**NHS CONTINUING HEALTHCARE NEEDS CHECKLIST**

Forclients with a **Northumberland GP** only**.**

**Please note that this checklist will be copied and sent to patients**

**If you have any queries on completion of this form please contact the admin team on 01670629008**

**Please Fax to 01670 629151**

From a secure address only, email to: [nar@northumbria-healthcare.nhs.uk](mailto:nar@northumbria-healthcare.nhs.uk)

Please ensure that the equality monitoring form at the end of this checklist is completed and returned with the checklist.

|  |  |  |
| --- | --- | --- |
| **Patient Details** | | |
| **Name & Address:**  **Postcode:**  **Telephone Number:** | | **Current Location** |
| **DOB:** | **NHS Number:** |  |
| **Referral Date:** |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Designated person(s) completing the checklist**  **Please note – in a care home setting, this must be a Senior Or Nursing member of staff and the Patient’s Care Manager.** | | | | |
| **Name** | **Signature** | **Role** | **Telephone number** | **Organisation** |
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**Please use the guidance to ensure all necessary information is provided as the form cannot be accepted unless it is complete.**

**The timescale to eligibility decision making does not start until this form has been accepted**

|  |  |
| --- | --- |
| **GP Details: This referral will only be accepted if the GP is within Northumberland** | |
| GP and Address | |
| Telephone Number | Consultant |

|  |
| --- |
| **Next of Kin ( Name Address and Telephone Number)** |
| **Section 117/Section 28a: Yes No Not Known** |
| **Are there any communication needs?**  **Eg Interpreter – language/dialect required Sensory Services – please specify?** |

**The Information leaflet is attached as the last two pages of this document. Please detach and give to the relevant person.**

I confirm that the patient and/or representative has been supplied with the CHC information leaflet

Name ……………………………Signature…………………….Designation…………………

I confirm receipt of the CHC information leaflet

Name……………………………Signature………………………………………………

**For easier arranging of the MDT, Who would the patient like to be invited to the meeting?** If unsure, please check with the patient’s representative, or write not known.

|  |  |  |
| --- | --- | --- |
| Name | Address | Telephone Number |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**If the patient has capacity please complete this section, otherwise please go to the next page.**

Do you understand what a CHC checklist is and do you consent to its completion? This may lead to subsequent CHC assessment and review as appropriate. **Yes No**

Do you understand and consent to professionals gathering, and recording information during this assessment processes. This information may be shared with other professionals and relevant organisations. ?

**Yes No**

Signature of Patient ……………………………….

Date …………………………………………………

**Does a relative hold a Lasting Power of Attorney for Welfare?**

**Yes No**

If Yes, Name of relative…………………………………………………………………………………….

Has it been registered?

**Yes No Unknown**

**Decision letters**

I would like to receive a copy of the decision letter  **Yes** **No**

And/or send it to

Patient Signature………………………………………………………………………….

Date ……………………………………………………………………………………......

**If the patient does not have capacity please complete the following section**

Re: Giving consent for an NHS CHC checklist and assessment, including the gathering, recording and sharing of information with professionals and organisations.

………………………………. is experiencing ………………………..which I believe represents an impairment of, or a disturbance in the functioning of their mind or brain.

I consider that as a result of this impairment or disturbance s/he is unable to :

Choose one or more

* Understand the information relevant to giving consent **Yes/No**
* Retain the information relevant to giving consent **Yes/No**
* Use or weight the information relevant to giving consent **Yes/No**
* Communicate their decision to consent **Yes/No**

I therefore consider …………………….. at this time, as being incapacitated to give informed consent in relation to the undertaking of an NHS CHC Checklist and Assessment

I have discussed undertaking this assessment with:

Name /Relationship/ Designation

……………………………………………………………………………………………………………………………………………………………………………………………………

We concur that it would be in ………………………………. best interests to undertake an NHS CHC Checklist and Assessment in order that a full and comprehensive understanding of their health care needs is established. This includes the gathering, and recording information during this assessment processes. This information may be shared with other professionals and relevant organisations

Name………………………………… Signature…………………………….

Date ………………………………….

**Past and Current Medical History – This must be completed for the referral to be accepted**

**Medication – This must be completed for the referral to be accepted**

|  |  |
| --- | --- |
| **Is the patient aware of the Diagnosis/ Prognosis?** | **Yes/No** |

**Is there anyone, involved in the care of the patient, and not represented at the meeting, that we need to contact for further information, to complete the CHC Assessment in a timely manner? E.g. other services.**

**Please compare the descriptions of the level of need to the needs of the individual and select level A, B or C as appropriate for each domain. Consider all the descriptions and select the one that most closely matches the individual. If the needs of the individual are the same or greater than anything in the A column, then “A” should be selected.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Behaviour\*** | | | | |
| C | | B | A | **Level Chosen/**  **Evidence if required** |
| No evidence of ‘challenging’ behaviour.  **OR**  Some incidents of ‘challenging’ behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care. | | ‘Challenging’ behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care. | ‘Challenging’ behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions. |  |
| **Cognition** | | | |
| C | | B | A | **Level Chosen/**  **Evidence if required** |
| No evidence of impairment, confusion or disorientation.  **OR**  Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident.  **OR**  Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment. | | Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident.  The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration. | Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues, they are unable to do so on most issues, even with supervision, prompting or assistance.  The individual finds it difficult, even with supervision, prompting or assistance, to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Psychological/Emotional** | | | |
| C | B | A | **Level Chosen/**  **Evidence if required** |
| Psychological and emotional needs are not having an impact on their health and well-being.  **OR**  Mood disturbance or anxiety or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance.  **OR**  Requires prompts to motivate self towards activity and to engage in care planning, support and/or daily activities. | Mood disturbance or anxiety symptoms or periods of distress which do not readily respond to prompts and reassurance and have an increasing impact on the individual’s health and/or well-being.  **OR**  Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in support, care planning and/or daily activities. | Mood disturbance or anxiety symptoms or periods of distress that have a severe impact on the individual’s health and/or well-being.  **OR**  Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and daily activities. |  |
| **Communication** | | | |
| C | B | A | **Level Chosen/**  **Evidence if required** |
| Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.  **OR**  Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing. | Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual. | Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Mobility** | | | |
| C | B | A | **Level Chosen/**  **Evidence if required** |
| Independently mobile.  **OR**  Able to weight bear but needs some assistance and/or requires mobility equipment for daily living. | Not able to consistently weight bear.  **OR**  Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning.  **OR**  In one position (bed or chair) for majority of the time but is able to cooperate and assist carers or care workers.  OR  At moderate risk of falls (as evidenced in a falls history or risk assessment) | Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning.  **OR**  Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate.  **OR**  At a high risk of falls (as evidenced in a falls history and risk assessment).  **OR**  Involuntary spasms or contractures placing the individual or others at risk. |  |
| **Nutrition** | | | |
| C | B | A | **Level Chosen/**  **Evidence if required** |
| Able to take adequate food and drink by mouth to meet all nutritional requirements.  **OR**  Needs supervision, prompting with meals, or may need feeding and/or a special diet.  **OR**  Able to take food and drink by mouth but requires additional/supplementary feeding. | Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed.  **OR**  Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG. | Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway.  **OR**  Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers.  **OR**  Nutritional status ‘at risk’ and may be associated with unintended, significant weight loss.  **OR**  Significant weight loss or gain due to an identified eating disorder.  **OR**  Problems relating to a feeding device (e.g. PEG) that require skilled assessment and review. |  |

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| --- | --- | --- | --- | --- |
| **Continence** | | | | |
| C | | B | A | **Level Chosen/**  **Evidence if required** | |
| Continent of urine and faeces.  **OR**  Continence care is routine on a day-to-day basis.  **OR**  Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc.  **AND**  Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation. | | Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation. | Continence care is problematic and requires timely and skilled intervention, beyond routine care. (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation). |  | |
| **Skin integrity** | | | | |
| C | | B | A | | **Level Chosen/**  **Evidence if required** |
| No risk of pressure damage or skin condition.  **OR**  Risk of skin breakdown which requires preventative intervention once a day or less than daily, without which skin integrity would break down.  **OR**  Evidence of pressure damage and/or pressure ulcer(s) either with ‘discolouration of intact skin’ or a minor wound.  **OR**  A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment. | | Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down.  **OR**  Pressure damage or open wound(s), pressure ulcer(s) with ‘partial thickness skin loss involving epidermis and/or dermis’, which is responding to treatment.  **OR**  A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment. | Pressure damage or open wound(s), pressure ulcer(s) with ‘partial thickness skin loss involving epidermis and/or dermis’, which is not responding to treatment.  **OR**  Pressure damage or open wound(s), pressure ulcer(s) with ‘full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule’, which is responding to treatment.  **OR**  Specialist dressing regime in place which is responding to treatment. | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Breathing\*** | | | |
| C | B | A | **Level Chosen/**  **Evidence if required** |
| Normal breathing, no issues with shortness of breath.  **OR**  Shortness of breath, which may require the use of inhalers or a nebuliser and has no impact on daily living activities.  **OR**  Episodes of breathlessness that readily respond to management and have no impact on daily living activities. | Shortness of breath, which may require the use of inhalers or a nebuliser and limit some daily living activities.  **OR**  Episodes of breathlessness that do not respond to management and limit some daily activities.  **OR**  Requires any of the following:   * low level oxygen therapy (24%); * room air ventilators via a facial or nasal mask;   other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep. | Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers.  **OR**  Breathlessness due to a condition which is not responding to therapeutic treatment and limits all daily living activities.   * **OR**   A condition that requires management by a non-invasive device to both stimulate and maintain breathing (non-invasive positive airway pressure, or non-invasive ventilation) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **\* Drug therapies and medication: symptom control\*** | | | |
| C | B | A | **Level Chosen/**  **Evidence if required** |
| Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.  **OR**  Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime.  **OR**  Mild pain that is predictable and/or is associated with certain activities of daily living; pain and other symptoms do not have an impact on the provision of care. | Requires the administration of medication (by a registered nurse, carer or care worker) due to:  – non-concordance or non-compliance, or  – type of medication (for example insulin); or  – route of medication (for example PEG).  **OR**  Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care. | Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage.  **OR**  Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care. |  |
| **\* Altered states of consciousness\*** | | | |
| C | B | A | **Level Chosen/**  **Evidence if required** |
| No evidence of altered states of consciousness (ASC).  **OR**  History of ASC but effectively managed and there is a low risk of harm. | Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. | Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.  **OR**  Occasional ASCs that require skilled intervention to reduce the risk of harm. |  |

|  |  |  |
| --- | --- | --- |
| **\* total from all pages** | | |
| C | B | A |
|  |  |  |

A full assessment for NHS Continuing Healthcare is required if there are:

* Two or more domains selected in column A
* Five or more domains selected in column B,
* one selected in A and four in B
* one domains selected in column A in one of the boxes marked with an asterisk (i.e. those domains that carry a priority level in the Decision Support Tool) with any number of selections in the other two columns.

Please choose **One only**

1. Referral for full assessment for NHS continuing healthcare is necessary
2. No referral for full assessment for NHS continuing healthcare is necessary
3. Does not meet the checklist criteria but due to the following rationale may require a full assessment.

If **3** has been chosen, please complete the rationale for the decision here:

**Clinical Recommendation for nursing placement** **(if appropriate). This** **must** **be an MDT decision and be evidenced. State briefly reason for recommendation for nursing care:**

**Name & Signature of NHS Clinician** ………………………………….

**List of MDT Members**: ……………………………………………………………………….

………………………………………………………………………………………………….

**Please copy this checklist and give a copy to the client/ appropriate person**

**About You**

Please provide us with some information about yourself. This will help us to understand whether everyone is receiving fair and equal access to NHS continuing healthcare. All the information you provide will be kept completely confidential by the Clinical Commissioning Group. No identifiable information about you will be passed on to any other bodies, members of the public or press.

1 What is your sex? Tick one box only.

4 What is your ethnic group?

Tick one box only.

|  |  |  |  |
| --- | --- | --- | --- |
| **A White** | | | |
| British |  |  | |
| Irish |  |  | |
| Any other White background, write below | | | |
|  | | | |
| **B Mixed** | | | | | |
| White and Black Caribbean | | |  | |  |
| White and Black African | | |  | |  |
| White and Asian | | |  | |  |
| Any other Mixed background, write below | | | | | |
|  | | | | | |
| **C Asian, or Asian British** | | | | | |
| Indian | | |  | |  |
| Pakistani | | |  | |  |
| Bangladeshi | | |  | |  |
| Any other Asian background, write below | | | | | |
|  | | | | | |
| **D Black, or Black British** | | | | | |
| Caribbean | | |  | |  |
| African | | |  | |  |
| Any other Black background, write below | | | | | |
|  | | | | | |
| **E Chinese, or other ethnic group** | | | | | |
| Chinese | | |  | |  |
| Any other, write below | | | | | |
|  | | | | | |

|  |  |
| --- | --- |
| Male |  |
| Female |  |
| Transgender |  |

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2 Which age group applies to you?

Tick one box only.

|  |  |
| --- | --- |
| 0-15 |  |
| 16-24 |  |
| 25-34 |  |
| 35-44 |  |
| 45-54 |  |
| 55-64 |  |
| 65-74 |  |
| 75-84 |  |
| 85+ |  |
|  |  |

3 Do you have a disability as defined by the Disability Discrimination Act (DDA)?

Tick one box only.

The Disability Discrimination Act (DDA) defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

|  |  |
| --- | --- |
| Yes |  |
| No |  |

5What is your religion or belief?

Tick one box only.

Christian includes Church of Wales, Catholic,

Protestant and all other Christian

denominations.

|  |  |
| --- | --- |
| None |  |
| Christian |  |
| Buddhist |  |
| Hindu |  |
| Jewish |  |
| Muslim |  |
| Sikh |  |
| Other, write below | | |
|  | | |

6 Which of the following best describes your

sexual orientation?

Tick one box only.

Only answer this question if you are aged **16**

years or over.

|  |  |
| --- | --- |
| Heterosexual / Straight |  |
| Lesbian / Gay Woman |  |
| Gay Man |  |
| Bisexual |  |
| Prefer not to answer |  |
| Other, write below | | |
|  | | |

# Information sheet S9 – NHS Continuing Health Care (CHC)

If you need support with your daily life because of a disability or illness, you may be eligible either for “social care” support, which is funded under arrangements made by Northumberland County Council, or for NHS Continuing Health Care (NHS CHC) funded by the NHS. In Northumberland, these two kinds of arrangement are both managed in the same way through a partnership between the NHS and the County Council. This makes it easier to ensure that people have continuity of support arrangements if their needs change either from social care to NHS CHC or vice versa.

Support funded through NHS CHC may involve similar services to social care support, including personal care in your own home or accommodation in a care home. One important difference is that there are no charges for NHS CHC, whereas most people have to make a financial contribution towards the cost of social care support (depending on their means).

You will only be eligible for NHS CHC if you have a “primary health need”. The Department of Health has published a booklet explaining how decisions are made about whether someone has a “primary health need”, based on the nature, complexity, intensity and unpredictability of their care needs. You can ask your care manager for a copy, or if you have access to the internet you can find it at www.tinyurl.com/CHCbooklet2013.

**How do I find out if I might be eligible for NHS CHC?**

If you are in hospital, and it becomes clear that you will need longer-term support after your discharge, or if you have support arranged by a care manager, the professionals working with you should consider whether you need an NHS CHC assessment. If you think that you might be eligible, but you are not sure whether this has been considered, please ask. If your care needs are fairly straightforward, they may tell you that you are not likely to be eligible, though you do still if you wish have a right to ask for an “NHS CHC checklist” to be completed to confirm whether there is a need to complete a full assessment of your needs.

If an NHS CHC checklist indicates that a full assessment is called for, a specialist nurse will consult all the health and social care professionals who are working with you and complete a “Decision Support Tool”. A recommendation on your eligibility for NHS CHC will then be made to Northumberland Clinical Commissioning Group (CCG) and a panel led by the CCG will then consider whether you are eligible. We will let you know in writing what decision the panel has made.

**What if I think the decision is wrong?**

The specialist nurse who coordinates your assessment should discuss the information with you before the Decision Support Tool is submitted, so usually the recommendation and decision should not be a surprise. However if you think something has gone wrong, please contact our Complaints Team, by phoning (01670) 62 88 88, or by writing to:

CHC Complaints, FREEPOST RLTX-LBXU-SHBS, County Hall, Morpeth, NE61 2EF  
Email: [CHCcomplaints@northumbria.nhs.uk](mailto:CHCcomplaints@northumbria.nhs.uk)

If you are still not happy with our response, we can let you know how to contact NHS England to ask for an independent review of the decision.

**What support will I get if I am eligible for NHS CHC?**

As with social care, we will aim to make sure that you have all the support which you need to protect your health, safety and dignity. If you become eligible for NHS CHC after previously being eligible for social care (or vice versa), we will make decisions about the *level* of support which you need in essentially the same way, though some of the *kinds* of support which you need may well be different (for instance some of your support may have to be provided by qualified health professionals).

Whether your support is funded as social care or as NHS CHC, we will aim to give you as much choice and control as possible over how it is provided. However we are only able to fund support which is necessary to meet your assessed needs, and we do have to consider the requirement to make efficient use of public resources.

**How much of my support will be funded by NHS CHC?**

If you are assessed as eligible for NHS CHC, all of the support that you need will be paid for by the NHS, including support such as home care or care home fees which could otherwise have been provided as social care.

When people who are *not* assessed as eligible for NHS CHC have a level of needs which is close to the level where NHS CHC would be approved, we sometimes agree a shared arrangement, in which part of the cost of your support will be paid for by the NHS and part by the County Council. In this case, you may have to contribute part (or all) of the cost of the social care support yourself, depending on your financial means.

**When might my eligibility for NHS CHC change?**

Whether your support is funded as social care or as NHS CHC, we will aim to review your needs and support arrangements at least every twelve months, and if there is a significant change in your needs we will carry out a review sooner than that.

Each time we review your needs, we will consider again whether you may be eligible for NHS CHC, or if your support is already funded as NHS CHC, whether you are still eligible. If we think your eligibility may have changed, we will go through the same process that is described above, to make sure that our decision takes account of all relevant issues.

**Can I arrange my own support with a direct payment?**

Yes. Where safety and quality can be assured, you can make support arrangements yourself using a direct payment paid into an account which you manage. This includes any additional support from health professionals which you have been assessed as needing as part of your NHS CHC plan, over and above what is routinely offered by the NHS. As with direct payments for social care, in order to make direct payments for NHS CHC we will first need to agree a support plan with you, setting out how you will use the money to meet your assessed needs in a safe and effective way.

Information sheet S9 –NHS Continuing Health Care (CHC)