

EXAMPLE PACK · A MADE-UP FAMILY

An example family pack for Margaret

Margaret is not a real person. Her family's answers are made up, and this is the pack written from them, so you can see every part before you buy. Your own pack is written from your own words, and any area you do not describe is marked, never filled in.

WHAT A REAL PACK LOOKS LIKE

A real pack arrives on screen, as two PDF files and by email.

Part 1 holds the papers to use at the MDT meeting: the family statement for all 12 care domains in the order of the Decision Support Tool, the four key characteristics and the family comment for the ICB.

Part 2 helps you prepare: the level we believe fits each domain and what the team will ask, questions for the meeting, an evidence list, a 7-day care diary and a plan for the day.

This example puts both parts in one file. At the end it shows the local resolution letter of the Family Pack + Local Resolution Letter, for an imagined refusal.

IN THIS EXAMPLE

1. Part 1: Your papers for the MDT meeting
2. Part 2: Prepare for the MDT meeting
3. After a refusal: the local resolution letter and the next steps

Guidance only, not legal or medical advice. The MDT recommends the levels and the ICB decides eligibility: nobody can promise an outcome. CHCexpert is an independent service and is not part of the NHS or any government body.

EXAMPLE PACK, A MADE-UP FAMILY · PART 1 OF 2

Your papers for the MDT meeting

The family statement for Margaret, written from the family's made-up answers.
Health conditions: Vascular dementia, type 2 diabetes, previous stroke with left-sided weakness, osteoporosis.

How to use these papers

1. Read every line and change anything that is not exactly right.
2. Send a copy to the assessor or care coordinator before the meeting, or take copies for everyone at the meeting.
3. At the meeting, go through it domain by domain and ask for anything the team has not recorded to be noted in the DST.
4. Ask for the family comment to be recorded in the DST, and for a copy of the completed DST with the decision.

Anything that is not exactly right or not true, change it or delete it. Only share what is true.

DST CARE DOMAIN 1 OF 12

1. Breathing

NO NEEDS REPORTED

No needs reported by the family in this area. If that changes before the meeting, tell the team.

2. Nutrition (food and drink)

FAMILY STATEMENT

WHAT WE SEE

Margaret cannot feed herself any more. A carer sits with her for every meal and feeds her a pureed diet, with every drink thickened as the speech and language therapist advised. She coughs on thin fluids and staff have to stop and wait for her to clear her throat.

HOW OFTEN AND HOW LONG

Three meals and at least six drinks a day. Each meal takes about 40 minutes because she holds food in her mouth and has to be prompted to swallow.

WHO IS NEEDED AND WHAT SKILL

One carer at a time, who must know her swallowing plan, recognise the signs of choking and know when to stop a meal.

WHAT HAPPENS IF CARE IS LATE

If nobody sits with her she does not eat or drink at all. When she was rushed in July she choked on a mouthful and staff had to clear her airway.

WHY THIS IS STILL A NEED IF IT LOOKS WELL MANAGED

She has not had a chest infection this year only because every drink is thickened and every meal is given slowly by a carer who follows the plan.

RECORDS THE TEAM SHOULD LOOK AT

The food and fluid charts, the weight records (she lost about 4 kg between June and September) and the speech and language therapy assessment.

3. Continence

FAMILY STATEMENT

WHAT WE SEE

Margaret is incontinent of urine and faeces and wears pads day and night. She does not know when she needs the toilet and pulls at her pads.

HOW OFTEN AND HOW LONG

Pads are changed about 6 times a day and twice at night. She has had two urine infections this year.

WHO IS NEEDED AND WHAT SKILL

Two carers for each change, because she cannot stand and resists being turned.

WHAT HAPPENS IF CARE IS LATE

Her skin on her bottom becomes red within a few hours, and a late change in the evening usually ends in her hitting out.

WHY THIS IS STILL A NEED IF IT LOOKS WELL MANAGED

Her constipation is under control only because staff record her bowels each day and give her laxative when the chart shows she needs it.

RECORDS THE TEAM SHOULD LOOK AT

The bowel chart and the care plan.

4. Skin and tissue viability

FAMILY STATEMENT

WHAT WE SEE

Margaret spends most of the day in a chair and the night in bed. Her skin is fragile. In August a red area on her left heel took three weeks to settle.

HOW OFTEN AND HOW LONG

She is repositioned every 2 hours in the day and every 3 hours at night, and her heels and sacrum are checked at every change.

WHO IS NEEDED AND WHAT SKILL

Two carers each time, using a slide sheet, as she cannot help.

WHAT HAPPENS IF CARE IS LATE

When her repositioning slipped during a staff shortage in August, the red area on her heel appeared within two days.

WHY THIS IS STILL A NEED IF IT LOOKS WELL MANAGED

Her skin is unbroken now only because she is turned on time, day and night, and lies on a pressure-relieving mattress.

RECORDS THE TEAM SHOULD LOOK AT

The repositioning charts and any skin assessment the nurses have done.

5. Mobility

FAMILY STATEMENT

WHAT WE SEE

Margaret cannot stand or take her weight since her stroke, and her left side is weak. Two carers move her with a hoist for every transfer. She grips the hoist and tries to stand up in the sling because she does not understand what is happening.

HOW OFTEN AND HOW LONG

About 8 transfers a day, each taking two carers around 15 minutes.

WHO IS NEEDED AND WHAT SKILL

Two carers trained in using the hoist, who talk her through each step and watch for her trying to stand.

WHAT HAPPENS IF CARE IS LATE

She tries to get out of her chair on her own. Before she moved to the home she fell four times in two months, and once she lay on the floor until the morning.

WHY THIS IS STILL A NEED IF IT LOOKS WELL MANAGED

She has not fallen in the home only because she is never left to get up alone and a sensor mat alerts staff when she moves.

RECORDS THE TEAM SHOULD LOOK AT

The falls log from before she moved, the moving and handling assessment and the sensor mat records.

6. Communication

FAMILY STATEMENT

WHAT WE SEE

Margaret speaks in short phrases and often uses the wrong words. She cannot tell staff when she is in pain, hungry or needs the toilet.

HOW OFTEN AND HOW LONG

Every day. On a good day she can answer a simple yes or no question; on a bad day she cannot.

WHO IS NEEDED AND WHAT SKILL

Carers who know her well read her signs: she rubs her hip when it hurts and goes quiet when she is unwell.

WHAT HAPPENS IF CARE IS LATE

When agency staff who do not know her are on shift, her pain is missed and she becomes agitated.

RECORDS THE TEAM SHOULD LOOK AT

The care plan section on communication and the pain assessment chart.

7. Psychological and emotional needs

FAMILY STATEMENT

WHAT WE SEE

Every afternoon from about 4 o'clock Margaret becomes anxious and tearful. She calls out for her late husband and asks to go home.

HOW OFTEN AND HOW LONG

Most days, for 2 to 3 hours.

WHO IS NEEDED AND WHAT SKILL

A carer who sits with her, holds her hand and talks about her garden. It works on some days but not on others.

WHAT HAPPENS IF CARE IS LATE

If nobody comes she gets louder and more distressed, and the distress carries on into the evening personal care.

RECORDS THE TEAM SHOULD LOOK AT

The daily notes for the late afternoon and any behaviour or mood charts.

8. Cognition

FAMILY STATEMENT

WHAT WE SEE

Margaret does not know where she is or what time of day it is, and some days she does not recognise me. She cannot remember that she cannot walk, so she tries to stand up many times a day.

HOW OFTEN AND HOW LONG

All the time. Staff remind her she must not stand up every time she tries.

WHO IS NEEDED AND WHAT SKILL

Staff who watch her all day and know how to redirect her calmly.

WHAT HAPPENS IF CARE IS LATE

She would try to stand and fall. She has no sense that this is dangerous.

WHY THIS IS STILL A NEED IF IT LOOKS WELL MANAGED

She is safe only because staff anticipate what she needs and watch her all day.

RECORDS THE TEAM SHOULD LOOK AT

The memory clinic letter, the care plan and the daily notes.

9. Behaviour

FAMILY STATEMENT

WHAT WE SEE

Margaret resists personal care. She hits out, scratches and grips staff during washing and changing, and she shouts for long periods in the evening.

HOW OFTEN AND HOW LONG

Two or three times a day, nearly always during personal care, and most evenings.

WHO IS NEEDED AND WHAT SKILL

Two carers who follow her care plan: they explain each step, stop and come back if she becomes distressed and never rush her.

WHAT HAPPENS IF CARE IS LATE

In September she scratched a carer's arm, and she has pushed another resident who came into her room.

WHY THIS IS STILL A NEED IF IT LOOKS WELL MANAGED

The incidents are fewer than in the summer only because staff follow the plan every time. When new staff do not, she hits out within minutes.

RECORDS THE TEAM SHOULD LOOK AT

The behaviour and incident charts and the care plan for personal care.

10. Drug therapies and medication (symptom control)

FAMILY STATEMENT

WHAT WE SEE

Margaret refuses her tablets or spits them out about half the time. Her diabetes tablets and her pain relief have to be given by a nurse who knows how to encourage her.

HOW OFTEN AND HOW LONG

Medicines four times a day. Her hip and back pain is worst when she is moved.

WHO IS NEEDED AND WHAT SKILL

A nurse gives her medicines and checks her blood sugar when she has not eaten.

WHAT HAPPENS IF CARE IS LATE

When she missed her tablets for two days in August her blood sugar went high and she was drowsy and more confused.

WHY THIS IS STILL A NEED IF IT LOOKS WELL MANAGED

Her blood sugar is stable only because the nurse persists with her tablets and checks her when she refuses meals.

RECORDS THE TEAM SHOULD LOOK AT

The medication administration records and the blood sugar log.

11. Altered states of consciousness

ASK THE TEAM

Not described. Ask the team what evidence they hold for this area, and add anything you see yourself at the meeting.

12. Other significant care needs

NO NEEDS REPORTED

No needs reported by the family in this area. If that changes before the meeting, tell the team.

The four key characteristics

NATURE, INTENSITY, COMPLEXITY AND UNPREDICTABILITY

NATURE

Margaret's care needs skilled knowledge every day: a swallowing plan to reduce the risk of choking, a hoist transfer with two trained carers, a care plan for personal care that keeps staff and other residents safe and a nurse who can get her to take her medicines.

INTENSITY

She needs help day and night: about 8 hoist transfers and 8 pad changes in 24 hours, repositioning every 2 to 3 hours, 40-minute meals, someone watching her all day and two carers for most care.

COMPLEXITY

Her needs feed each other. Her confusion means she cannot swallow safely without prompting, cannot remember not to stand and does not understand personal care, which is when she hits out. Pain she cannot describe makes her more distressed and harder to move.

UNPREDICTABILITY

She tries to stand without warning many times a day, her distress in the afternoon settles on some days but not others and her blood sugar goes high when she refuses tablets. Help that is late leads to choking, falls, sore skin or injury to staff.

HOW THE NEEDS AFFECT EACH OTHER

Her cognition affects nearly every other area: she cannot follow her swallowing plan, judge the risk of standing or understand why she is being washed. Her pain and her communication difficulties mean distress is often missed, which then shows up as behaviour during care.

The MDT recommends and the ICB decides. Any one characteristic, alone or with others, can show a primary health need.

Family comment for the ICB

Ask the team to record this in the DST box for the individual's view of their needs, and any disagreement in the box for disagreement with the domain levels.

FAMILY COMMENT

We are Margaret's family and we visit her most days, at different times, so we see her care in the mornings, the afternoons and the evenings. We ask the team to record our view of her needs in the DST.

Margaret's needs are not stable and they are not simple. She cannot swallow safely without a trained carer, she cannot bear weight, she cannot judge even the most basic risk and she resists the personal care she needs every day, hitting out at the carers who give it. Each of these needs makes the others harder to meet.

Many of her needs look well managed. They are well managed only because of the care she gets: thickened drinks and slow, careful feeding, turning day and night, staff who watch her all day and two carers who follow her plan for personal care. When that care slipped in the summer, she choked, her heel became sore and she scratched a carer. We ask the team to record these needs as needs, with what the care prevents.

We believe her cognition fits severe, as she cannot recognise danger even when reminded, and her nutrition fits high because of the choking and the weight loss. If the team records a lower level in any domain, we ask for our disagreement and our reasons to be recorded in the DST.

We also ask the team to consider how her needs interact and that her needs are likely to change, and to set an early review date if that is the case.

EXAMPLE PACK, A MADE-UP FAMILY · PART 2 OF 2

Prepare for the MDT meeting

Everything to get ready before you share the papers in Part 1: the level we believe fits each domain, the questions the team is likely to ask, what to bring and a plan for the day.

AT A GLANCE

The level we believe fits, domain by domain

Matched to the closest description in the Decision Support Tool, honestly, including where your account fits a lower level. The MDT recommends the levels and the ICB decides.

CARE DOMAIN	THE LEVEL WE BELIEVE FITS
1. Breathing	No needs reported
2. Nutrition (food and drink)	High (may)
3. Continence	Moderate (likely)
4. Skin and tissue viability	Moderate (likely)
5. Mobility	High (likely)
6. Communication	Moderate (likely)
7. Psychological and emotional needs	Moderate (may)
8. Cognition	Severe (may)
9. Behaviour	High (likely)
10. Drug therapies and medication (symptom control)	Moderate (likely)
11. Altered states of consciousness	Ask the team
12. Other significant care needs	No needs reported

2. Nutrition (food and drink)

The level we believe fits best: High (may)

swallowing problems needing skilled help to reduce the risk of choking and aspiration, with weight loss

The choking in July, the thickened fluids and the weight loss suggest high. The team may say moderate if they see her needs as feeding that takes a long time, so the speech and language therapy assessment matters.

WHAT THE TEAM WILL ASK YOU

- What exactly does the speech and language therapy plan say, and when was it written?
- Has a GP or dietitian reviewed the weight loss?

3. Continence

The level we believe fits best: Moderate (likely)

continence care is routine but needs monitoring to reduce risks, such as double incontinence and repeated urine infections

Double incontinence, two urine infections and constipation that needs monitoring fit moderate. Nothing the family describes suggests the skilled care above routine care that high needs.

WHAT THE TEAM WILL ASK YOU

- When were the two urine infections, and were they confirmed by a test?

4. Skin and tissue viability

The level we believe fits best: Moderate (likely)

needs preventive care several times each day, such as repositioning, to stop the skin breaking down

Repositioning day and night with checks at every change fits moderate. There is no open wound now, which is why it does not reach high.

WHAT THE TEAM WILL ASK YOU

- Has a skin or tissue viability assessment been done, and what does it say?

5. Mobility

The level we believe fits best: High (likely)

cannot bear weight and cannot cooperate with transfers, with a high risk of falls shown by falls history

She cannot bear weight, she works against the hoist rather than helping and she has a falls history. That fits high.

WHAT THE TEAM WILL ASK YOU

- What does the falls risk assessment say?

6. Communication

The level we believe fits best: Moderate (likely)

needs are difficult to understand, and carers who know her read her non-verbal signs

She can still answer simple questions on some days, which fits moderate rather than high.

WHAT THE TEAM WILL ASK YOU

- Do the staff use a pain assessment tool for people who cannot say they are in pain?

7. Psychological and emotional needs

The level we believe fits best: Moderate (may)

distress and anxiety that do not readily settle with reassurance and have a growing impact

Her distress settles with reassurance on some days, so it sits between low and moderate. The daily notes will show how often it does not settle.

WHAT THE TEAM WILL ASK YOU

- On how many days in the last month did she not settle with reassurance?

8. Cognition

The level we believe fits best: Severe (may)

cannot judge basic risks even with help and depends on others to anticipate her needs

She cannot judge the most basic risk, standing up, even when reminded. The team may record high if they see some awareness on her better days, so record any examples.

WHAT THE TEAM WILL ASK YOU

- Does she ever understand a warning, even for a moment?
- When was her last memory assessment?

9. Behaviour

The level we believe fits best: High (likely)

behaviour that poses a predictable risk to others, which planned interventions reduce but do not always remove

The pattern is predictable, around personal care, and the plan reduces the risk without removing it. That fits high.

WHAT THE TEAM WILL ASK YOU

- How many incidents are on the incident chart for the last month?

10. Drug therapies and medication (symptom control)

The level we believe fits best: Moderate (likely)

medication has to be given by a nurse or carer because she refuses it, with predictable pain affecting her care

Refusal and pain on movement fit moderate. If her blood sugar needs nurse monitoring because it swings, the team may consider high, so ask what the blood sugar log shows.

WHAT THE TEAM WILL ASK YOU

- How often has her blood sugar been out of range in the last month?

What the pattern may mean

The DST guidance says a priority level in one of the four priority domains, or two or more severe levels, would usually be expected to lead to a recommendation of eligibility, and that a severe need with needs in several other domains, or several high or moderate needs, may also show a primary health need. The statement suggests severe in cognition, high in nutrition, mobility and behaviour and moderate in five other domains. That may show a primary health need, but the levels cannot be added up and the decision rests on the whole picture.

The MDT recommends and the ICB decides. Any one characteristic, alone or with others, can show a primary health need.

Questions to ask at the meeting

1. Which assessments, records and dates did the team use for each domain, and can we see them?
2. Are needs that are well managed being recorded as needs, with what the care prevents (DST guidance para 31)?
3. If the team cannot agree between two levels, will it choose the higher level and record the evidence and any differences of opinion (DST guidance para 25)?
4. Will our view, and any disagreement we have with a domain level, be recorded in the DST with our reasons (Practice Guidance note 33)?
5. Where one condition causes needs in more than one domain, is each need recorded in its own domain, for example cognition and behaviour (DST guidance para 28)?
6. Is the likely deterioration over the coming months recorded, and will an early review date be set if needs are changing (DST guidance para 27)?
7. Will we get a copy of the completed DST with the decision and the reasons (DST guidance para 43)?
8. When will the ICB make its decision? The National Framework expects the process in most cases to take no more than 28 days from the positive Checklist.
9. Has the team seen the speech and language therapy plan and the record of the choking episode in July?
10. Will the weight loss between June and September be recorded in the nutrition domain?
11. Has the team read the incident chart for September, including the scratch to a carer and the push of another resident?
12. Will the effect of agency staff who do not know her plan be considered in the behaviour domain?
13. Has the team seen the blood sugar log for the days she refused her tablets?
14. How will the team record that she tries to stand many times a day without any sense of danger?
15. Has anyone used a pain assessment tool for people who cannot say they are in pain?

BEFORE THE MEETING

Evidence to gather or ask for

- Speech and language therapy assessment: shows the swallowing plan and the risk of choking
- Food and fluid charts and weight records: show the 40-minute meals and the weight loss
- Behaviour and incident charts: show how often she hits out and the September incidents
- Repositioning charts: show turning day and night and the heel in August

- Falls log from before she moved: shows the four falls in two months
- Medication administration records and blood sugar log: show the refusals and the high readings in August
- Memory clinic letter: describes her cognition
- Our family diary: records what we see on our visits, at different times of day

Your 7-day care diary

WHAT TO WRITE DOWN FOR MARGARET

- Each time she tries to stand, and what staff did
- How long each meal takes and any coughing or choking
- Each time she hits out or shouts, what was happening and how long it lasted
- Late afternoon distress: did reassurance work, and how long it took
- Times she refused tablets, and any blood sugar checks
- Night-time turns and pad changes, with times

Write it at the time, with times and dates, and sign each entry. Ask the care home or care staff to keep their own detailed notes for the same week: the National Framework says a provider can be asked to keep a diary showing the nature and frequency of needs.

DAY	DAYTIME: WHAT HAPPENED, WHEN, HOW LONG, WHO HELPED	NIGHT: WHAT HAPPENED, WHEN, HOW LONG, WHO HELPED	WHAT WOULD HAVE HAPPENED WITHOUT HELP
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

On the day of the meeting

1. Arrive 10 minutes early with three copies of Part 1 and your diary.
2. Ask who is at the meeting and what each person's role is.
3. Go through the domains in order and show the evidence for each one.
4. Ask the team to record well-managed needs as needs, with what the care prevents.
5. Before the meeting ends, ask which levels the team recommends and whether your view has been recorded.
6. Take notes of who said what about each domain, and ask that the family's contribution is recorded in the DST.
7. Ask for a copy of the completed DST with the decision.

FAMILY PACK + LOCAL RESOLUTION LETTER ONLY

After a refusal: *the letter to the ICB*

For this example, imagine the ICB decided on 20 November 2026 that Margaret is not eligible, and the MDT recorded lower levels than her family believes fit. This is the letter the £149.99 pack writes from the decision and the family statement, with the next steps.

SEND THIS TO THE ICB

Local resolution request letter

BEFORE YOU SEND IT

Read every line, replace each [placeholder], change anything that is not right and send it yourself, by email or post, keeping a copy. Send it within the time limit in the decision letter.

SUBJECT

NHS Continuing Healthcare: request for local resolution for [full name], [date of birth], [NHS number if you have it], decision letter dated 20 November 2026

LETTER

[Your name]

[your address]

[date]

[ICB name and address]

Dear Sir or Madam,

I am writing on behalf of my mother, [full name], about the ICB's decision of 20 November 2026 that she is not eligible for NHS Continuing Healthcare. I ask the ICB to review this decision through its local resolution process, within the time limit in the decision letter. I would welcome an informal discussion first and, if that does not resolve matters, a formal meeting.

LETTER (CONTINUED)

Cognition. The MDT recorded high. I believe the evidence fits severe. My mother cannot judge the most basic risk: she tries to stand many times a day although she cannot bear weight, even when staff remind her. She depends on staff to anticipate her needs and watch her all day.

Nutrition. The MDT recorded moderate. I believe high is likely. She needs skilled help to reduce the risk of choking and aspiration: her drinks are thickened, a trained carer feeds her slowly and she choked in July when she was rushed. She lost about 4 kg between June and September.

Behaviour. The MDT recorded moderate. I believe high is likely. She hits out, scratches and grips staff during personal care two or three times a day. In September she scratched a carer and pushed another resident. Her care plan reduces the risk but does not remove it.

Taken together, the nature, intensity, complexity and unpredictability of her needs show a primary health need. Her confusion affects her swallowing, her safety and her personal care, and she tries to stand without warning many times a day.

The decision letter says her needs are well managed by the nursing home. The National Framework says a decision should not be based on the ability of the care provider to manage her care or on the fact that a need is well managed, and the DST guidance says well-managed needs are still needs. Her needs are well managed only because of the care she receives.

The family's view of her needs was not recorded in the DST. The National Framework says the individual's own view, with any supporting evidence, should be given appropriate weight, and the practice guidance says the concerns of a representative who disagrees should be considered and recorded.

Please send me the evidence and records the MDT used, the notes of the meeting, a written summary of any informal discussion and the ICB's timescales for local resolution.

Yours faithfully,

[your name]

[Your relationship to the person], acting under [consent / lasting power of attorney / deputyship]

CHECK BEFORE YOU SEND

- ☐ Fill in every [placeholder], including her NHS number if you have it.
- ☐ Check each level against the copy of the DST you hold.
- ☐ Send it within the time limit in the decision letter and keep a copy.

Asking NHS England for an independent review

YOUR DATES (TYPICAL TIME LIMITS, CHECK YOUR LETTERS)

- **20 May 2027:** About 6 months after the written decision: the usual time limit to ask the ICB to review it (local resolution). Check the time limit in the decision letter.
1. Local resolution comes first. Every ICB must publish a fair and transparent process with timescales: usually an informal discussion with a written summary, then, if needed, a formal meeting with someone who can decide the next steps and a full written record. You can ask to go straight to a formal meeting.
 2. After the final local resolution outcome, write to NHS England to ask for an independent review. The usual time limit is 6 months from that outcome; the ICB's letter tells you how to request the Application for Independent Review form.
 3. Return the form within 6 weeks. New evidence is only considered if the ICB should reasonably have obtained or considered it.
 4. An independent review panel has an independent chair. It looks at the procedure and the primary health need decision. Panels are normally held online, you get the case file, and you can attend or send your views in writing. Legal representation is not necessary.
 5. It typically takes 3 to 6 months. The panel's recommendation is advisory but should be accepted in all but exceptional circumstances.
 6. An independent review cannot look at the eligibility criteria themselves, the type or place of care offered or complaints about treatment.
 7. After the independent review you can complain to the Parliamentary and Health Service Ombudsman, usually within 12 months.
 8. Be specific when you write: "two or three times a day" rather than "a lot". Say what made care more complicated, whether needs were hard to predict and the care relatives give.

FREE INDEPENDENT ADVICE

Free independent advice: Beacon (0345 548 0300, beaconchc.co.uk) and Age UK. If care was paid for during a period you believe the person should have been eligible, ask the ICB and Beacon about a review of that period. CHCexpert does not handle claims.

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