**Continuing Healthcare Consent Form**

**Part A** – MUST be completed for all patients

**Part B** - Complete if individual has mental capacity

**Part C** – Complete if individual **does not** have mental capacity

***All sections to be completed by the responsible professional***

**Part A.**

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| **Personal Details of individual being assessed** |
| **Personal Details of Responsible Professional**  |
| Name of professional: |  | Job Title: |  |
| Email address: |  | Telephone number: |  |
| Organisation name: |  | Consent form completion date: |  |

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:

1. determine eligibility for NHS Continuing Healthcare (CHC)
2. assist in care and support planning (whether or not eligible for CHC)

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| 1. | Does the individual have any communication difficulties that may impact upon their ability to consent?*If yes please provide details of how these have been addressed below.* | Yes / No(*Please delete as appropriate*) |
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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.

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| **Assessment of individual’s Mental Capacity***Mental capacity should be assessed at the time the decision needs to be made.* |
| 2. | 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?***If yes please complete Part B*** ***If no please complete Part C*** | Yes / No(*Please delete as appropriate*) |
| 3. | Is this patient subject to Section 117 (MHA 1983) | Yes / No(*Please delete as appropriate*) |

**Part B – Consent for individuals that have mental capacity**

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| **Statement from responsible professional** |
| A1. | I have explained the process and purpose of the CHC assessment | X(*Please indicate positively*) |
| A2. | 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 | (*Please indicate positively*) |
| A3. | 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. | (*Please indicate positively*) |
| A4. | Has the individual been given a copy of the *NHS Continuing Healthcare and NHS-funded Nursing Care Public Information Leaflet?* | Yes / No(*Please delete as appropriate*) |
| A5. | Has the patient given consent but is physically unable to sign the form on the next page? *If yes please provide reasons below.* | Yes / No(*Please delete as appropriate*) |
|  |
| Responsible professional name *(PRINT)*: |  | Responsible professional signature: |  |
| Responsible professional Designation: |  | Date: |  |

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| **Statement from Individual**Please read this carefully (or ask someone to read it to you) and tick/confirm those statements below that you agree with. You have the right to change your mind or withdraw your consent at any time. |
| A6. | **Statement of Consent***(Please select one of the following statements by deleting as appropriate or circling option of choice)* | I consent to the NHS Continuing Healthcare (CHC) assessment as explained to me, including the sharing of information about me between professionals involved.*(This may include Adult Social Services, GP, Clinical Commissioning Groups, Continuing Healthcare Teams, Financial and Quality Teams, this list is not exhaustive)* **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. (*Please delete as appropriate*) |
| A7. | **Statement of Consent regarding representatives***(Please select one of the following statements by deleting as appropriate or circling option of choice)* | 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. *Please list family/friend(s)/advocate in the space provided below***OR**I **do not** consent to any family/friend(s)/advocate being involved in my assessment nor to my personal health and social care information being shared with them.*Please list family/friend(s)/advocate in the space provided below* |
| **Name**  | **Relationship** | **Contact telephone number & address** |
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| Individual’s name *(PRINT)*: | Mr Allert is mostly sleepy and he gave verbal consent.  |
| Individual’s signature: | Verbal consent.  | Date: |  |

N.B. If the individual has given consent but is physically unable to sign the form please confirm and give reason in section A5 above.

**Part C – Record of Mental Capacity Assessment and Best
Interest Decision**

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

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| **Assessment** |
| Based on the above information, my judgement is that, ………………………………. (Name of Individual assessed) does not have the mental capacityto 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 Assessor:  |  | Assessor signature: |  |
| Assessor Job Title: |  | Date of assessment: |  |

Before deciding that the individual lacks mental capacity to consent you should consider:

1. whether the Individual might regain or acquire capacity to consent in the future and, if so,
2. 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 or her to do so have been taken without success’*

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| 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.*)*: |
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| **Mental Capacity Assessment**On the date given above and in relation to the decision whether or not to give consent to a CHC assessment and sharing information: |
| B1. | Is the Individual 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?)Please give reasons below: | Yes / No(*Please delete as appropriate*) |
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| B2. | Is the Individual 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 Individual record and retain the information)Please give reasons below: | Yes / No(*Please delete as appropriate*) |
|  |
| B3. | Is the Individual 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)Please give reasons below: | Yes / No(*Please delete as appropriate*) |
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| B4. | Is the Individual able to communicate their decision? (Verbally, using sign language or by any other means?)Please explain below how the decision was communicated or give reasons if answer is ‘No’ | Yes / No(*Please delete as appropriate*) |
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In order to establish that someone does not have the mental capacity to make a particular decision the assessor 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.

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| B5. | Does the Individual have an impairment of, or a disturbance in the functioning of, their mind or brain?Please state below 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.) | Yes / No(*Please delete as appropriate*) |
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| **Permissions**If the individual lacks mental capacity to consent have either of the following been appointed?**If so please ensure an original or certified copy of this document is provided to the CHC Team.** |
| **Document** | **Yes** | **No**  | **Contact Details** |
| Someone with a Registered Lasting Power of Attorney for Health and Welfare (LPA) |  |  |  |
| Court appointed Deputy (Health and Welfare) |  |  |  |

Either of the above has the authority to give or decline consent on behalf of the individual and therefore must be consulted and their decision respected and recorded.

**BEST INTEREST DECISION ( NO POA OR DEPUTYSHIP)**

If none of the above is identified, state who is responsible for making the best interest decision on behalf of the patient.

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| **Best Interest Decision** | **Yes** | **No**  | **Contact Details** | **Signature** |
| Nominated Family member or friend to decide on the assessment and sharing of information in patient’s best interest.  |  |  |  |  |
| Lead Coordinator to make a “welfare decision” in the patient’s best interest.  |  |  |  |  |
| Comments |  |  |  |  |