**Professional Guidance**

This Document should be used for adults of 18 years or older.

Prior to making a decision regarding whether or not to proceed with NHS Continuing Healthcare screening the professional should consider if the patient is subject to a *Mental Health Act Section 117 Aftercare* arrangement.

Responsibility for the provision of section 117 services lies jointly with LAs and the NHS. Where a patient is eligible for services under section 117 these should be provided under section 117 and not under NHS continuing healthcare.

However, a person in receipt of after-care services under section 117 may also have ongoing care/support needs that are not related to their mental disorder and that may, therefore, not fall within the scope of section 117. Also a person may be receiving services under section 117 and then develop separate physical health needs (e.g. through a stroke) which may then trigger the need to consider NHS continuing healthcare only in relation to these separate needs, bearing in mind that NHS continuing healthcare should not be used to meet section 117 needs. Where an individual in receipt of section 117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase, consideration should be given to the use of the Fast Track Pathway Tool.

Before we can undertake the NHS Continuing Healthcare (CHC) assessment, we require a number of consents to proceed. These consents can only be provided by the patient, when they have mental capacity to do so. Part 1 of this form should be used in these circumstances.

The NHS and social services assume that the patient has capacity to decide unless there is clear evidence that they do not. In these situations the person carrying out the assessment has to conduct a Mental Capacity Assessment and if the patient lacks mental capacity to make a decision to proceed with the CHC assessment, the professional must then make a Best Interest Decision to proceed on their behalf. Part 2 of this form should be used in these circumstances.

If a patient, without mental capacity to decide, has a representative who has a valid Lasting Power of Attorney for Health and Welfare or is a Court Appointed Deputy, this representative can make the Best Interest Decision to proceed with the assessment. There are no other circumstances when another person can provide the consents required. Part 3 should be used in these circumstances.

The professional should explain to the patient the consent decisions required and that they may withdraw consent at any time, although this may affect what service the CCG is able to provide.

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| **Our commitment to you**:   * To assess your case in line with the National Framework for NHS Continuing Healthcare and Funded Nursing Care 2012 * To manage your personal information in line with current legislation and guidance * To ensure you are provided with support through care package management and reviews * To work with you to resolve disputes through the appeals and resolutions process * Provide you with information relevant to support your consenting decisions | |
| **To enable us to proceed with your assessment please provide your consent for the following:** | |
| Consent to proceed with a CHC assessment which will be used to inform a decision about your eligibility for NHS CHC services | |
| To access any of your relevant health and social care records from, for example, hospital and community health services, social services, care home or specialist service providers | |
| To permit your GP surgery to share your medical record (hard copy or electronic) with the health and social care professionals involved in your CHC assessment and care | |
| To permit the CCG to add information resulting from the CHC assessment into your GP medical record and for your GP to view this information | |
| Communication of your eligibility decision to those involved in your care | |
| Allowing, if eligible for NHS CHC, for regular reviews to take place and for on-going discussions about the management of your care | |
| Storage of your personal records by the CHC team in accordance with data protection legislation | |
| Consent to share information with your nominated next of kin or a representative if you wish this. Please provide their contact details below | |
| Where there are disputes, sharing your information with colleagues involved in the dispute resolution process outlined in the National Framework for CHC | |
| Where relevant, sharing your information for audit purposes to improve services and provide assurance to NHS England that we are delivering a service in accordance with the National Framework for CHC. This data will be anonymised and will not identify you personally | |
| Please indicate below if there is any health and social care information you do not wish us to access | |
| **Part 1 – CONSENT GIVEN BY A PERSON WHO HAS MENTAL CAPACITY**  Where a patient is unable to consent to the CHC process themselves please go to Part 2 and 3 | |
| Patient’s Permanent Address:  Postcode:  Tel Home/Mob: | Address of Placement (if applicable):  Postcode:  Tel Home/Mob: |
| If you have ticked the box above to nominate a next of kin or other representative to be involved in the assessment and for us to share your information, please provide their contact details | |
| Name of representative: Relationship:  Address: Postcode:  Tel Home/Mob: | |
| I consent to the NHS CHC assessment, care planning and review processes. I am signing to say I have read and understood the information given on page 2 of this document and have completed the consent sections above | |
| Patient Signature:  Date: | |
| **Professional Only**  If the patient has capacity, but is unable to read or write:  If the patient can indicate their consent by making their mark (on the consent form above) this should be encouraged. It is good practice for the mark to be witnessed and to be recorded in the case notes.  Where the patient has capacity but is only able to verbally consent, this must be witnessed by two people:   |  |  |  |  | | --- | --- | --- | --- | | Name | Designation / relation | signature | date | |  |  |  |  | |  |  |  |  | | |

**PART 2 – CONSENT WHEN A PERSON LACKS MENTAL CAPACITY**

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| **Part 2:** For patients where it is felt they are Unable to Consent to the Continuing Healthcare process. All sections must be completed.  This section must be completed by the professional completing the first stage of the CHC Assessment using the CHC Checklist Tool. All parts of this section must be completed before for the assessment can proceed | | |
| **Section 2a**  **Assessment of Capacity** – as per the Mental Capacity Act 2005 | | |
| Does the person have a temporary or permanent impairment or a disturbance in the functioning of the mind or brain?  If ‘Yes’ are they able to understand, retain and weigh up the information and communicate their decision?  If ‘No’ they will lack capacity | Yes/No (Give reasons)  Yes/No (Give reasons) | |
| I have considered whether the person is likely to regain capacity.  If **YES**, can the decision wait until then? If **NO**, is the person likely to regain capacity?  If **YES**, can the decision wait until then? If **NO**, continue with the Best Interest Decision | | |
| **Section 2b**  **Best Interest Decision** | | |
| Are you aware if this person has refused this CHC Assessment process in a Valid Advanced Directive?  Where possible and appropriate have you consulted with other professionals, relevant documentation (e.g. GP notes, care plans, nursing notes) and those close to the person?  Do you believe this process to be in the person’s best interest? | Yes/No (Give reasons)  Yes/No (Give reasons)  Yes/No (Give reasons) | |
| **Section 2c**  **Involvement from family and/or advocate including IMCA** (if appropriate)  It is good practice to consult with those close to the person (e.g. spouse/partner, family or advocate) unless you have good reason to believe that the person would not have wished for particular individuals to be consulted, or unless the urgency of their situation prevents this. | | |
| I confirm I have been involved in the discussion with the relevant professional over the capacity  assessment of …………………………………………………………………………………  I understand that they are unable to give their consent. I also understand the assessment can lawfully be provided if it is in their best interest. | | |
| Name: | | Relationship to person being assessed: |
| Address: | | Signature:  Date: |
| **If you have not liaised with family members or an advocate please state why:** | | |
| **Section 2d**  **Signature of Health or Social Care Professional**  The CHC Assessment process is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for him/herself. Where possible and appropriate I have discussed the patient’s condition with those close to him/her and taken their knowledge of the client’s views and beliefs into account in determining what is in their best interests.  **I have/have not sought a second opinion** | | |
| **Signature:** | | **Designation:** |
| **Print Name:** | | **Date:** |
| **Where a second opinion sought, s/he should sign below to confirm agreement** | | |
| **Signature:** | | **Designation:** |
| **Print Name:** | | **Date:** |

**Part 3 Legal Representative – Decision Maker** (when the patient lacks capacity)

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| Where the representative holds Legal Authorisation – Please note Sections 2a, 2b and 2d must be completed by a **health or social care professional** | | |
| **Source of Legal Authorisation:**  Please tick appropriate box. Please note you may be asked to provide evidence of your legal status  Lasting Power of Attorney for health and  welfare  Deputyship for health and welfare  Guardianship | **For health/social care professionals only** – have you seen the evidence (source of Legal Authorisation)? **Yes/No**  Name:  Signature:  Profession:  Date: | |
| Full Name of Representative: | Relationship to person being assessed: | |
| Address: | Tel Home/Mobile:  Email: | |
| **Legal Representative:**  I **confirm** that I have received information on the Continuing Healthcare Process | | Tick |
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| I **confirm** that it is in the best interests of ……………………………….…….. to have an NHS Continuing Healthcare Checklist/Fast Track Tool/comprehensive assessment completed. | |  |
| I **confirm** that I agree with the principles set out on page 2 and have completed the consents form on page 3 | |  |
| Signature: | | |
| Date: | | |