to be Different

caretobedifferent.co.uk

Detailed free guidance including domain-by-domain guides and appeals advice.

Age UK

ageuk.org.uk — Factsheet 20

Free factsheet on NHS Continuing Healthcare and NHS-Funded Nursing Care.

MoneySavingExpert

moneysavingexpert.com/family/nhs-continuing-healthcare

Plain-English guide to NHS Continuing Healthcare.

Specialist solicitors

Farley Dwek, Hugh James Solicitors, Martin Searle, Winston Solicitors

Handle CHC cases including appeals and retrospective claims. Some offer no-win-no-fee for retrospective claims.

CareHomeGuide.uk

carehomeguide.uk

Free independent directory of 14,779 CQC-rated care homes across England. Search by location, care type, and CQC rating.

CareHomeGuide

carehomeguide.uk

This guide provides general information about NHS Continuing Healthcare and related funding. It does not constitute legal or medical advice. Always seek professional advice relevant to your specific circumstances. All figures are correct as of April 2026.