

Assessment practice and evidence quality

Independent evidence report on NHS Continuing Healthcare in England

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15 October 2026 | Version 1.0

This report develops the project's assessment-practice evidence note of 8 October 2026. It examines reported experiences, self-reported educational needs, investigated failures and professional expectations. It also proposes a practical approach to reviewing the quality of evidence and decision records.

Main findings

Historical inquiry evidence identifies concerns about specialist knowledge, communication and adherence to guidance. Its percentages cannot be treated as current national or dementia-specific estimates.

A nursing survey identified lower self-reported confidence in determining a primary health need than in other CHC work. Confidence is not an independent test of competence.

Ombudsman casework documents failures and consequences in selected cases. Regulatory referrals demonstrate that concerns reached the NMC, but are not equivalent to upheld allegations.

The quality of the final decision depends on the underlying observations, the completeness of the evidence and the reasoning connecting that evidence to the recommendation.

A defensible examination should trace specific discrepancies and professional opinions through the record. Adverse outcomes alone do not establish misconduct or deliberate manipulation.

Purpose and scope

The report provides an evidence summary and suggested assurance questions. It does not estimate a national assessment error rate or determine whether any named assessor breached professional standards. No personal case records are included.

Prepared independently for Continuing Healthcare: Evidence and Experience. This is not an NHS publication or a peer-reviewed study. The companion report, Assessment standards and national guidance, summarises the policy and professional benchmarks.

1. What the published sources establish

Historical inquiry evidence [1]

Parkinson's UK's written evidence to the Public Accounts Committee (31 May 2016), summarising a 2013 APPG inquiry, reported that 59% of assessments lacked a professional with relevant specialist expertise; 40% of people reported insufficient empathy and transparency; and 21% of examined cases showed departures from national guidance in timing or decision-making.

These are the inquiry's reported findings, not current national rates. The summary does not provide sufficient sampling and denominator detail for independent precision estimates here. Its explanation linking expertise to incorrect decisions is an attributed interpretation, not a causal estimate from this report.

Nurses' educational needs [2]

Lee and Hayes (2020) used an online survey, informed by a literature review and focus groups, circulated through the RCN older people's forum. Respondents generally reported confidence in CHC work but less confidence in determining a primary health need through the four characteristics. The authors recommended local multidisciplinary training and a competency framework.

The published abstract was checked through the authors' university record. The full article was not examined for this report. Sample size, response rate and detailed distributions remain unverified here. Self-report and recruitment through a professional forum limit generalisation.

Investigated service failures [3]

PHSO's 2020 report analysed 60 selected resolved CHC cases. It identified problems in care and support planning and retrospective reviews, with consequences including unnecessary payments, unmet care and prolonged uncertainty. The cases demonstrate particular failures, not their national prevalence. Responsibility may involve administration, commissioning and organisational decisions as well as assessment.

Concerns referred to the regulator [4]

The NMC describes complaints questioning nurses' roles in rejected or amended CHC applications. Cases were typically closed at initial assessment or after investigation, for reasons including no need for regulatory action, difficulty identifying the nurse or insufficient prospect of a finding of impaired fitness to practise.

This establishes that concerns reached the regulator. It does not establish that the allegations were upheld. Regulatory closure also cannot determine every aspect of an eligibility dispute: the questions and evidential thresholds differ.

2. Reviewing the quality of the evidence

The following are proposed audit questions developed for this report. They are not a validated scoring instrument, new eligibility criteria or a claim that every suggested process is mandatory.

Stage	Questions for an evidence review
Observation	What was observed, by whom and when? Are direct observations distinguishable from assumptions, copied entries and retrospective recollections?
Care delivered	Does the record describe interventions, frequency, monitoring, skilled responses and the support needed to maintain stability?
Change over time	Are deterioration, fluctuation and changes in care recorded with dates? Does the evidence cover the relevant assessment period?
Completeness	Which sources were sought? Are specialist assessments, risk assessments, care records and representative observations available? What evidence is missing?
Conflicting accounts	Where accounts differ, is the discrepancy identified and investigated? Does the final record explain why evidence was preferred or discounted?
Interaction of needs	Does the reasoning connect needs and their effects on care rather than considering every domain in isolation?
Professional opinions	Who expressed each opinion? Is dissent preserved accurately? Does the final recommendation distinguish agreement from unresolved disagreement?
Final document	Can the final wording and domain levels be traced to supporting evidence? Are material changes identifiable, dated and explained?

An illustrative documentation problem

A care note saying only that a person was settled does not explain what staff did to maintain that state. A fuller account might record the support provided, its frequency, the response and any continuing risks. This example illustrates evidence completeness; it does not establish an eligibility level or imply that the person had an unrecorded need.

When records and family observations differ

An observation from a relative should be attributed, dated where possible and considered alongside other evidence. The reviewer should establish whether the discrepancy reflects different observation periods, intermittent symptoms, incomplete recording or another explanation. Absence of an entry alone cannot resolve which explanation is correct.

3. Implications, limitations and references

Professional expectations [5]

NMC assessor guidance requires nurses to practise within competence, use accurate person-centred assessments, collaborate, record reasons and avoid financial or commercial influence. It also emphasises openness when assumptions prove incorrect. These are benchmarks for practice, not evidence that a breach has occurred.

Suggested assurance priorities

Use case-based supervision to examine reasoning; review whether specialist advice is accessible; audit discrepancies between source records and final recommendations; and track whether complaints lead to specific corrections and learning. These are proposals for assurance, rather than interventions whose effectiveness this report has tested.

Limits of the synthesis

This is a focused update of the retained 8 October evidence note, not an exhaustive search of all studies or regulatory determinations. Historical inquiry findings, abstract-level survey evidence and selected complaints cannot be pooled into a national prevalence estimate. No inference of routine dishonesty or single explanation for geographical variation is made.

References and source status

[1] Parkinson's UK (2016). Discharging older people from acute hospitals. Written evidence ACH0004, section 5. Inquiry findings reported in a parliamentary submission.

<https://committees.parliament.uk/writtenevidence/68157/html/>

[2] Lee G, Hayes N (2020). A survey of nurses involved in assessing the eligibility of older people for NHS continuing healthcare. *Nursing Older People* 32(6):20-26. DOI: 10.7748/nop.2020.e1266. University record and abstract inspected.

<https://kclpure.kcl.ac.uk/portal/en/publications/a-survey-of-nurses-involved-in-assessing-the-eligibility-of-older/>

[3] PHSO (2020). Continuing Healthcare: Getting it right first time. Investigated casework.

<https://www.ombudsman.org.uk/publications/continuing-healthcare-getting-it-right-first-time>

[4] NMC. The NMC and insight. Section: Continuing health care assessments. Regulator account.

<https://www.nmc.org.uk/about-us/nmc-insights/the-nmc-and-insight/>

[5] NMC. Supporting information for nurse assessors. Professional guidance.

<https://www.nmc.org.uk/standards/guidance/supporting-information-for-nurse-assessors/>

Online sources checked 15 October 2026. Suggested citation: Continuing Healthcare: Evidence and Experience. Assessment practice and evidence quality. Independent evidence report. Version 1.0. watkin.care; 2026.

Preparation: source retrieval and drafting used ChatGPT assistance. No external audit or independent academic peer review was undertaken. The project has a family advocacy perspective, disclosed to make the context of interpretation clear.