

Please complete this form as fully as possible.
Your comments contribute towards compliance with requirements under the National Framework, Mental Capacity Act 2005 and Data Protection regulations.



NHS Continuing Healthcare Consent Form

West Hampshire Clinical Commissioning Group (CCG) hosts the NHS Continuing Healthcare Service on behalf of Fareham and Gosport, South Eastern Hampshire, North Hampshire and North East Hampshire and Farnham CCGs. West Hampshire CCG will process information about your screening and assessment and may share your information with the relevant CCG to which your GP Practice is a member of to:

- a) Determine eligibility for NHS Continuing Healthcare (CHC)¹ or NHS Funded Nursing Care (FNC)
- b) Assist in care and support planning (whether or not eligible for CHC or FNC)

Surname/family name (of individual being assessed).....

First Names

Date of birth

NHS number (or other identifier)... ..

Responsible professional² Name:.....

Job title

Organisation.....

Contact Details for responsible professional

Telephone.....

Email

Date form completed.....

This section MUST BE completed for the application for FNC to be processed.

To be retained in individual's records/notes

¹ 'determine eligibility' includes resolving any dispute regarding eligibility at local level or, where necessary, at an Independent Review Panel held by NHS England.

² In this context the 'responsible professional' means the professional who is responsible for obtaining consent, normally at Checklist stage. Since the Checklist can be completed by a range of professionals any of these could be the 'responsible professional' in terms of gaining consent.

All sections to be completed by the responsible professional

This form relates to consent to completion of the NHS Continuing Healthcare Checklist (screening tool), the completion of a full assessment for NHS Continuing Healthcare, and the sharing of personal health and social care information in order to:

- a) Determine eligibility for NHS Continuing Healthcare (CHC)³ or NHS Funded Nursing Care (FNC)
- b) Assist in care and support planning (whether or not eligible for CHC or FNC)

All information being gathered, collated and shared as part of the NHS Continuing Healthcare Process may be shared with:

- Relevant staff within the CCG that will fund my care (if I am eligible)
- Relevant staff within Adult Social Care Services
- Any outsourced provider contracted by the CCG
- Services that support the NHS Continuing Healthcare process such as the finance and quality teams
- Service Providers who contribute to my care and any agencies acting on their behalf
- Independent Review Panel at NHS England/Parliamentary and Health Service Ombudsman (PHSO) for the preparation of case files i.e. part of any future Disputes Resolution or Appeals Process
- Relevant staff within NHS South of England Procurement Services (SoEPS) to procure and negotiate a competitive contract for the service user.
- Relevant family members as identified on this form

Does the individual have any communication difficulties that may impact upon their ability to consent? Yes

If yes how have these been addressed?

N.B. Under the Mental Capacity Act a person must be assumed to have capacity unless it is established that they lack capacity and a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.

³ 'determine eligibility' includes resolving any dispute regarding eligibility at local level or, where necessary, at an Independent Review Panel held by NHS England.

Assessment of Individual's Mental Capacity

Mental capacity should be assessed at the time the decision needs to be made.

In your judgement does the individual have the mental capacity to give consent, bearing in mind that mental capacity is always decision specific and time specific?

Yes/No

If yes – Please complete **Part 1** only

If no – Please complete **Part 2** only

PART 1- Consent for individuals

Statement from responsible professional

This section should be fully completed if the responsible professional believes the individual has capacity to consent. If the individual has capacity to consent, only part one should be completed.

I have explained the process and purpose of the CHC assessment

I have advised the individual how their health and social care information may be used and that it will be shared for this assessment process with a number of different health and social care professionals as detail on page 2.

I have explained that if the Checklist indicates that a full CHC assessment is required, this does not mean they will necessarily be found eligible for CHC.

Has the individual been given a copy of the *NHS Continuing Healthcare and NHS-funded nursing care Public Information Booklet*?

Yes/No

If No, does a copy need to be sent?

Comment:

The individual has given consent but is physically unable to sign the form on the next page for the following reasons

Signed Date

Name (Print)

Profession/Job Title:

.....

Statement from Individual:

Please read this carefully (or ask someone to read it to you) and tick/confirm those statements in sections (a) and (b) that you agree with. You have the right to change your mind or withdraw your consent at any time.

Statement of Consent:

(a) Consent to CHC assessment process:

I consent to the NHS Continuing Healthcare (CHC) assessment as explained to me, and detailed in this form including the sharing of information about me between professionals involved.

OR

I **do not** consent to the CHC assessment process and understand that this means I cannot be considered for CHC eligibility and this may affect the ability of the NHS and Local Authority to provide appropriate services to meet my needs.

(b) Consent to share information related to the CHC assessment process:

I consent to any relevant family/friend(s)/advocates being involved in my assessment as considered appropriate by the professionals involved and understand that my personal health and social care information may be shared with them for the purposes of this assessment.

OR

I limit my consent to the following specific family/friend(s)/advocate being involved in my assessment and understand that my personal health and social care information may be shared with them for the purposes of this assessment.

Name	Relationship	Contact Tel

OR

I do not consent to any family/friends/advocate being involved in my assessment nor to my personal health and social care information being shared with them.

Individual's SignatureDate

Individual's Name (PRINT)

N.B. If the individual has given consent but is physically unable to sign the form please confirm and give reason on page 4 above.

This section must be completed if the responsible professional believes the individual lacks capacity to consent.

PART 2- Record of Mental Capacity and Best Interest Decision

(This section should only be completed for Individuals that lack the mental capacity to consent)

Name of person completing the mental capacity assessment

Job title

Date of assessment.....

Before deciding that the individual lacks mental capacity to consent you should consider:
a) Whether the individual might regain or acquire capacity to consent in the future and, if so,
b) Whether the NHS Continuing Healthcare (CHC) assessment process can be delayed until they are able to give consent.

The 2nd principle of the Mental Capacity Act states that:
'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success'

Describe what steps have been taken to enable the person to make the decision themselves (e.g. use of interpreter or communication aids, ensuring they have all the relevant information in an accessible form, considering times of day when their ability to understand is better, treating a medical condition which may be affecting their mental capacity, involving someone who knows them etc.)

Mental Capacity Assessment

On the date given above and in relation to the decision whether or not to give consent to CHC assessment and sharing information:

1. Is the person able to understand the information relevant to the decision?
(I.e. were you satisfied that the person could understand the nature of the decision, why the decision needed to be made at the time and whether they could understand the likely effects of deciding one way or another or making no decision at all?)

Yes No

Please give reasons:

2. Is the person able to retain the information long enough to use it to make the decision? *(I.e. long enough to complete the decision-making process, including making and communicating their decision. Consideration should be given to the use of notebooks, photographs, videos, voice recorders, posters etc. to help the person record and retain the information)*

Yes No

Please give reasons:

3. Is the person able to use or weigh up this information as part of the decision making process? *(E.g. to consider the consequences, benefits and risks, of making the decision one way or another or making no decision at all? Understand the pros and cons)*

Yes No

Please give reasons:

4. Is the person able to communicate their decision? *(Verbally, using sign language or by any other means?)*

Yes No

Please explain how the decision was communicated or give reasons if answer is 'NO':

*In order to establish that someone does not have the mental capacity to make a particular decision the responsible professional must have a **reasonable belief** (i.e. on the balance of probabilities) that they lack mental capacity. If the answer is 'YES' to **all** the above questions, the person must be assessed to have the mental capacity to make the decision themselves.*

*An answer of 'NO' to **any one** of the above four questions indicates that the person lacks mental capacity to make the decision in question if the reason for this is because they have an impairment or a disturbance in the functioning of their mind or brain.*

5. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?⁴

Yes No

Please state the nature of the impairment (e.g. dementia, acquired brain injury, learning disability, acute confusional state, short-term memory loss, concussion, symptoms of drug / alcohol use) and the basis of this information (e.g. recent clinical assessments, established diagnosis etc.)

6. How does the impairment (if any) impact the person's decision-making ability at this time, for this decision?

⁴ In the case PC & Anor v City of York Council (2013) EWCA Civ 478 it was clarified that it is important to assess whether the person is able to make the decision in question before considering whether they have an impairment of the mind or brain.

Assessment

Based on the above information, my judgement is that,

..... (Name of person being assessed)

Does/Does not have the mental capacity (delete as appropriate)
to make a decision regarding consent to the NHS Continuing Healthcare assessment
process and the sharing of information in order for this assessment to take place.

Name of Responsible Professional (Print name)

Signature

Job Title:

This section must be completed by
the person undertaking the
capacity assessment and a
signature is required.

If the person is assessed to have capacity, the responsible professional should go back and complete part one.

Best Interests Decision

If the individual lacks mental capacity to consent, a best interest decision for valid consent must be made on their behalf.

(A) Where there is an appointed decision-maker

Has either of the following been appointed?

Decision-maker (for valid consent)	Yes	No	Name and Contact Details	* Original document seen?
Someone with a Registered Lasting Power of Attorney (Health and Welfare)				
Court appointed Deputy (Health and Welfare)				

Either of the above have been appointed and therefore must be valid consent authority.

Please note the original document can sign as appointed decision-maker.

Valid consent authority

The best interest decision relating to this consent form can only be accepted by POA or deputyship for Health and Welfare

FULL CONTACT details must be added in this section.

You must check and confirm that you have seen the original documentation. We do not require a copy to be sent with the application.

If POA documentation is not available, you can check details with the Office of the Public Guardian:
<https://www.gov.uk/government/publications/search-public-guardian-registers>

If you cannot confirm POA details, please provide an explanation and proceed to part B, best interest decision.

If No, please state reason why consent declined and continue to complete this form. Please note: the signature of the responsible professional should be added at the end of the form, not at this section which is for the appointed decision-maker

Name of appointed decision-maker.....

This section **MUST** be signed by the Health and Welfare POA or Deputy as identified decision maker.

Signature of appointed decision-makerDate

If you are unable to obtain consent from the POA or they are unable to sign (e.g. they live abroad or do not visit often) then you are able to proceed to part B best interest decision. Please add comments to explain why best interest applies.

In accordance with the Mental Capacity Act (MCA), you must make every attempt to contact the Health and Welfare POA/Deputy to discuss.

See MCA code of practice 2007.

CHC Name.....

MHC No.....

DOB.....

The Mental Capacity Act requires that all involved must comply with the MCA 2005 Code of Practice 2007.

In the event of consent being declined by the persons appointed decision-maker, please let them know you are required to discuss their decision and next steps towards compliance with the National Framework (National Framework: National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care, revised 2012) with CHC Line Management.

Please continue with CHC assessment process. According to the terms of the National Framework, the expectation is that it will be in the individual's best interest to have an assessment for CHC and for information about their health and welfare to be shared for this purpose.

Please give details regarding your discussion with the person's appointed decision-maker and line management

Appointed decision maker:

Line management:

(B) Where there is NOT an appointed decision-maker

If the individual lacks mental capacity and there is no-one with an LPA or a Deputy with the relevant authority (i.e. to make health and welfare decisions), a best interest decision must be made by the responsible professional

The Mental Capacity Act requires the responsible professional to be the best interest decision maker and consult with family/friends before making a best interest decision. However, as noted in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, the expectation is that it will be in an individual's best interest to have an assessment for CHC/FNC and for information about their health and welfare to be shared for this purpose. Please give details regarding any consultation you have made with family/friends and the outcome of this.

Best Interest Decision Outcome

Is it in the individual's best interest to be assessed for NHS CHC and for information about their health and welfare to be shared for this purpose?

Yes No

Please state the reasons for best interest decision.

Information Sharing where an LPA / Court Order – health & welfare not confirmed/ or in place, compliance with the MCA requires information is shared appropriately and proportionately in the individuals best interest⁵

Please provide details of who should receive details regarding the outcome decision

Name	Address	Relationship
<i>* Delete as applicable</i>		
Outcome decision	Checklist	Decision Support Tool
		Panel notes

This information can be shared with the named person for 6 months from the date of this form under best interest decision to enable appeals process if required.

Is there any written evidence that the client does not wish this information to be shared with any individual?

Yes No

(If yes, provide details below)

Details:

Is a referral required to The IMCA Service?

Yes No

⁵ Mental capacity act 2005 section 4(7)

Please Note:

If the person has no-one else to support them in the CHC assessment process and the outcome of the assessment process could result in a best interest decision being made regarding changes to their place of residence, support and representation should be made on their behalf by an Independent Mental Capacity Act Advocate (IMCA) a referral should be made to the local IMCA Service (this refers to the role of an IMCA under Section 35 of the Mental Capacity Act and is not the same as an ordinary advocacy service).

Signature of Responsible Professional

.....
Name
.....

This section must be signed by the responsible professional involved in making the best interest decision (either with or without an appointed decision maker)