The 'support tool' that unlocks care . . . or shuts you out

WHAT IS NHS CONTINUING HEALTHCARE?

This is the name of a care package arranged and funded entirely by the NHS. The funding covers all care and residential costs if you have to move into a care home – regardless of any savings or assets you have. If you do not qualify for the funding, you are expected to pay for your care, accommodation or both until your assets, including property, are worth £23,250 or less.

WHO IS ELIGIBLE?

Eligibility is not automatic if you have a condition, illness or diagnosis such as Alzheimer's or Parkinson's. People with the same diagnosis can have very different needs – one might get funding, another not. Assessments score a patient's needs and determine whether, overall, their need for care is a health need.

HOW ARE NEEDS ASSESSED?

Health and social care professionals use a checklist called a decision support tool that marks patients on their behaviour, cognition and ability to communicate, among other categories. The levels range from "N" for no needs to "P" for priority – the most severe. Under the NHS guidelines, you will be recommended for funding if one category is classed as priority or at least two are severe. But the ultimate decision rests with the local clinical commissioning group (CCG).

CAN I APPEAL AGAINST A DECISION?

You can take your case to an independent review panel, which can recommend that the CCG make a retrospective payment or agree to fund the cost of care. But the panel cannot force a CCG to pay. If you are still found to be ineligible, you can approach the Parliamentary and Health Service Ombudsman.

Data given to Money shows that complaints about continuing healthcare funding rose from 414 in 2013-14 to 423 in 2014-15. Between April and November this year, 415 complaints were made. Rulings in favour of complainants are up from 16.9% in 2013-14 to 19.5% so far in 2015-16.

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