Decision Support Tool for Continuing NHS Healthcare

2019

Contents

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 Continuing NHS Healthcare in Wales (2018) (The Framework).* It is split into two parts; the first section (User Notes, pages 4-13), set out guidance around the application of the DST. The DST itself begins at page 14 and it is this section that should be issued to the individual.
2. The DST must only be used in conjunction with the guidance in the 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 Continuing NHS Healthcare (CHC) in Wales. All staff using the DST should be familiar with Frameworks 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 a person'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.

Note: *This document is intended to be as clear and accessible as possible for people having an assessment for CHC, and their families and carers. 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 make sure that persons and carers or representatives (where consent is given), understand and agree to what has been written and that advocacy support is offered. In order to assist this, a range of leaflets have been developed that aim to provide advice and information about the CHC assessment process in a format that may be more easily understood by those undergoing assessment and their families/representatives. Local Health Boards (LHBs) are required by the Welsh Government to provide these leaflets at appropriate stages of the assessment process. Links to these leaflets are provided on the following sites:*

https://gov.wales/topics/health/nhswales/healthservice/chc-framework/?lang=en
http://www.cciss.org.uk/home

The DST is also available on the sites (as a Word document) and pages or boxes can be expanded as necessary.

It is important to note, however, that the DST is a national tool. 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).

User Notes

UNDERPINNING PRINCIPLES

(From the National Framework for the Implementation of Continuing NHS Healthcare in Wales, 2019)

Principle 1: People first.
Individuals who turn to health and social care providers when they have complex needs have to know that their best interests are the primary focus of the people assessing 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) are responsible for the integrity of their assessments, expert professional advice and decisions which should be underpinned with a rationale. Assessments can only be challenged on the basis of their quality. They cannot be challenged on financial grounds.

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. 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.

Principle 4: No delays in meeting a persons 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.

Principle 5: Understand diagnosis; focus on need.
Individuals do not define themselves by their medical 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 and their carers 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.

Extra care must be taken to communicate carefully and using the preferred means of communication with the individual. Information also needs to be provided in the most appropriate formats, including copies of relevant assessment and care planning documentation.

Where possible, the professional should attempt to establish the preferred means of communication of any individual prior to undertaking any assessment. Assessments together with any provision of care and support services have to be linguistically sensitive.

Users and carers will be empowered if they are able to speak with staff in their first language. It is important to recognise the concept of language need. For many Welsh speakers, language is an integral element of their care. Many people can only communicate and participate in their care as equal partners effectively through the medium of Welsh. Effective communication is a key requirement of assessment and the provision of any support required.

The same considerations apply to British Sign Language (BSL) users. The evidence suggests that BSL users prefer to communicate directly with professionals who can communicate fluently in BSL when discussing care and support needs. Many local authorities employ special social workers who work with deaf people and can communicate in BSL. Most local authorities employ specialist social workers for deaf people and can assist with assessments.

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’.

Any decision on eligibility must be clearly and professionally explained to an individual. See Communicating the Decision on Eligibility (see paragraphs 3.97 to 3.99 in the 2018 Framework).

PROCESS

4. The process for the assessment and determination of eligibility for CHC is described in detail in **Section 4** of the National Framework for the Implementation of Continuing NHS Healthcare in Wales (2019). Multi-disciplinary teams should refer to that document directly; the contents **are not** repeated in this Decision Support Tool ("DST").
5. The DST is not an assessment in itself and it does not replace professional judgement in determining eligibility. It is simply a means of recording the rationale and facilitating logical and consistent decision-making.
6. It must only be used following a comprehensive multi-disciplinary assessment of a person's health and social care needs and their desired outcomes. The Multi-disciplinary Team should use this tool to support consideration of not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments.

How should consent be approached within the DST?

7. This area is covered in greater detail in **Section 3** of the Framework. Where the individual concerned has capacity, their informed consent should be obtained before the completion of the DST (if consent was not already obtained through a checklist). This consent needs to cover both the completion of the tool and the sharing of relevant information between the professionals involved.
8. 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 permanently eligible for CHC should have the opportunity to be considered for eligibility. Guidance in such situations is set out in **Section 3** of the Framework.
9. 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.
10. 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** later in this document)

The role of the individual in the process

11. The individual should be invited to be present or represented wherever practicable. The assessment of needs that informs completion of the DST should be carried out with the knowledge and consent of the individual and with a full opportunity to participate. They should be given the opportunity to be supported or represented by a carer, family member, friend or advocate if they so wish. The eligibility assessment process should draw on those who have direct knowledge of the individual and their needs.

12. This means the individual or their representative(s) should be given reasonable notice of completion of the DST to enable them to arrange for a family member or other person to be present, taking into account their personal circumstances. If it is not practicable for the individual (or their representative) to be present, their views should be obtained and actively considered in the completion of the DST. Those completing the DST should record how the individuals (or their representative) contributed to the assessment of their needs and if they were not involved, why this was.

13. Even where an individual has not chosen someone else to support or represent them, where consent has been given the views and knowledge of family members should be taken into account.

14. Completion of the DST should be organised so that the individual understand the process and receives advice and information to enable them to participate in informed decisions about their future care and support. The reasons for any decisions should be transparent and clearly documented.

Who can complete the DST?

15. Multi-disciplinary Team (MDT) members are responsible for working with the individual and/or their representatives to undertake a thorough and objective assessment of the person's 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.

16. 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 Decision Support Tool ("DST"), 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. The Multi-disciplinary Team should use this tool to support consideration of not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments. Conversely, the DST should **not** be completed without a multi-disciplinary assessment of needs.

17. 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.

18. The documentation should be organised e.g. collated into a single folder or section of the patient 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.

19. If the collated integrated assessment and care plan are sufficiently robust there is no requirement to duplicate paperwork by copying information into the DST document. It will be acceptable in these circumstances to only complete:

    - the DST Summary Sheet (matrix)
    - the summary record of the MDT recommendation and rationale on eligibility
    - the Equality Monitoring Form

The Use of "Care Domains"

20. 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 tool 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.

21. Completion of the tool 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 Decision Support Tool 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 person rather than DST scores in isolation.

Scoring of domains – Levels of Need

22. 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.

23. 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 person'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.

24. 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. A person 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 a person's need or generalised assumptions about the effects of a particular condition.

25. It is important that the wording of domain levels is carefully considered and assumptions are not made. The fact that a person 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 a person is described as having 'severe' learning disabilities does not automatically mean that they should be placed on the 'severe' level of the Cognition domain).

26. The fast-track process should always be used for any person with a rapidly deteriorating condition that may be entering a terminal phase. For other persons 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 Continuing NHS Healthcare 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.

27. 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.

28. 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.

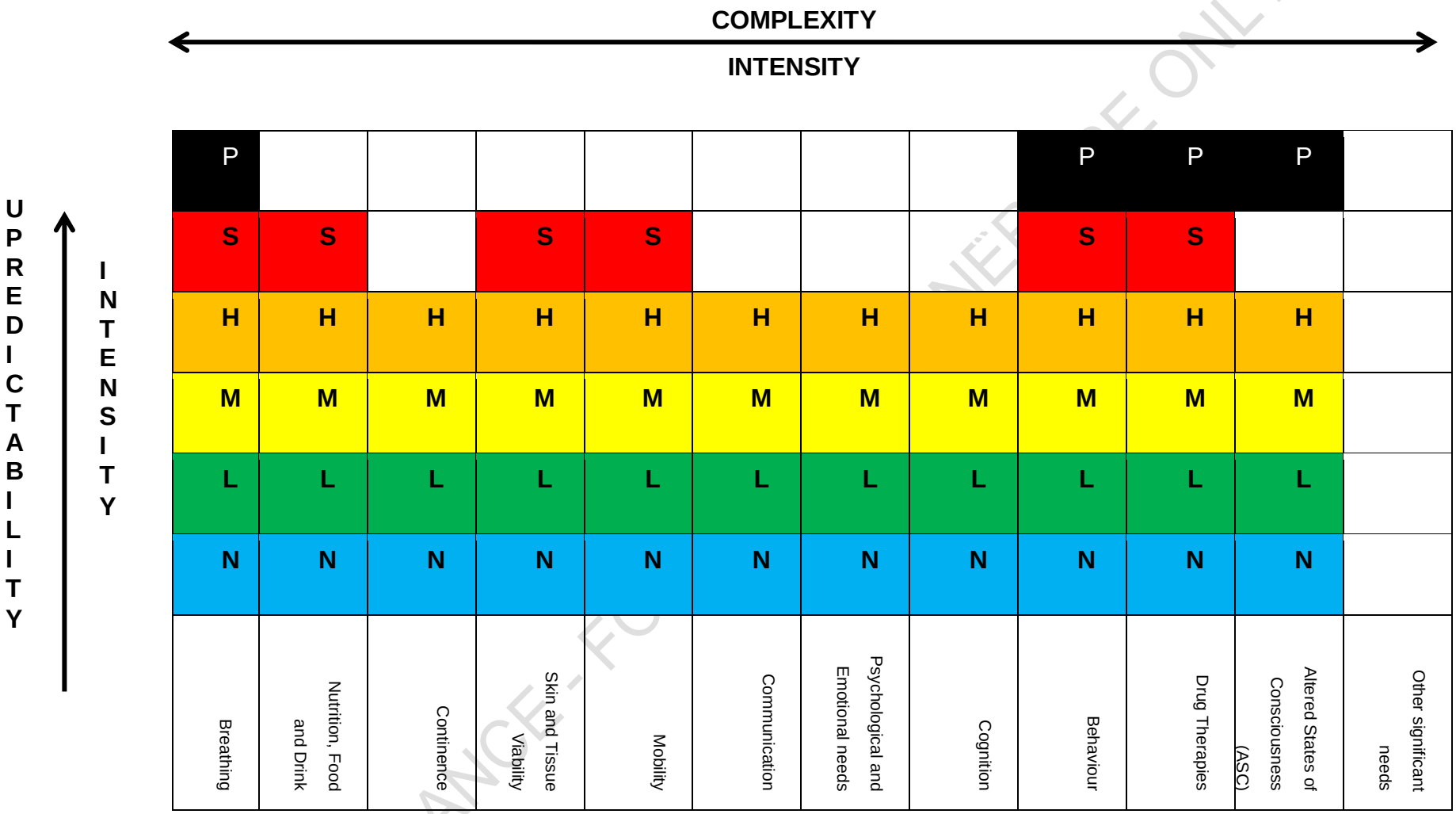
29. Within each domain there is space to justify why a particular level is appropriate, based on the available evidence about the assessed needs. It is important that needs are described in measurable terms, using clinical expertise, and supported with the results from appropriate and validated assessment tools where relevant.

30. 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 Continuing NHS Healthcare 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.

31. 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.

32. There may be circumstances where a person 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 assessors 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 a person 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.



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

COMPLETING THE DST AND ESTABLISHING A PRIMARY HEALTH NEED

33. At the end of the DST, there is a summary sheet to provide an overview of the levels chosen and a summary of the person'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.

34. Under these circumstances, clear reasons need to be recorded for the decision whether or not a person 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 emphasised throughout the Framework, the decision on eligibility should not be based on 'tick box scores' in isolation.

35. 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 person's needs.

36. 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 person, all domains should be completed.

37. 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 person of the timescales for confirmation of the MDT recommendation and arrangement of the CHC care package (i.e. no more than 21 days unless there are exceptional circumstances). (See Sections 3 & 4 of the National Framework.).

38. The Equality Monitoring Form should be completed by the person who is the subject of the DST, if the person agrees to this. Where the person 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 LHB's processes for processing equality data.

COMMUNICATING THE DECISION/ SHARING OF INFORMATION

39. In line with requirements set out in the Framework, a copy of the completed DST (including the recommendation) should be forwarded to the person (or, where appropriate, their representative) if requested and dependent on authority to share and receive information. This should include the final decision made by the LHLHB, along with the reasons for the decision.

40. If someone is acting as the person'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 person 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 person.
c) a "best interest" decision to share information made under the Mental Capacity Act (where the person lacks capacity to consent to the sharing of information).

41. Where a person 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.

Decision Support Tool for Continuing NHS Healthcare

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	**Current Location** (i.e. where MDT assessment is taking place)

Gender _____

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

Please delete answer as appropriate

Was the person involved in the completion of the DST?

Yes/No

Was the person offered the opportunity to have a representative such as a family member or other advocate present when the DST was completed?

Yes/No

If yes, did the representative attend the completion of the DST?

Yes/No

Decision Support Tool for Continuing NHS Healthcare

Section 1 – Personal Details

PLEASE GIVE THE CONTACT DETAILS OF THE REPRESENTATIVE (NAME, ADDRESS AND TELEPHONE NUMBER)

Summary

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

2. Person'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 person (or their 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.

Decision Support Tool for Continuing NHS Healthcare
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. Assessors' (including MDT members) name/address/contact details noting lead coordinator:

Decision Support Tool for Continuing NHS Healthcare
Section 1 – Personal Details

6. Contact details of GP and other key professionals involved in the care of the person:

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

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, a person 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 person, 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.

Decision Support Tool for Continuing NHS Healthcare
Section 2 – Care Domains
Please refer to the user notes

1. Breathing

Description	Level of need
Normal breathing, no issues with shortness of breath.	No needs
Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Low
Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not respond to management and limit some daily living activities. **OR** Requires any of the following: • low level oxygen therapy (24%). • room air ventilators via a facial or nasal mask. • other therapeutic appliances to maintain airflow where person can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Moderate
Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to treatment and limits all daily living activities.	High
Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway. **OR** Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bilevel positive airway pressure, or non-invasive ventilation)	Severe
Unable to breathe independently, requires invasive mechanical ventilation.	Priority

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

Please refer to the user notes

2. Nutrition – Food and Drink: Persons 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 a person 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 person's nutritional status.

1. Describe the actual needs of the person, 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.

Decision Support Tool for Continuing NHS Healthcare
Section 2 – Care Domains
Please refer to the user notes

2. Nutrition – Food and Drink

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 via an established feeding regime.	Moderate
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 person or specifically trained carers or care workers. **OR** 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

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

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 person, 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.

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

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

Please refer to the user notes

4. Skin (including tissue viability): 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 person, 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.

Decision Support Tool for Continuing NHS Healthcare
Section 2 – Care Domains
Please refer to the user notes

4. Skin (including tissue viability)

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

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

Please refer to the user notes

5. Mobility: This section considers persons 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 person, 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.

Decision Support Tool for Continuing NHS Healthcare
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 person 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

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

Please refer to the user notes

6. Communication: This section relates to difficulties with expression and understanding, in particular with regard to communicating needs. A person'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 person 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 person, 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.

Decision Support Tool for Continuing NHS Healthcare
Section 2 – Care Domains
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 person 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 person.	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.	High

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

Please refer to the user notes

7. **Psychological and Emotional Needs:** In considering the individual's level of need in this domain, careful consideration should be given to the individual's ability to engage in care planning or withdrawal from activities due to their psychological and emotional needs and the degree of support required. If an individual has a level of need in the domain of cognition the individual may not be able to engage in care planning or has withdrawn from any attempts to engage them in daily activities, however the inability or withdrawal should be carefully considered to establish if there is any evidence of psychological or emotional needs that are having an impact on their health and well-being.

1. Describe the actual needs of the person, 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.**

Decision Support Tool for Continuing NHS Healthcare
Section 2 – Care Domains
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
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. **OR** Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.	Low
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 person's health and/or well-being. **OR** Due to their psychological or emotional state the person has withdrawn from most attempts to engage them in care planning, support and/or daily activities.	Moderate
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the person's health and/or well-being. **OR** Due to their psychological or emotional state the person has withdrawn from any attempts to engage them in care planning, support and/or daily activities.	High

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

Please refer to the user notes

8. Cognition: This may apply to, but is not limited to, persons 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 person.

Please refer to the National 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 person (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.

Decision Support Tool for Continuing NHS Healthcare
Section 2 – Care Domains
Please refer to the user notes

8. Cognition

Description	Level of need
No evidence of impairment, confusion or disorientation.	No needs
Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the person has insight into their impairment.	Low
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 person is usually able to make choices appropriate to needs with assistance. However, the person 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.	Moderate
Marked or short-term memory issues, or both, associated with disorientation to time and/or place, with possible inability to recognise various family members, friends or care staff. The individual has insight into only a very limited range of basic needs and lacks awareness of the risks of their environment. Despite having supervision, guidance or assistance they are constantly unable to make choices or decisions relating to basic issues, thereby putting themselves at a significant risk of harm and deterioration to their health. The individual is completely dependent on others to anticipate their needs and maintain their safety.	High

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

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 a person 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 person, 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 to 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.

Decision Support Tool for Continuing NHS Healthcare
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 person 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 person is nearly always compliant with care.	Moderate
'Challenging' behaviour of a type and/or frequency 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

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

Please refer to the user notes

10. Drug Therapies and Medication: Symptom Control: The person'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, a person 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 person 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.

Decision Support Tool for Continuing NHS Healthcare
Section 2 – Care Domains
Please refer to the user notes

10. Drug Therapies and Medication: Symptom Control

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: refusal or misuse 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 refusal or misuse of medication, which is likely to have a significant impact on the individual's health and well-being.	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

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

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 person 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.

Decision Support Tool for Continuing NHS Healthcare
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

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

Please refer to the user notes

12. Other Significant Health Care Needs to be taken into consideration: There may be circumstances, on a case-by-case basis, where a person may have particular 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 assessors 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 person, 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.

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

Please refer to the user notes

Assessed Levels of Need

Care Domain	P	S	H	M	L	N
Breathing						
Nutrition – Food and Drink						
Continence						
Skin (including tissue viability)						
Mobility						
Communication						
Psychological Needs						
Cognition						
Behaviour						
Drug Therapies and Medication						
Altered States of Consciousness						
Totals						

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

Please refer to the user notes

Please note below any views of the person 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. Where the person is represented or supported by a carer or advocate, their understanding of the person's views should be recorded.

Decision Support Tool for Continuing NHS Healthcare
Section 3 – Recommendation

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 person is eligible for Continuing NHS Healthcare. This should take into account the range and levels of need recorded in the Decision Support Tool and what this tells you about whether the person 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 person's primary needs are health needs should include consideration of:

- **Nature**: This describes the particular characteristics of a person's 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 person, 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 person'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 person'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 please 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 Continuing NHS Healthcare and the assessment and care plan, as agreed with the person, 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.

Decision Support Tool for Continuing NHS Healthcare
Section 3 – Recommendation

Please refer to the user notes

Recommendation on eligibility for Continuing NHS Healthcare, 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

Decision Support Tool for Continuing NHS Healthcare
Glossary

Glossary

Assessment
A process whereby the needs of a person are identified and their impact on daily living and quality of life is evaluated.

Care
Support provided to persons to enable them to live as independently as possible, including anything done to help a person 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 a person needs complex and/or multiple services to support them. Care coordinators are usually the central point of contact with the person. Regionally, different terms may be used to describe this role.

Care package
A combination of support and services designed to meet a person'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 a person's need that involves working with the person 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 person'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 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 a patient 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 person's primary need is a health need. It can be provided in any setting. Where a person 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 person'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 person'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 a person 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 their patients/clients in order to improve delivery of care and reduce fragmentation.

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

Multi-disciplinary Team
A team of at least two professionals, usually from both the health and the social care disciplines. It does not refer only to an existing multi-disciplinary team such as an ongoing

team based in a hospital ward. It should include those who have an up-to-date knowledge of the person's needs, potential and aspirations.

Near future
Refers to needs that are reasonably considered by the Multi-disciplinary Team to be likely to arise before the next planned review of the person.

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.

Decision Support Tool for Continuing NHS Healthcare
Section 4 – Equality Monitoring Form

This need only be completed if a CHC Checklist hasn't been completed (as this includes an equality monitoring form).

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 *Equality Act 2010?*		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. https://www.gov.uk/definition-of-disability-under-equality-act-2010
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)

Christian includes Church of Wales, Catholic, Protestant and all other Christian denominations

Christian	Buddhist	Hindu	Jewish	Muslim	Sikh

* Any other, write here