



Llywodraeth Cymru
Welsh Government

Continuing NHS Healthcare

Decision Support Tool for Practitioners' use only

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Foreword

1. The Decision Support Tool (DST) is a national tool to support practitioners in the application of the *National Framework for the Implementation of NHS Continuing Healthcare in Wales (2021) (2021 Framework)*.
2. The DST must only be used in conjunction with the guidance in the 2021 Framework. It brings together information from the assessment of needs and applying evidence in a single practical format to facilitate consistent evidence-based recommendations and decision making regarding eligibility for NHS Continuing Healthcare (CHC) in Wales. All staff using the DST should be familiar with the Framework's underpinning principles and have received appropriate training.
3. No assessment tool will be perfect and for that reason it is important that the DST is used in context. It cannot and should not replace professional judgement on whether the totality of an individual's needs demonstrate the four key characteristics of a primary health need. It simply supports multi-disciplinary teams (MDTs) to demonstrate that they have implemented a rational and consistent approach to their decision-making.
4. Information on CHC can be located on the [Welsh Government's webpages](#).

Note: This document is intended to be as clear and accessible as possible for individuals having an assessment for CHC, and/or their representative(s) who may be their family members or carers or any other representative an individual chooses to support them. However, in order to be medically accurate some words are used that may not be immediately understandable to someone who is not professionally trained. The Care Co-ordinator must ensure that the individual and/or their representative, (where consent is given), understands and agrees to what has been written about their assessed needs and that advocacy support is offered.

The NHS Continuing Healthcare Booklet for Individuals, Families and Carers has been developed to provide individuals with advice, information and a step by step guide to the CHC process. The Care Co-ordinator must ensure that individuals are provided with this booklet at the beginning of the CHC assessment process. The booklet is available on the [Welsh Government's webpages](#).

The DST is a national tool, and content should not be changed, added to or abbreviated in any way. However, Local Health Boards may attach their logo and additional patient identification details if necessary (e.g. adding NHS number, etc).

VERSION CONTROL: VERSION 2 PUBLISHED MARCH 2022

Minor amendments to ensure consistency in Domain names and amend text for the description of Cognition Domain – High Level of need.

User Notes

Practitioners must be fully aware of the 2021 Framework's underpinning principles prior to undertaking a CHC assessment.

UNDERPINNING PRINCIPLES

Principle 1: People first

Individuals who turn to health and social care providers when they have complex needs have to know and experience that their best interests and rights are the primary focus of the people assessing, making decisions and supporting them. The focus will be manifested in the dignity and respect shown to them as individuals. Individuals who have a primary health need are entitled to CHC funding. They should therefore feel supported throughout the process of determination of eligibility and be confident that they will receive the quality of care required to meet their needs.

Principle 2: Integrity of decision-making

Members of the Multi-disciplinary Team (MDT) (**further information at Section 2 of the 2021 Framework**) are responsible for the integrity of their assessments, expert professional advice and decisions which should be underpinned with a clear rationale. Recommendations on eligibility made by the MDT can only be challenged at the quality assurance stage in exceptional circumstances, and for clearly articulated reasons. This process should not be used as a gate-keeping function or for financial control. A decision not to accept the MDT's recommendation should never be made by one person acting unilaterally. The final eligibility decision should be independent of budgetary constraints, and finance officers should not be part of the decision making process.

Principle 3: No decisions about me without me

Individuals are the experts in their own lives. Including them and/or their carers (be they paid or unpaid) as empowered co-producers in the assessment and care planning process is not an optional extra. They must be invited to attend and fully participate in any assessment of their care and support needs. Where the available care options carry financial or emotional consequences, professionals must not avoid honest and mature conversations with the individual and/or their representative. Professionals must be mindful that some individuals may need support or advocacy to express their wishes, feelings and aspirations. Individuals or their representatives are entitled to determine themselves who they would like to receive support or advocacy from.

Principle 4: No delays in meeting an individual's needs due to funding discussions

The individual must not experience delay in having their needs met because agencies are not working effectively together. Joint funding and pooled budget options must be

considered wherever these can promote more agile, and as a consequence, more efficient responses to individual needs and preferences. Commissioners have a responsibility to resolve concerns/disputes at the earliest opportunity by having relevant local protocols in place as set out in the disputes process at **Section 7** of the 2021 Framework.

Principle 5: Understand diagnosis; focus on need

Individuals do not define themselves by their medical or clinical diagnosis and nor should the professionals who are supporting them. Health and social care providers must work together to gain a holistic understanding of need and the impact on the individual's daily life. The aim of assessment, treatment and the planning and commissioning of longer-term care should be to deliver quality and tailored support which maximises independence and focuses on what is most important from the perspective of the individual and their carers.

Principle 6: Co-ordinated care & continuity

Fragmented care is distressing, unsafe and costly. It can result in unnecessary change to living arrangements, which in turn creates instability and insecurity. Every effort must be made to avoid disruption to care arrangements wherever possible, or to provide smooth and safe transition where change is required in the best interests of the individual. Where an individual whose care was arranged through Direct Payments becomes eligible for CHC funding, the health board must work with them in a spirit of co-production and make every effort to maintain continuity of the personnel delivering the care, where the individual wishes this to be the case.

The individual or their representative must have a named contact for advice and support, who can co-ordinate a prompt response to any change in need.

Principle 7: Communicate

The vast majority of complaints, concerns and disputes have poor communication at their core. It is unacceptable for professionals to claim not to have time to communicate – it will take longer to put the situation right later and trust will have been broken. The individuals seeking our help and their carers will, by the nature of the interaction, require clear communication and support.

Therefore, communication with the individual or their representative must be in the language/format or method of their choice. This includes all verbal and written communication throughout the eligibility process, including the use of the Checklist, DST and Fast Track processes, and the provision of care and support services.

Individuals and/or their representatives will be empowered if they are able to speak with staff in their preferred language. It is important to recognise the concept of language as an integral element of an individual's care and their ability to participate in all aspects as equal partners. Effective communication is a key requirement of assessment and the

provision of any support required. In Wales, services must be offered in ways that are compliant with the Welsh Language Standards.

The same considerations apply to British Sign Language (BSL) users. Evidence suggests that BSL users prefer to communicate directly with professionals who can communicate fluently in BSL when discussing care and support needs. Many LAs employ special social workers who work with deaf people and can communicate in BSL. In cases where professionals cannot communicate directly in BSL, interpreters will have to be used either directly or via video computer link.

All professionals involved in an assessment of the needs of people with severe speech and communication difficulties will need to establish the preferred means of communication before starting the assessment. Assessment specifically concerned with communication may require the assistance of the 'National Centre for Electronic Assistive Technology'.

There should be no delays, to the individual in receiving their assessment or provision of care and support, regardless of the language/format or method of communication used throughout the CHC eligibility process.

Any decision on eligibility must be clearly and professionally explained to the individual or their representative, in the language of their choice. See **Communicating the Decision on Eligibility at Section 4 of the 2021 Framework**.

PROCESS

5. The process for the assessment and determination of eligibility for CHC is described in detail in **Section 4** of the 2021 Framework. MDTs should refer to that document directly, the contents **are not** repeated in the DST.
6. Discussions about an individual's needs, along with any consideration of eligibility for CHC, including the use of the DST, must be undertaken in a formal MDT meeting. The individual or their representative, must be invited to attend this meeting to be fully involved in the completion of the DST.
7. The DST is not an assessment itself, and it does not replace professional judgement on whether an individual's overall needs, the interaction between their needs, and evidence from relevant risk assessments demonstrate the four key characteristics of a primary health need.
8. The DST is completed following the MDT's comprehensive assessment and evaluation of an individual's health and social care needs and their desired outcomes. It is used to support the MDT to record evidence in a single practical format, which demonstrates

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they have implemented a rational consistent evidence-based recommendation regarding eligibility for CHC.

9. All sections of the DST must be completed by appropriately trained MDTs in line with the guidance set out in the 2021 Framework.
10. The DST is split into two parts; the User Notes which set out guidance on the application of the DST. The second part, **Sections 1 - 4**, are to be completed by the MDT. A copy of the completed DST **Sections 1 – 4** (including the recommendation) should be forwarded to the individual (or, where appropriate, their representative) together with the final decision made by the LHB, including the rationale for the LHB's decision.

CONSENT

11. This area is covered in greater detail in **Section 3** of the 2021 Framework.
12. Where the individual concerned has capacity, their informed consent should be obtained before completion of the DST (if consent has not already been obtained when the Checklist was completed). This consent needs to cover both the completion of the DST and the sharing of relevant information between the professionals involved.
13. If there is a concern the individual does not have the capacity to consent to the assessment process or to the sharing of information, this should be determined in accordance with the [Mental Capacity Act 2005](#) and the associated code of practice. It may be necessary for 'best interest' decisions to be made, bearing in mind the exception that all who are eligible for CHC should have the opportunity to be considered for eligibility.
14. The fact that an individual may have significant difficulties in expressing their views does not itself mean they lack capacity to make a decision. Appropriate support and adjustments should be made available in compliance with the Mental Capacity Act and with equalities legislation.
15. Robust data-sharing protocols, within and between organisations, will help to ensure confidentiality is respected whilst all necessary information is available to complete the DST. (See **Communicating the Decision/ Sharing of Information at paragraphs 64 to 67**.)

KEY ROLES AND RESPONSIBILITIES IN THE CHC ELIGIBILITY PROCESS

16. In implementing the principles detailed above, all of those involved have key roles and responsibilities to play. These include the following:

The individual whose needs are being assessed

17. It is essential that the individual whose needs are being assessed is central to the assessment and care planning process, as set out at **Principle 3** above. They are the expert in their own lives and situation. The assessment will by its nature often be triggered by illness or other life event and every effort must be made by the professionals involved to support the individual to participate in discussions which will impact on their future. This relies on the individual providing honest information, expressing their views and aspirations, and being open if they require further explanation, or there are issues that the team need to understand to effectively meet their needs.
18. Throughout the CHC assessment process the individual may choose to have a representative to support them, or speak or act on their behalf, on an informal or formal basis, including at any meetings they attend. The representative could be a family member, their carer or any other representative they choose.
19. The individual's representative will have an important role in supporting them and professionals must make every effort to facilitate their involvement. In order to achieve the best possible outcome for the individual, including support for recovery and maintenance of independence, carers/family/representatives will be expected to respond to reasonable requests for information and/or to attend the multi-disciplinary team meeting in a timely manner. Where there are a number of family members involved, a key contact should be nominated, who will then be responsible for communicating with other family members. Further information on the MDT meeting is at **paragraph 35 to 38**.

Where the individual does not have capacity, but has an authorised representative

20. Where it has been identified that the individual does not have capacity to give their consent or to participate effectively in the decision-making process, a representative may act on their behalf if they have the appropriate authority as set out at **Section 3** of the 2021 Framework. The authorised representative can choose to be supported by an advocate or representative of their choice.

The role of the family/ carer or other representative when a 'Best Interest' decision is made

21. Where the individual does not have capacity to make decisions, and there is no representative with the authority to make decisions on their behalf, as set out at **Section 3 of the 2021 Framework**, the LHB should make a 'best interest' decision on the individual's care and support needs. Where a 'best interests' decision needs to be made, the decision-maker must take into account the views of any relevant third party who has a genuine interest in the individual's welfare (if it is reasonable and practicable to consult them). This will normally include family, friends and advocates. An individual may choose to have a family member or other person, who should operate independently of LHBs and LAs, to act as an advocate on their behalf.

22. The decision-maker should be mindful of the need to respect confidentiality and should not share personal information with third parties unless it is considered in the best interests of the individual for the purposes of the CHC assessment of eligibility. Where the individual has made an 'advanced statement' to the effect that they do not want personal information shared with specific individuals, this should be taken into account in assessing the individual's best interests.
23. Although the decision-maker must take account of the views of relevant third parties, those consulted (including family members) do not have the authority to consent to or refuse consent to the actions proposed as a result of the best interests' process. The responsibility for the decision rests with the decision maker, not with those consulted. Where there is a difference of opinion between the decision-maker and those consulted, every effort should be made to resolve this informally. However, this process should not unduly delay timely decisions being made in the person's best interests.
24. The individual and/or their representatives cannot be members of the MDT. However, they must be given the opportunity to be fully involved in the CHC process and be given every opportunity to attend the MDT meeting where the DST is to be completed so that they are fully able to participate in its completion, as an equal partner.
25. Therefore, the individual or their representative, must be given reasonable notice of the MDT meeting to enable them to attend, taking into account their personal circumstances. If they do not wish to be present, where consent is given, their views and knowledge should be obtained and actively considered in the completion of the DST.
26. Completion of the DST should be organised so that the individual or their representative, understands the process and receives information and support to enable them to participate in informed decisions about their future care and support. The reasons for any decisions made should be transparent and clearly documented.
27. At **Section 1 (2)** of the DST, the MDT should record the individual and/or their representative's views on their care needs, and whether they consider the MDT assessment has accurately reflected their needs.
28. At **Section 1 (3)** it should be recorded whether and how the individual and/or their representative contributed to the assessment of their needs. If they were not involved, it must be recorded whether or not they were invited or whether they declined to participate.

The role of the Care Co-ordinator/Lead Professional

29. The Care Co-ordinator is the named individual responsible for co-ordinating the whole process of assessment for longer-term care. They are accountable for ensuring that the assessment process is co-produced, robust, and timely. They must ensure that the

individual or their representative is kept informed of the process and fully involved in discussions about their care.

30. The Care Co-ordinator is most likely to be a health professional and it will be important to maintain continuity where for example, the individual has a progressive disease and specialist key professional. This person-centred approach would suggest that it may also be acceptable for a social worker with a long-standing relationship with the individual and the family to act as Care Co-ordinator. This would be subject to inter-agency agreement, with the final decision on who acts as Care Co-ordinator resting with the LHB.
31. The 'Care Co-ordinator' role can be referred to as the Lead Professional. We use the term 'Care Co-ordinator' in this document but it reads across to the Lead Professional function. We note that the term 'Care Co-ordinator' has specific meaning in relation to care and treatment planning for people with mental health needs. Whilst the same professional may also co-ordinate the CHC assessment, they are different functions. Where the Care Co-ordinator changes there should be a formal handover of relevant information.
32. The Care Co-ordinator's role includes:
 - Ensure consent has been obtained
 - identifying and securing the involvement of all the appropriate MDT members
 - ensuring that MDT members understand their role in the comprehensive assessment and their contribution to the decision-making process;
 - ensuring that the individual and/or other representative(s) have all the information they need to understand and fully contribute to the assessment and decision-making process. This will include securing access to advocacy support if required.
 - ensuring that all assessments are collated in one place and are of sufficient quality to provide the evidence required to support fair and rational decision-making
 - ensuring that there is a clear timetable for the decision-making process and that the process complies with the requirements of this Framework
 - ensuring that the MDT's expert advice to the LHB on eligibility and the rationale is clearly recorded and communicated to the necessary parties, including the individual or their representative
 - liaising with the individual or their representative(s) within 48 hours of the MDT meeting at which CHC eligibility was determined. This is to ensure that the outcome is fully understood and to answer any questions they may have on reflection.
 - Ensuring compliance with local protocols including quality assurance arrangements and, if required, disputes resolution and appeals processes, prior to escalation to the next level of management
33. Specific responsibilities in regard to the individual or their representative include:

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- establish the individual or their representative's language, format or method of communication as soon as it is considered the individual may have a primary health need and be eligible for CHC;
- provide the CHC Booklet for Individuals, Families and Carers as soon as it is considered the individual may have a primary health need and be eligible for CHC;;
- explain timescales and key milestones, including timescales for review
- inform them of other individuals likely to be involved in the process
- inform them of any potential delays
- provide a clear channel of communication between the individual or their representative(s) and the MDT.

34. A detailed description of the Care Co-ordinator function can be found in the **2021 Framework**.

The role of the Multi-disciplinary Team members

35. Multi-disciplinary Team (MDT) members are responsible for working with the individual and/or their representatives to undertake a thorough and objective assessment of their needs, for providing expert advice to the LHB regarding eligibility for CHC and for making recommendations as to the setting and skill set required to deliver the co-produced care plan.
36. The MDT works together to collate and review the relevant information on the individual's health and social care needs. The MDT uses this information to help clarify individual needs, through the completion of the DST (**DST, see paragraphs 58 to 63**) and then works collectively to make a professional judgement about the eligibility for CHC, which will be reflected in its recommendation. This process is known as a multi-disciplinary assessment for eligibility for CHC.
37. Members of the MDT are responsible for the integrity of their assessments, professional advice and decisions which should be underpinned with a clear rationale. They may be challenged on the quality of their assessment, if for example there are gaps in the information required. They must not be subjected to pressure to change their professional views due to financial constraints.
38. The Chair of the MDT, who must be one of the members detailed below, is responsible for ensuring that the individual and/or their representative, appears to know what to expect during the MDT meeting, are actively included in the discussion and subsequently understand the rationale for the decision made.

Members of the MDT

39. It is important that those contributing to this process have the relevant skills and knowledge. MDT members **MUST** comprise of health and social care staff presently or recently involved in assessing, reviewing, treating or supporting the individual, who can meaningfully contribute to the assessment process, unless in exceptional

circumstances. This allows the individual to have confidence that MDTs involved in the recommendation discussions understand their needs. As a minimum, the MDT must include:

- at least two professionals, who have direct knowledge of the individual and their needs, from different healthcare professions, i.e. nurses, GPs or consultants, occupational therapists, other Specialists e.g. Speech and Language / Behavioural Specialists (unless there is only one such professional with the relevant knowledge)
- a social worker

And could also include the following where appropriate:

- Care home staff
- Domiciliary care staff

40. It is not appropriate that senior managers or finance managers from either the LHB or LA, are present in the MDT meeting, for any reason.
41. The MDT meeting is held to determine a primary health need only. Any dispute between the LHB and LA regarding commissioning of services or funding **must not** be discussed at the MDT meeting. This dispute should be resolved following the dispute resolution process set out in the Framework.

Completing the DST

42. When completing the DST, the MDT (**see paragraphs 35 to 38**) should use the DST to support their consideration of not just the individual's overall needs, but also the interaction between their needs, and evidence from relevant risk assessments. The DST should **not** be completed without a multi-disciplinary assessment of needs.
43. The DST provides practitioners with a needs-led approach by portraying need based on 12 'care domains' (including an open domain for needs that do not readily fit into the other 11). The tool is in four sections:
 - Section 1 – Personal information.
 - Section 2 – Care domains.
 - Section 3 – Recommendations.
 - Section 4 – Equality Monitoring Form.
44. The documentation should be organised e.g. collated into a single folder or section of the individual's notes, to ensure the CHC process and the outcomes can be easily identified via a clear audit trail. Where an LHB uses electronic records, the same principles must apply, i.e. the information must be organised and collated into a single folder to ensure it is possible to make appropriate checks that the process is being followed and that outcomes are easily identifiable.

The Use of Care Domains

45. The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. The DST provides practitioners with a method of bringing together and recording the various needs in 12 'care domains', or generic areas of need. Each domain is broken down into a number of levels. The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided. The domains are:
- Breathing
 - Nutrition
 - Continence
 - Skin Integrity
 - Mobility
 - Communication
 - Cognition
 - Psychological & Emotional Needs
 - Behaviour
 - Drug Therapies and Medication
 - Altered States of Consciousness
 - Other Significant Care Needs.
46. Completion of the DST should result in a comprehensive picture of the individual's needs that captures their nature, and their complexity, intensity and/or unpredictability – and thus the quality and/or quantity (including continuity) of care required to meet the individual's needs. Figure 1 indicates how the domains in the DST can illustrate (both individually and through their interaction) the complexity, intensity and/or unpredictability of needs. The overall picture, and the descriptors within the domains themselves, also relate to the nature of needs.

The focus must be on a rounded and holistic assessment of the individual rather than DST levels of need in isolation.

Assessing levels of need

47. Each domain is subdivided into statements of need representing no needs ('N' in the table below), low (L), moderate (M), high (H), severe (S) or priority (P) levels of need, depending on the domain (see Figure 1). The detailed descriptors of them are set out in the 12 domain tables for completion later in this document.
48. The descriptions in the DST are examples of the types of need that may be present. They should be carefully considered but may not always adequately describe every individual's circumstances. There is an expectation that the MDT will be able to

collectively reach a conclusion about the level of need within each of the domains and therefore eligibility.

49. If, however, after considering all the relevant evidence, it proves difficult to decide or agree on the level, the MDT should choose the higher of the levels under consideration and record the evidence in relation to both the decision and any significant differences of opinion, and by which practitioner. This information should be summarised within the overall recommendation. An individual must not be recorded as having needs between levels. It is important that differences of opinion on the appropriate level are based on the evidence available and not on presuppositions about an individual's need or generalised assumptions about the effects of a particular condition.
50. It is important that the wording of domain levels is carefully considered and assumptions are not made. The fact that an individual has a condition that is described as 'severe' does not necessarily mean that they should be placed on the 'severe' level of the relevant domain. Similarly the fact that a risk assessment indicates a 'high' risk does not necessarily mean that an individual should be placed on the 'high' level of the relevant domain. It is the domain level whose description most closely fits their needs that should be selected (for example, the fact that an individual is described as having 'severe' learning disabilities does not automatically mean that they should be placed on the 'severe' level of the Cognition domain).
51. The fast-track process should always be used for any individual with a rapidly deteriorating condition that may be entering a terminal phase. For other individuals who have a more slowly deteriorating condition and for whom it can reasonably be anticipated that their needs are therefore likely to increase in the near future, the domain levels selected should be based on current needs but the likely change in needs should be recorded in the evidence box for that domain and taken into account in the recommendation made. This could mean that a decision is made that they should be eligible for CHC immediately (i.e. before the deterioration has actually taken place) or, if not, that a date is given for an early review of their needs and possible eligibility. Professional judgement based on knowledge of the likely progression of the condition should determine which option is followed.
52. It should be remembered that a single condition might give rise to separate needs in a number of domains. For example someone with cognitive impairment will have a weighting in the cognition domain and as a result may have associated needs in other domains, all of which should be recorded and weighted in their own right.
53. Some domains include levels of need that are so great that they could reach the 'priority' level (which would indicate a primary health need), but others do not. This is because the needs in some care domains are considered never to reach a level at which they on their own should trigger eligibility; rather they would form part of a range of needs which together could constitute a primary health need.
54. Within each domain there is space to record why a particular level is appropriate, based on the available evidence about the assessed needs. It is important that needs are

described in measurable terms, using clinical expertise, and supported with the results from appropriate and validated assessment tools where relevant.

55. Needs should not be marginalised because they are successfully managed. Well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need will this have a bearing on CHC eligibility. However, there are different ways of reflecting this principle when completing the DST. For example, where psychological or similar interventions are successfully addressing behavioural issues, consideration should be given as to the present-day need if that support were withdrawn or no longer available and this should be reflected in the Behaviour domain.
56. It is not intended that this principle should be applied in such a way that well-controlled physical health conditions should be recorded as if medication or other routine care or support was not present. For example, where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain. Similarly, where someone's skin condition is not aggravated by their incontinence because they are receiving good continence care, it would not be appropriate to weight the skin domain as if the continence care was not being provided.
57. There may be circumstances where an individual may have particular needs that are not covered by the first 11 defined care domains within the DST. In this situation, it is the responsibility of the MDT to determine and record the extent and type of the needs in the "additional" 12th domain provided entitled 'Other Significant Health Care Needs' and take this into account when deciding whether an individual has a primary health need. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility.

Figure 1: How the different care domains are divided into levels of need

		COMPLEXITY											
		INTENSITY											
UNPREDICTABILITY	INTENSITY	P								P	P	P	
		S	S		S	S		S		S	S		S
		H	H	H	H	H	H	H	H	H	H	H	H
		M	M	M	M	M	M	M	M	M	M	M	M
		L	L	L	L	L	L	L	L	L	L	L	L
		N	N	N	N	N	N	N	N	N	N	N	N
		Breathing	Nutrition	Continence	Skin Integrity	Mobility	Communication	Cognition	Psychological and Emotional needs	Behaviour	Drug Therapies & Medication	Altered States of Consciousness (ASC)	Other significant care needs

Key: N = No needs L = Low M = Moderate H = High S = Severe P = Priority

COMPLETING THE DST AND ESTABLISHING A PRIMARY HEALTH NEED

58. At the end of the DST, there is a summary sheet to provide an overview of the levels chosen and a summary of the individual's needs, along with the MDT's recommendation about eligibility or ineligibility. A clear recommendation of eligibility for CHC would be expected in the following two circumstances:

- A level of **priority** needs in any one of the four domains that carry this level.
- A total of two or more incidences of identified **severe** needs across all care domains.

Where the following occur, this may also indicate a primary health need, requiring further consideration:

- one domain recorded as severe, together with needs in a number of other domains, or
- a number of domains with high and/or moderate needs.

59. Under these circumstances, clear reasons need to be recorded for the decision whether or not the individual has a primary health need. In all cases, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments should be taken into account in deciding whether a recommendation of eligibility for CHC should be made. MDTs are nevertheless reminded that, as

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emphasised throughout the 2021 Framework, the decision on eligibility should not be based on 'tick box levels of need' in isolation.

60. It is not possible to equate a number of incidences of one level with a number of incidences of another level, as in, for example 'two moderates equals one high'. The judgement whether someone has a primary health need must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of the individual's needs.
61. If needs in all domains are recorded as '**no need**', this would indicate ineligibility. Where all domains are recorded as '**low need**', this would be unlikely to indicate eligibility. However, because low needs can add to the overall picture, influence the continuity of care necessary, and alter the impact that other needs have on the individual, all domains should be completed.
62. The Care Co-ordinator should ensure that all parts of the DST have been considered. The MDT's recommendation on eligibility must be completed (agreed/signed by MDT members), and forwarded to the LHB for quality assurance and commissioning of the care package. The Care Co-ordinator should also advise the individual of the timescales for confirmation of the MDT recommendation and arrangement of their CHC care package if eligible, this should be no later than 2 weeks from the date of the DST meeting unless there are exceptional circumstances. (See **Sections 4** of the 2021 Framework.).
63. The Equality Monitoring Form should be completed by the individual who is the subject of the DST, if the individual agrees to this. Where the individual needs support to complete the form, this should be arranged by the Care Co-ordinator. The Care Co-ordinator should forward the form to the appropriate location, in accordance with the relevant LHBs processes for processing equality data.

COMMUNICATING THE DECISION/ SHARING OF INFORMATION

64. In line with requirements set out in the 2021 Framework, the individual or where appropriate, their representative (dependant on authority to share and receive information), should be informed of the eligibility decision as soon as possible following the MDT meeting.
65. If someone is acting as the individual's representative they are entitled to receive a copy of the DST, provided that the correct basis for sharing such information has been established. This basis could be any one of the following:
 - a) consent from the individual concerned (where they have capacity to give this).
 - b) consent from a court appointed deputy (health and welfare) or someone who holds Lasting Power of Attorney (health and welfare) for that individual.
 - c) a "best interest" decision to share information made under the Mental Capacity Act (where the individual lacks capacity to consent to the sharing of information).

66. Where an individual lacks capacity but has an appointed Lasting Power of Attorney (property and finance), information (including a copy of the completed DST) should be shared in order for them to carry out their LPA duties, unless there are compelling and lawful reasons why this should not happen. If there is doubt, advice should be sought.
67. This information should be communicated in the individual or their representative's language of choice and should include:
- the decision on primary health need, and therefore whether or not they are eligible for CHC
 - the reasons for the decision
 - a copy of the completed DST
 - details of who to contact if they need further information
 - how to request an appeal of the eligibility decision if they are dissatisfied with the decision

NHS Continuing Healthcare Decision Support Tool

Section 1 – Personal Details

Date of completion of Decision Support Tool _____

Name

D.O.B.

NHS number and GP/Practice:

Permanent Address and

Telephone Number

Location the MDT assessment took place

<input type="text"/>	<input type="text"/>
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Gender _____

PLEASE ENSURE THAT THE EQUALITY MONITORING FORM AT THE END OF THE DST IS COMPLETED

Please delete answer as appropriate

Was the individual and/or their representative provided with the CHC Booklet for Individuals, Family and Carers at the start of the CHC process? **Yes/No**

Was the individual involved in the completion of the DST? **Yes/No**

Was the individual offered the opportunity to have a representative such as a family member, carer or other advocate present when the DST was completed? **Yes/No**

If yes, did the representative attend the completion of the DST? **Yes/No**

Is the individual currently in receipt of direct payments? **Yes/No**

NHS Continuing Healthcare Decision Support Tool

Section 1 – Personal Details

Contact details of the individual's representative (name, address and telephone number)

Summary

1. Summary pen portrait of the individual's situation, relevant history and current needs, including clinical summary and identified significant risks, drawn from the multi-disciplinary assessment:

2. Individual's view of their care needs and whether they consider that the multi-disciplinary assessment accurately reflects these:

3. Please note below whether and how the individual and/or representative contributed to the assessment of their needs. If they were not involved, please record whether they were not invited or whether they declined to participate.

NHS Continuing Healthcare Decision Support Tool

Section 1 – Personal Details

4. Please list the assessments and other key evidence that were taken into account in completing the DST, including the dates of the assessments:

5. MDT members name/address/contact details, noting lead coordinator:

NHS Continuing Healthcare Decision Support Tool

Section 1 – Personal Details

6. Contact details of GP and other key professionals involved in the care of the individual.
Please indicate which of these have contributed to the assessment of needs for the MDT to consider when completing this DST.

Please refer to the user notes

1. Breathing: As with all other domains, the breathing domain should be used to record needs rather than the underlying condition that may give rise to the needs. For example, an individual may have chronic obstructive pulmonary disease (COPD), emphysema or recurrent chest infections or another condition giving rise to breathing difficulties, and it is the needs arising from such conditions which should be recorded.

- 1. Describe below the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.**
- 2. Circle the assessed level overleaf.**

Please refer to the user notes

1. Breathing

Description	Level of need
Normal breathing, no issues with shortness of breath.	No needs
<p>Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities.</p> <p>OR</p> <p>Episodes of breathlessness that readily respond to management and have no impact on daily living activities.</p>	Low
<p>Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities.</p> <p>OR</p> <p>Episodes of breathlessness that do not respond to management and limit some daily living activities.</p> <p>OR</p> <p>Requires any of the following:</p> <ul style="list-style-type: none"> • 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. 	Moderate
<p>Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers.</p> <p>OR</p> <p>Breathlessness due to a condition which is not responding to treatment and limits all daily living activities.</p>	High
<p>Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway.</p> <p>OR</p> <p>Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy</p> <p>OR</p> <p>A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bi-level positive airway pressure, or non-invasive ventilation)</p>	Severe
Unable to breathe independently, requires invasive mechanical ventilation.	Priority

Please refer to the user notes

2. Nutrition: Individuals at risk of malnutrition, dehydration and/or aspiration should either have an existing assessment of these needs or have had one carried out as part of the assessment process, with any management and risk factors supported by a management plan. Where an individual has significant weight loss or gain, professional judgement should be used to consider what the trajectory of weight loss or gain is telling us about the individual's nutritional status.

- 1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.**
- 2. Circle the assessed level overleaf.**

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NHS Continuing Healthcare Decision Support Tool
Section 2 – Care Domains

Please refer to the user notes

2. Nutrition

Description	Level of need
Able to take adequate food and drink by mouth to meet all nutritional requirements.	No needs
Needs supervision, prompting with meals, or may need feeding and/or a special diet. OR Able to take food and drink by mouth but additional risk assessment indicates additional/supplementary feeding is required.	Low
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.	Moderate
Requires 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 Problems relating to a feeding device (for example PEG) that require skilled assessment and review.	High
Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled competent intervention and clinical decision making over a 24 hour period to ensure nutrition/hydration, for example I.V. fluids. OR Unable to take food and drink by mouth, intervention inappropriate or impossible.	Severe

Please refer to the user notes

3. Continence: Where continence problems are identified, a full continence assessment exists or has been undertaken as part of the assessment process, any underlying conditions identified, and the impact and likelihood of any risk factors evaluated.

- 1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.**
- 2. Take into account any aspect of continence care associated with behaviour in the Behaviour domain.**
- 3. Circle the assessed level overleaf.**

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Please refer to the user notes

3. Continence

Description	Level of need
Continent of urine and faeces.	No needs
Continence care is routine on a day-to-day basis; 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.	Low
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.	Moderate
Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).	High

Please refer to the user notes

4. Skin Integrity: Evidence of wounds should derive from a wound assessment chart or tissue viability assessment completed by an appropriate professional. Here, a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin.

- 1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.**
- 2. Circle the assessed level overleaf.**

**NHS Continuing Healthcare Decision Support Tool
Section 2 – Care Domains**

Please refer to the user notes

4. Skin Integrity

Description	Level of need
No risk of pressure damage or skin condition.	No needs
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(s). OR A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Low
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 An identified skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.	Moderate
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/are responding to treatment. OR Specialist dressing regime in place; responding to treatment	High
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 are not responding to treatment and require regular monitoring/reassessment. OR Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule'. OR Multiple wounds which are not responding to treatment.	Severe

NHS Continuing Healthcare Decision Support Tool Section 2 – Care Domains

Please refer to the user notes

5. Mobility: This section considers individuals with impaired mobility. Please take other mobility issues such as wandering into account in the Behaviour domain where relevant. Where mobility problems are indicated, an up-to-date Moving and Handling and Falls Risk Assessment should exist or have been undertaken as part of the assessment process, and the impact and likelihood of any risk factors considered. The assessment should ordinarily have been completed within the last 3 months. However professional judgement should be applied to determine whether there is anything of relevance outside this timeframe that ought to be considered. It is important to note that the use of the word 'high' in any particular falls risk assessment tool does not necessarily equate to a high level need in this domain.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, with reference to movement and handling and falls risk assessments where relevant. Describe the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

Section 2 – Care Domains

Please refer to the user notes

5. Mobility

Description	Level of need
Independently mobile	No needs
Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Low
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 the majority of 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)	Moderate
Completely unable to bear weight 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 recent falls history and risk assessment). OR Involuntary spasms or contractures placing the individual or others at risk.	High
Has a clinical condition such that, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.	Severe

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Please refer to the user notes

6. Communication: This section relates to difficulties with expression and understanding, in particular with regard to communicating needs. An individual's ability or otherwise to communicate their needs may well have an impact both on the overall assessment and on the provision of care. Consideration should always be given as to whether the individual requires assistance with communication, for example through an interpreter, use of pictures, sign language, use of Braille, hearing aids, or other communication technology.

- 1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.**
- 2. Circle the assessed level overleaf.**

Please refer to the user notes

6. Communication

Description	Level of need
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.	No needs
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.	Low
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.	Moderate
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 individual has to have most of their needs anticipated because of their inability to communicate them.	High

Please refer to the user notes

7. **Psychological and Emotional Needs:** There should be evidence of considering psychological needs and their impact on the individual's health and well-being, irrespective of their underlying condition. Use this domain to record the individual's psychological and emotional needs and how they contribute to the overall care needs, noting the underlying causes. Where the individual is unable to express their psychological/emotional needs (even with appropriate support) due to the nature of their overall needs (which may include cognitive impairment), this should be recorded and a professional judgement made based on the overall evidence and knowledge of the individual.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

Please refer to the user notes

7. Psychological and Emotional Needs

Description	Level of need
Psychological and emotional needs are not having an impact on their health and well-being.	No needs
<p>Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts, distraction and/or reassurance.</p> <p>OR</p> <p>Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.</p>	Low
<p>Mood disturbance, hallucinations 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.</p> <p>OR</p> <p>Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.</p>	Moderate
<p>Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being.</p> <p>OR</p> <p>Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.</p>	High

Please refer to the user notes

8. Cognition: This may apply to, but is not limited to, individuals with learning disability and/or acquired and degenerative disorders. Where cognitive impairment is identified in the assessment of need, active consideration should be given to referral to an appropriate specialist if one is not already involved. A key consideration in determining the level of need under this domain is making a professional judgement about the degree of risk to the individual.

Please refer to the 2021 Framework guidance about the need to apply the principles of the Mental Capacity Act in every case where there is a question about an individual's capacity. The principles of the Act should also be applied to all considerations of the person's ability to make decisions and choices.

- 1. Describe the actual needs of the individual (including episodic and fluctuating needs), providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.**
- 2. Where cognitive impairment has an impact on behaviour, take this into account in the Behaviour domain, so that the interaction between the two domains is clear.**
- 3. Circle the assessed level overleaf.**

Please refer to the user notes

8. Cognition

Description	Level of need
No evidence of impairment, confusion or disorientation.	No needs
<p>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.</p> <p>OR</p> <p>Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.</p>	Low
<p>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.</p>	Moderate
<p>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 consistently 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.</p>	High
<p>Cognitive impairment that <u>may</u>, for example, include, marked short-term memory issues, problems with long-term memory or severe disorientation to time, place or individual.</p> <p>The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration.</p>	Severe

Please refer to the user notes

9. Behaviour: Human behaviour is complex, hard to categorise, and may be difficult to manage. Challenging behaviour may be caused by a wide range of factors. These may include extreme frustration associated with communicating difficulties, an inappropriate environment or fluctuations in mental state. Challenging behaviour in this domain includes but is not limited to:

- aggression, violence or passive non-aggressive behaviour
- severe disinhibition
- intractable noisiness or restlessness
- resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance,
- severe fluctuations
- inappropriate interference with others
- identified high risk of self-harm or suicide

The assessment of needs of an individual with serious behavioural issues should include specific consideration of the risk(s) **to themselves, others or property** with particular attention to aggression, self-harm and self-neglect and any other behaviour(s), irrespective of their living environment.

- 1. Describe the actual needs of the individual, including any episodic needs. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the behaviour is likely to be displayed across a range of typical daily routines and the frequency, duration and impact of the behaviour.**
- 2. Note any overlap with other domains.**
- 3. Circle the assessed level overleaf.**

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Section 2 – Care Domains**

Please refer to the user notes

9. Behaviour

Description	Level of need
No evidence of 'challenging' behaviour.	No needs
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 individual is compliant with all aspects of their care.	Low
'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 individual is nearly always compliant with care.	Moderate
'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.	High
'Challenging' behaviour of severity and/or frequency that poses a significant risk to self, others or property. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.	Severe
'Challenging' behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.	Priority

Please refer to the user notes

10. Drug Therapies and Medication: The individual's experience of how their symptoms are managed and the intensity of those symptoms is an important factor in determining the level of need in this area. Where this affects other aspects of their life, please refer to the other domains, especially the psychological and emotional domain. The location of care will influence who gives the medication.

In determining the level of need, it is the knowledge and skill required to manage the clinical need and the interaction of the medication in relation to the need that is the determining factor. In some situations, an individual or their carer will be managing their own medication and this can require a high level of skill. References below to medication being required to be administered by a registered nurse do not include where such administration is purely a registration or practice requirement of the care setting (such as a care home requiring all medication to be administered by a registered nurse).

- 1. Describe below the actual needs of the individual and provide the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.**
- 2. Circle the assessed level overleaf.**

Please refer to the user notes

10. Drug Therapies and Medication

Description	Level of need
Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.	No needs
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.	Low
Requires the administration of medication (by a registered nurse, carer or care worker) due to: Non-concordance or non-compliance of medication, 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.	Moderate
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the 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.	High
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. Even with such monitoring the condition is usually problematic to manage. OR Severe recurrent or constant pain which is not responding to treatment. OR Risk of non-concordance with medication, placing them at risk of relapse	Severe
Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition OR Unremitting and overwhelming pain despite all efforts to control pain effectively.	Priority

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Please refer to the user notes

11. Altered States of Consciousness (ASC): ASCs can be caused by a range of conditions including transient ischemic attacks (TIAs), epilepsy and vasovagal syncope.

General drowsiness, for example, would not constitute an ASC for the purposes of this domain, unless associated with a diagnosed clinical condition.

- 1. Describe below the actual needs of the individual providing the evidence that informs the decision overleaf on which level is appropriate (referring to appropriate risk assessments), including the frequency and intensity of need, unpredictability, deterioration and any instability.**
- 2. Circle the assessed level overleaf.**

Section 2 – Care Domains

Please refer to the user notes

11. Altered States of Consciousness (ASC)

Description	Level of need
No evidence of altered states of consciousness (ASC).	No needs
History of ASC but it is effectively managed and there is a low risk of harm.	Low
Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Moderate
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.	High
Coma. OR ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.	Priority

Please refer to the user notes

12. Other significant care needs: There may be circumstances, on a case-by-case basis, where an individual may have particular health needs which do not fall into the care domains described above or cannot be adequately reflected in these domains. If the boxes within each domain that give space for explanatory notes are not sufficient to document all needs, it is the responsibility of the MDT to determine and record the extent and type of these needs here

The lack of availability of information to complete this domain should not be used to inappropriately affect the overall decision on eligibility.

1. Enter below a brief description of the actual needs of the individual, including providing the evidence why the level in the table overleaf has been chosen (referring to appropriate risk assessments), and referring to the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

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Please refer to the user notes

Other significant care needs

Description	Level of need
	Low
	Moderate
	High
	Severe

Please refer to the user notes

Assessed Levels of Need

Care Domain	P	S	H	M	L	N
Breathing						
Nutrition						
Continence						
Skin Integrity						
Mobility						
Communication						
Psychological & Emotional Needs						
Cognition						
Behaviour						
Drug Therapies and Medication						
Altered States of Consciousness						
Other significant care needs						
Totals						

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Please refer to the user notes

Please note below any views of the individual and/or their family, carer or representative, on the completion of the DST that have not been recorded above, including whether they agree with the domain levels selected. Where they disagree, this should be recorded below, including the reasons for their disagreement.

Please refer to the user notes

Recommendation of the Multi-disciplinary Team filling in the DST

Please give a recommendation on the next page as to whether or not the individual is eligible for CHC. This should take into account the range and levels of need recorded in the DST and what this tells you about whether the individual has a primary health need. Any disagreement on levels used or areas where needs have been counted against more than one domain should be highlighted here. Reaching a recommendation on whether the individual's primary needs are health needs should include consideration of:

- **Nature:** This describes the particular characteristics of an individual needs (which can include physical, mental health, or psychological needs), and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.
- **Intensity:** This relates to both the extent ('quantity') and severity (degree) of the needs and the support required to meet them, including the need for sustained/ongoing care ('continuity').
- **Complexity:** This is concerned with how the needs present and interact to increase the skill needed to monitor the symptoms, treat the condition(s) and/or manage the care. This can arise with a single condition or can also include the presence of multiple conditions or the interactions between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as when a physical health need results in the individual developing a mental health need.
- **Unpredictability:** This describes the degree to which needs fluctuate, creating challenges in managing them. It also relates to the level of risk to the individual's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, or unstable or rapidly deteriorating condition.

Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered when completing the DST.

Also indicate whether needs are expected to change (in terms of deterioration or improvement) before the case is next reviewed. If so, please state why and what needs you think will be different and therefore whether you are recommending that eligibility should be agreed now or that an early review date should be set.

Where there is no eligibility for CHC and the assessment and care plan, as agreed with the individual, indicates the need for support in a care home setting, the team should indicate whether there is the need for registered nursing care in the care home, giving a clear rationale based on the evidence above.

Please refer to the user notes

Recommendation on eligibility for CHC, below, detailing the conclusions on the issues outlined on the previous page. This should include the following headings:

- Overview;
- Nature;
- Intensity;
- Complexity;
- Unpredictability; and
- Recommendation.

Signatures of MDT making above recommendation:

Health professionals

Printed Name	Designation	Professional Qualification	Signature	Date

Social care/other professionals

Printed Name	Designation	Signature	Date

Assessment

A process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated.

Care

Support provided to individuals to enable them to live as independently as possible, including anything done to help an individual live with ill health, disability, physical frailty or a learning difficulty and to participate as fully as possible in social activities. This encompasses health and social care.

Care Coordinator

A person who coordinates the assessment and care planning process where an individual needs complex and/or multiple services to support them. Care coordinators are usually the central point of contact with the individual. Regionally, different terms may be used to describe this role.

Care package

A combination of support and services designed to meet an individual's assessed needs.

Care plan

A document recording the reason why and what support and services are being provided and the outcome that they seek.

Care planning

A process based on an assessment of an individual's needs that involves working with the individual to identify and agree the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Care worker

Care workers provide paid support to help people manage the day-to-day activities of living. Support may be of a practical, social care nature or to meet a individual's healthcare needs.

Carer

Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is usually unpaid.

Cognition

The higher mental processes of the brain and the mind, including memory, thinking, judgement, calculation, visual spatial skills and so on.

Cognitive impairment

Cognitive impairment applies to disturbances of any of the higher mental processes, many of

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which can be measured by suitable psychological tests. Cognitive impairment, especially memory impairment, is the hallmark and often the earliest feature of dementia.

Compliance

The extent to which a patient takes, or does not take, medicines as prescribed.

Concordance

An agreement between an individual and a health professional regarding the provision of care. Concordance and compliance are frequently used interchangeably.

Continuing NHS Healthcare

A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need. It can be provided in any setting. Where an individual lives in their own home, it means that the NHS funds all the care that is required to meet their assessed health and social care needs. Such care may be provided both within and outside the individual's home, as appropriate to their assessment and care plan. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the individual's accommodation, board and care.

Contracture

Abnormal, usually permanent, condition of joint flexion and fixation caused by atrophy and shortening of muscle fibres or loss of normal elasticity of skin causing muscle contraction.

Long-term conditions

Those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies.

Mental capacity

The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of an individual who lacks capacity is set out in section 2 of the Mental Capacity Act as: 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.

Multi-disciplinary

Multi-disciplinary refers to when professionals from different disciplines, such as social work, nursing, occupational therapy, work together to address the holistic needs of individuals in order to improve delivery of care and reduce fragmentation.

Multi-disciplinary assessment

Multi-disciplinary assessment is an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.

Multi-disciplinary Team

A team that must include those who have an up-to-date knowledge of the individual's needs, potential and aspirations, unless in exceptional circumstances. It should consist of at least two healthcare professionals, i.e. nurses, GP's or consultants, occupational therapists, other Specialists e.g. Speech and Language / Behavioural Specialists, as well as a social care worker. The MDT could also include, where appropriate, care home or domiciliary care staff.

It does not refer only to an existing multi-disciplinary team such as an ongoing team based in a hospital ward.

Near future

Refers to needs that are reasonably considered by the Multi-disciplinary Team to be likely to arise before the individual's next planned review.

Pressure-related injury

Area of damage to the skin or underlying tissue which has occurred as a result of prolonged pressure to that area.

Pressure ulcer

Also known as decubitus ulcer or bed sore. Area of local damage to the skin and underlying tissue due to a combination of pressure, sheer and friction.

Registered nurse

A nurse registered with the Nursing and Midwifery Council. Within the UK all nurses, midwives and specialist community public health nurses must be registered with the Nursing and Midwifery Council and renew their registration every three years to be able to practise.

Rehabilitation

A programme of therapy and re-enablement designed to maximise independence and minimise the effects of disability.

Social care

Social care refers to the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships (*Our health, our care, our say: a new direction for community services*, paragraph 1.29). It is provided by statutory and independent organisations and can be commissioned by Local Authorities on a means-tested basis, in a variety of settings.

Social services

Social services are provided by 22 local authorities in Wales. Personally and in partnership with other agencies, they provide a wide range of care and support for people who are deemed to be in need.

Spasm

A sudden, involuntary contraction of a muscle, a group of muscles, or a hollow organ, or a

similarly sudden contraction of an orifice. A spasm is usually accompanied by a sudden burst of pain.

Specialist assessment

An assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care, for example stroke, cardiac care, bereavement counselling.

NHS Continuing Healthcare Decision Support Tool

Section 4 – Equality Monitoring Form

This Section only needs to be completed if a CHC Checklist equality monitoring form hasn't already been completed.

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

Please tick only one box in each category.

1. SEX	
Male	
Female	
Transgender	

2. SEXUAL ORIENTATION					
Only answer this question if you are aged 16 years or over. Which applies to you? (*If 'Other', please highlight and write in box provided)					
Heterosexual / Straight	Lesbian / Gay Woman	Gay Man	Bisexual	Prefer not to say	*Other

* Any other, write here

3. AGE GROUP –								
Which applies to you?								
0-15	16-24	25-34	35-44	45-54	55-64	65-74	75-84	85+

4. DISABILITY	
Do you have a disability, as defined by the <i>Equality Act 2010</i> ?	The Equality Act defines a person with a disability as someone who 'A physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities.'

Yes	
No	

5. ETHNIC GROUP –									
Which applies to you? (*If 'Other', please highlight and write in box provided)									
White		Mixed		Asian or Asian British		Black or Black British		Chinese or other group	
British		White and Black Caribbean		Indian		Caribbean		Chinese	
Irish		White and Black African		Pakistani		African		Other*	
Other*		White and Asian		Bangladeshi		Other*			
		Other*		Other*					

* Any other, write here

6. RELIGION						
Which applies to you? (*If 'Other', please highlight and write in box provided)						
<i>Christian includes Church of Wales, Catholic, Protestant and all other Christian denominations</i>						
Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	

* Any other, write here