NHS
Cheshire and Merseyside

All-Age Continuing Care

Procedure for Dealing with Previously Unassessed Periods of Care

Cheshire and Merseyside Integrated Care Board Version 1.

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Introduction

NHS Continuing Healthcare (NHS CHC) is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing healthcare needs. To qualify for NHS CHC, an individual must have a 'primary health need' which is assessed using the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care published 1 October 2007 (revised 2022)[1] (National Framework).

The purpose of this guidance is to ensure practitioners work in a consistent way and to advise of the process needing to be followed when a request for a Previously Unassessed Period of care is received. Consideration of a retrospective application will generally only be made from 1 April 2012 onwards. This is because of a previous Department of Health Closedown which took place in 2012. There should be very few cases in relation to periods of care before 1st April 2012 that have not already been considered and all requests will be reviewed for any exceptional circumstances. It is expected that these instances will be rare.

Whilst the general principles of the National Framework are applied when completing a review of a previously unassessed period of care (PUPoC) the National Framework does not include explicit guidance on how a PUPoC should be completed. There will be some variations in how a PUPoC assessment is completed, the outlines of this process are described within the guidance below.

A notable difference is that when an NHS CHC assessment is completed the patient, or their representative will be invited to attend a multi-disciplinary meeting to complete the assessment. During the PUPoC process this meeting does not take place. Instead, a care needs portrayal document (NPD) is produced. This will detail the patients' needs during the period under review and the claimant will be invited to provide written comments on the NPD prior to the Decision Support Tool[2] (DST) and CHC assessment being completed.

The ICB aims to complete a PUPoC request where the duration of the care period to be reviewed is one year or less within 6 months of receipt of the completed application and consent forms. Where the duration of the period of care exceeds one year the request should not take longer than 12 months to complete, except in exceptional circumstances.

NHS Cheshire and Merseyside will ensure that staff have the appropriate skills and knowledge to deliver high quality retrospective CHC assessments; practitioners will complete the NHS England and NHS Improvement e-learning training and attend regular update training.

This document sets out how to complete an NHS CHC assessment for a previously unassessed period of care (PUPoC).

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1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1087562/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care-July-2022-revised.pdf

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1112535/NHS-continuing-healthcare-decision-support-tool-referral-form.pdf

1. Retrospective Review Process: Establishing if a case is suitable for a Retrospective Review.

A request for a previously unassessed period of care assessment is defined in the guidance issued by the Department of Health and Social Care as a request for an ICB to consider NHS CHC eligibility where the ICB had responsibility for an individual, for a specific past period of care, where:

- There was no consideration of NHS CHC eligibility by the relevant ICB for that individual during the past period of such care.
- That individual had funded that past period of care in full or part.
- There is appropriate, objective evidence that the individual should have been considered for eligibility for NHS CHC in accordance with The National Health Service Commissioning Board and CCG Regulations and the National Framework

ICB's should follow the Department of Health and Social Care guidance to support a consistent approach to PUPoC requests across all ICB's in England.

1.1 On receipt of a request for an assessment of eligibility for NHS CHC for a PUPoC, the receiving body must complete several preliminary checks to establish if it should be done, as set out below:

1.2. NHS Cheshire and Merseyside will first have to establish whether it is the correct responsible commissioner[3] for the individual who is the subject of the PUPoC request. If NHS Cheshire and Merseyside is not the responsible commissioner, they will inform the applicant who they need to make their application to and return to them any documents and paperwork they may have submitted. NHS Cheshire and Merseyside will inform the relevant ICB of the request.

1.3. Any requests that are made to look at a period of care before 1 April 2012 will only be accepted in exceptional circumstances as this period has been subject to a Department of Health closedown.

1.4. Claims made by solicitors or claims companies should only be accepted where the company can show they have authority to act on behalf of the individual. Therefore, any request that is not accompanied by the individual's instruction to the company to act on their behalf should be logged but no further action taken if the company cannot produce its authority to act within a reasonable timeframe of 28 days.

If NHS Cheshire and Merseyside do not receive the authority to act within 28 days of the date of receipt of the letter, they will consider the request has been withdrawn; this will be confirmed in writing. Requests for an extension will need to have been previously agreed as per section 1.6 below.

1.5. If the patient lacks capacity, and the claim has been made by a relative, friend or carer, NHS Cheshire and Merseyside will make sure that the person making the claim is authorised to do so.

NHS Cheshire and Merseyside will check whether the applicant (or the client of the solicitor making the claim) is one of the following:

- A person holding Lasting Power of Attorney registered with the office of the Public Guardian.
- The holder of Enduring Power or Attorney registered with the Court of Protection.
- A deputy / receiver appointed by the Public Guardianship Office of the Court of Protection.

[3] The responsible Commissioner is determined by the CCG that the patients' GP is registered with at the start of the period requested. The responsible commissioner may change depending on if and when the patient is found eligible for CHC funding and if they moved during the review period. https://www.england.nhs.uk/wp-content/uploads/2022/06/B1578_i_who-pays-framework-final.pdf

If the applicant cannot satisfy any of the above-mentioned criteria, NHS Cheshire and Merseyside will refer to the Mental Capacity Act[4] and decide if a Best Interest's Decision should made.

1.6. If the individual is deceased, NHS Cheshire and Merseyside will ensure that there is sufficient proof that the representative is an executor or administrator to the estate. The representative will need to provide a copy of one of the documents listed below:

- The deceased's will
- Grant of Probate
- Letters of administration

If ICB do not receive the appropriate authority to act within 8 weeks of the date of receipt of the letter, ICB will consider the request has been withdrawn.

It is however recognised there may be exceptional circumstances which should be considered, and an extension of time considered, for example, if there is a delay in obtaining a grant of probate or letters of administration.

Applicants need to be aware that should NHS CHC funding be awarded to receive this the applicant will need to hold the appropriate authority and be able to provide proof of payment[5]. NHS Cheshire and Merseyside will support obtaining proof of payment, if entitlement to reimbursement is proven but the amount of money paid in care costs is not, NHS Cheshire and Merseyside should reimburse the claimant at the known rate of care home bed cost at that time.

For financial governance, audit and accountability purposes it is appropriate to ask the individual or representative to provide the required proof within 6 months unless exceptional circumstances apply such as delays due to other agencies. NHS Cheshire and Merseyside will evidence that it has monitored the progress with the individual or their representative, delays due to other agencies are evidenced and any exceptional circumstances have been considered.

Every effort should be made to obtain proof of fees paid. The onus of proof is on the individual or their representative to provide evidence of their loss.

1.7. Once NHS Cheshire and Merseyside are in receipt of the completed consent, authority to act and application form they will aim to complete the retrospective review within six months where the duration of the care period to be reviewed is one year or less, and within 12 months where the duration of the care period to be reviewed exceeds one year, however this is dependent upon care providers delivering copies of requested records in a timely way.

1.8. ICB will make sure that the PUPoC request does not relate to a previously assessed period of care.

NHS Cheshire and Merseyside will check its records to consider the following:

(i) Has the person been considered for continuing healthcare previously for the period for care being requested? This may be either using the Checklist process, or a full continuing healthcare assessment.

(ii) If a Checklist was carried out, it should:

- Have been completed appropriately.
- Be clinically sound.
- Reflect the patient information known at the time; relate to the relevant period(s).

[4] https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

[5] https://www.england.nhs.uk/wp-content/uploads/2015/04/nhs-cont-hlthcr-rdress-guid-fin.pdf

- The appropriate patient/representative was informed how to challenge this decision in writing. (NB where the patient is recorded at the time of the assessment not to have capacity the outcome letter being sent to them only is not appropriate).

(iii) Was the individual in receipt of NHS Funded Nursing Care (FNC)? If so a FNC assessment should have taken place once it had been established that the individual was not eligible for NHS CHC. Providing a proper consideration of the need for NHS CHC was made prior to the FNC assessment or annual review, then a further assessment of the past period of care may not be necessary, (Dennison 2014)[6]

(iv) If there is evidence that the individual or their representative refused consent for assessment of a past period of care at the time, the NHS should not accept a new request for an assessment of the same period.

2.0 Retrospective Review Process: Completing an assessment of eligibility for a previously unassessed period of care.

Acknowledgment of application and consent forms.

2.1. A request for a retrospective review will be acknowledged within five working days of its receipt, the applicant will be sent a letter of acknowledgement and an application form (Appendix 1) which includes a section to provide patient and applicant details, reasons for making the request and consent.

2.2. NHS Cheshire and Merseyside must obtain the individual's informed consent for the retrospective review to go ahead. If the individual does not have capacity or the application is from the estate of a deceased person, then NHS Cheshire and Merseyside will obtain consent from the appropriate party with authority to act:

2.3. The consent should include informing the applicant that they are agreeing to the gathering, scrutiny and sharing of records and information with all persons involved in the review process. On occasions it may be necessary to share the applicants details when requesting records.

2.4. Work to progress the review cannot start until the application form and supporting documentation are returned to NHS Cheshire and Merseyside. Applicants are asked to return their completed form and consent within 28-days, where this is not possible the applicant needs to contact NHS Cheshire and Merseyside team to request an extension.

The Checklist

2.3. The first step in the assessment process for most people will be the NHS CHC Checklist[7] . The Checklist is a screening tool, which will help NHS Cheshire and Merseyside work out whether a full assessment of the past period of care is required. The current version of the NHS CHC checklist should be used in accordance with the national framework.

2.4. The threshold of the Checklist is set intentionally low, to ensure that all those who may be entitled to NHS CHC have a full assessment.

2.5. The Checklist is intended to be a relatively quick and straightforward process. NHS Cheshire and Merseyside will use the information supplied by the applicant in their completed application

[6] Dennison, R (on the application of) v Bradford Districts Clinical Commissioning Group [2014] EWHC 2552(Admin) (23 July 2014) https://www.bailii.org/ew/cases/EWHC/Admin/2014/2552.html

[7] https://www.gov.uk/government/publications/nhs-continuing-healthcare-checklist

form, where it evident that the applicant is unsure of the details required NHS Cheshire and Merseyside will gather and reference additional evidence until there is sufficient to complete the checklist.

2.6. If the claim spans a few years, the Checklist will be applied periodically, either where there is significant change or annually, to ensure it picks up deterioration, for example it may be that applying the Checklist at the beginning of the claim period will indicate a full CHC assessment is not necessary, however later in the claim period, due to the progression of their illness, the Checklist may indicate a full assessment is necessary.

2.7. If a Checklist indicates a full assessment is not necessary, for all or part of a claim period, the applicant should be advised in writing and reasons given, including a copy of the completed Checklist. The letter should explain the next steps – i.e. If dissatisfied with the decision, the applicant can request that the checklist and decision is reviewed. Should they remain unhappy with the outcome following this review they will be advised of their option to make a complaint via the organisations general Complaints process.

Gathering and scrutinising the evidence, completing the CHC assessment

2.8. To complete a robust retrospective assessment NHS Cheshire and Merseyside will collect any available contemporaneous evidence from relevant sources.

If the individual was in a care home, then care home records relevant to the claim period will be requested, along with GP records, hospital records if applicable, social care assessments if applicable, any relevant notes from other NHS services such as Community Mental Health or Speech and Language Therapists.

Process for record requesting:

If the applicant has any patient records or relevant information, it is requested that they share them with the team completing the review at the time of sending in their completed application form.

Legislation exists and where a Subject Access Request is made for records and the record holder is expected to provide copies of records within a calendar month of receipt of request [8].

An 'Access to Records Request' is required for deceased patients and the record holder should provide copies of records within 21 days where the record has been added to in the last 40 days, and within 40 days otherwise[9].

A minimum of three attempts to gather records from each care provider will be made, this may be either by telephone, email or letter and a record of these attempts will be kept.

The applicant and NHS Cheshire and Merseyside will be informed when records are not provided following the first request, and the applicant will be asked if they are able to provide any support in obtaining copies of records.

If any records are not available, the care provider will be asked to sign a disclaimer stating that they cannot provide copies of the records, should this happen, the applicant will be informed.

It is important to be aware that the various care providers cited above are obliged to retain records for limited periods of time. Private care homes are guided by the Care Quality Commission and determine their own local policy; at the time of writing this guidance the general retention period is three years. There is a Records Management Code of Practice for Health and

[8] https://ico.org.uk/your-data-matters/time-limits-for-responding-to-data-protection-rights-requests/
[9] https://researchbriefings.files.parliament.uk/documents/SN07103/SN07103.pdf

Social care which provides details of the required record retention periods, and these range from 8-30 years depending on the type of record[10]

2.9. An appropriately trained healthcare practitioner will scrutinise the evidence and compile a needs portrayal document (NPD), (Appendix 2). The needs portrayal will combine all the relevant information from the different sources of evidence to build up a comprehensive picture of the individual's needs across the whole period under review. The evidence will be compiled in chronological order and broken down into the different care domains within the eligibility criteria.

2.10 The needs portrayal document is the starting point after collecting all the evidence. The nurse assessor will complete a first draft of the needs portrayal and share it with the applicant to obtain the applicant's views and gather any additional evidence the applicant may wish the ICB to consider. The applicant should be asked to respond within 28 days, where possible, to allow timely completion of the PUPoC request.

The completion of a needs portrayal document can be considered on a case-by-case basis. Should the nurse assessor conclude that the document would not be beneficial the rationale for this decision will be clearly documented.

2.11 If a written submission is provided by the applicant this will be appended to the needs portrayal document and considered at the assessment stage with the evidence within the care needs portrayal; this consideration should be reflected within the decision support tool document (DST).

2.12 Once the needs portrayal is finalised the information will be used to compile a DST and to complete a CHC assessment to determine if the patient was eligible for CHC funding. The current version of the DST should be used to process the PUPoC request.

2.13 A 'closed' multi-disciplinary team (MDT) of professionals will consider the case, they will complete a DST to assist in the analysis of the case; the applicant will not be invited to attend this meeting; however, their views and opinions will be considered by the MDT. Where a claim period spans several years, then the eligibility criteria may need to be applied several times.

The core purpose of the MDT is to make a recommendation on eligibility for NHS Continuing Healthcare drawing on the multidisciplinary assessment of needs and following the processes set out in this National Framework.

In accordance with regulations an MDT in this context means a team consisting of at least:

- two professionals who are from different healthcare professions,

or

- one professional who is from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014.

Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals. Standing Rules require that, as far as is reasonably practicable, NHS Cheshire and Merseyside must consult with the relevant local authority before making any decision about an individual's eligibility for NHS Continuing Healthcare and in doing so cooperate with that local authority in arranging for such persons to participate in an MDT for that purpose.

2.14 The claim period should be broken down into manageable chunks with the criteria applied to each separate timeframe. A good guide is to split the claim into periods of 12 months; however,

[10] NHS Digital – Records Management Code of Practice for Health and social care 2016. https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016

there may be a significant event or clear deterioration that will determine the split. For example, if after the initial 13 months the individual has a stroke, or a serious pressure sore, then this may be a good point to split the periods under consideration.

2.15 The Primary Health Need Test will be applied as part of the MDT deliberations. A patient has a 'Primary Health Need' when the nature of their care is judged to be beyond that which a local authority could legally provide. To assist in their deliberations NHS Cheshire and Merseyside will consider whether the nature, complexity, intensity, or unpredictability of the individual's needs indicate they had a 'primary health need' during the period under review.

2.16 The National Framework requires that the MDT completes the DST and makes an eligibility recommendation to NHS Cheshire and Merseyside which should be accepted unless in exceptional circumstances, this principle also applied to retrospective CHC assessments. using the National Framework and will be adhered to; NHS Cheshire and Merseyside will complete the DST, apply the Primary Health need test, and make a funding recommendation. NHS Cheshire and Merseyside may follow a local decision-making process prior to issuing the outcome of the assessment – such as verification by an ICB third party who has not been involved in the retrospective review and MDT process. This is not mandated and is to be determined by each locality.

3. Retrospective Review Process: Communicating the CHC Eligibility Decision

3.1 Once approval from NHS Cheshire and Merseyside has been provided NHS Cheshire and Merseyside will write to the applicant to inform them of the outcome of their requested review. A copy of the needs portrayal and DST(s) will be sent with the decision letter; the DST(s) will provide a detailed rationale for the recommendation that has been made.

3.2 If the individual was found eligible for all or part of the period under consideration, NHS Cheshire and Merseyside will arrange to make a restitution payment in line with the Department of Health Redress Guidance[11].

3.3 If the individual was found not to be eligible for NHS CHC funding for all or part of the period being considered, then the decision letter will be sent to the applicant with details of who to contact if they disagree with the decision.

4 Dispute Resolution

4.1. If the applicant disagrees with the decision made by NHS Cheshire and Merseyside, NHS Cheshire and Merseyside should make it clear in the decision letter how to formally dispute the outcome of a PUPoC review.

4.2. There are two stages involved in dealing with a CHC eligibility decision dispute against an NHS CHC retrospective review recommendation outcome.

A local resolution dispute process at ICB level.

and

A review by an Independent Review Panel (IRP) arranged NHS England and Improvement.

4.3. All reasonable attempts should be made by NHS Cheshire and Merseyside to resolve a dispute

[11] NHS England Redress Guidance (NHSE 2015) Source: https://www.england.nhs.uk/wp-content/uploads/2015/04/nhs-cont-hlthcr-rdress-guid-fin.pdf

locally. This will include:

- A face to face/virtual meeting or telephone conversion (if preferred) with the applicant to discuss their reasons for appealing the PUPoC outcome.

- A review of the decision, if key evidence has been overlooked NHS Cheshire and Merseyside may return the case for the team to review it again including the missing evidence.

There will be a local Standard Operating procedure in place which will provide applicants with more details of the dispute process.

4.4. Once the appeal process has been completed the claimant will be informed of the outcome. The outcome letter will provide details of 'next steps' that the applicant can take if they are unhappy with the outcome. NHS Cheshire and Merseyside should make it clear in the decision letter how to formally dispute the outcome of a PUPoC review this will include their option to contact NHS England for an Independent Review of their case.

5. Independent Review and The Parliamentary Health Services Ombudsman.

If NHS Cheshire and Merseyside has exhausted attempts to resolve the applicants dispute at a local level, they will be advised that they can request a review by an Independent Review Panel.

To do this the applicant will need to contact their local NHS England Continuing Healthcare Department within six months of the date of their local dispute resolution outcome letter.

Details of the Independent review process can be found within the National framework In addition, the NHS England, NHS Continuing Healthcare: Independent Review Process Public Information Guide, will be shared within the applicant's outcome letter.

Following completion of the Independent Review Process if the claimant is unhappy with the outcome, they will be advised that they have the option to raise a complaint with the Parliamentary Health Services Ombudsman; the details of this will be included in the Independent Panel's outcome letter.

Department of Health & Social Care

NHS England

Appendix 1 – application form for individuals

Requests for assessments of previously unassessed periods of care from 1 April 2012

Published 14 December 2023

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Application form 14

Introduction

This is a template application form intended to help individuals prepare for their application.

Please contact your local integrated care board for information on the process for making a request and to be sent an application form to complete.

Guidance for completing the application form.

This application form serves as a record of the request for an assessment of a previously unassessed period of care for NHS continuing healthcare (NHS CHC) from 1 April 2012. Please complete all questions in as much detail as possible.

You will have the opportunity to submit your own documents as evidence of care needs and payments for such care alongside this form.

Types of evidence which may help you to complete this form and may support the application can include:

- hospital records
- residential care home records or home care records
- GP records

- nursing records or care charts
- symptom diaries and/or daily care sheets
- care and support plans
- letters, including appointment details and discharge letters
- records from other health professionals or specialists - for example, speech and language therapists, tissue viability nurses or physiotherapists
- prescriptions
- invoices, receipts and bank statements with details of paid-for care

Please note: this list is not exhaustive. Further examples of relevant evidence can be found in Practice Guidance note 22 in the National framework for NHS continuing healthcare and NHS-funded nursing care (2022).

If you would benefit from support or advice with completing this form, please consider speaking with a health or social care professional, or someone who knows about your care needs or health situation.

Application form

Personal details of the individual this request is for

Full name	
Date of birth	
Date of death, if applicable	
Home address	If the individual is now resident in a care home, please also provide their home address prior to moving:
Address of care homes, if applicable	Please give the details of all care homes the individual has lived in during the time period being considered: Name and address of care home 1:

	From (DD/MM/YYYY): To (DD/MM/YYYY): Name and address of care home 2: From (DD/MM/YYYY): To (DD/MM/YYYY): If you require additional space, please continue answers on separate paper.
NHS number	
Name and address of GP that individual was registered with immediately prior to period of care to be considered	
Dates you are requesting for assessment of a past period of care	

Information about the individual's needs and assessment history

Please complete the following as fully as possible. If you require additional space, please continue answers on separate paper.

Were any of the following assessments undertaken? (Please delete as appropriate.)

NHS continuing healthcare checklist
Yes/No/Unsure

NHS continuing healthcare decision support tool
Yes/No/Unsure

NHS-funded nursing care assessment
Yes/No/Unsure

If yes, please provide the relevant dates:

Was the individual in hospital immediately prior to the period you are asking to be assessed? If so, which hospital? Please include a summary of the relevant treatment history and admissions/discharges from hospital.

During the review period, was the individual seeing any health professionals - for example, a medical consultant, community psychiatric nurse, district nurse, speech and language therapist, tissue viability nurse or others? If so, please provide a summary of details below including which professionals, frequency of appointments, when they were first referred, and whether they have been discharged.

Please provide a summary of the care needs of the individual for the claim period. For detailed description of these needs, individuals can consult the decision support tool (DST) form - NHS continuing healthcare decision support tool on GOV.UK. You may wish to consider the following:

Breathing	Mobility	Behaviour
Nutrition and/or food and drink	Communication	Medication and/or drug therapies, including symptom control
Continence needs	Psychological and emotional needs	Altered states of consciousness
Skin and/or tissue viability	Cognition	Any other significant care needs

Please list below any existing evidence which you think may help support your claim and which you intend to forward with this application. Any existing evidence of the individual's care needs relevant to the claim period should be submitted along with this application form. This could include GP records or any other records detailing care provided to the individual during the claim period. This evidence may help to speed up the assessment process.

Please list below any existing evidence that the individual paid for their care which you think may help support your claim and which you intend to forward with this application. Any existing evidence of payments relevant to the claim period should be submitted alongside this application form. This could include receipts and/or bank statements. This evidence might help to speed up the reimbursement process (if applicable).

Personal details of the individual completing this application

Full name	
Home address	
Relationship to the individual this request is for, if applicable	
Telephone number	
Mobile number	
Email address	

Submission

Please sign and date this application form

Name……

Signature……

Date
(DD/MM/YYYY)……

You may also be required to complete a consent form and provide proof of your authority to make this claim.

Please return the following documents to us as soon as possible and no later than 28 days from the date this form was sent to you:

- this application form
- consent form (if applicable)
- authority documents (if applicable)
- evidence of care needs and payments for care received

Department of Health & Social Care

NHS England

www.gov.uk/dhsc

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Appendix 2 – needs portrayal template.

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Cover page

Integrated care board	
Individual's name	
NHS number	

Date of birth:		Date of death (if applicable):		Gender:		Age:		Ethnicity:	

Applicant's name:		Start date of periods under consideration:	
Relationship to the individual:		End date of periods under consideration:	

Address of individual: at time of period under consideration (please add all addresses)	GP details

Name of person preparing the report:		Signature:	
Professional qualifications of person preparing the report:		Date:	

Summary of evidence used

	Please tick if used to inform this document (If evidence is not available, please state the reason - for example, care home closed; notes destroyed)
Care home records	
Hospital records	
GP records	
Social care services records and/or assessments	
District nursing records and/or community records	
Mental health records	
NHS continuing healthcare (CHC) and/or NHS-funded nursing care (FNC) assessments	
Other specialist records (for example, dietician, physiotherapy, speech and language therapy, tissue viability) Please specify.	

Guidance notes for completing this document

This document is intended to be an objective record of an individual's health and social care needs during a specified period.
For more guidance on how to complete this needs portrayal please refer to the guidance notes below.

It is to be completed by an individuals with the appropriate skills or qualifications to pick out the relevant information as required. The needs should be drawn from all the available sources of evidence, including that from the applicant.

As far as possible, your findings should be in chronological order.

Remember to reference the source of information on the form (for example, care home records) and to identify the point in the records. This will make it easier to refer to if necessary.

Where information is not available or there is no supporting evidence, state this clearly.

Medical history

Medical history in date order (High-level overview) If the individual is deceased, include cause of death if known		
Date	Findings	Source of information

Summary of individual's situation

Summary pen portrait of the individual’s situation, relevant history (particularly clinical history), including clinical summary and identified significant risks. Please include social history, capacity and safeguarding.

Findings	Source of information For example, care home records, GP records

Chronology of key event

Events leading up to this needs portrayal including:

- individual's pathway
- hospital admissions and dates
- relevant assessments and dates
- previous NHS CHC considerations if applicable and dates

Date	Findings	Source of information

Date	Findings	Source of information

Care domains

Breathing: This domain includes but is not limited to: breathlessness due to respiratory, cardiac, other condition Smoking history	Disease history Exacerbation or COPD medications and the need for oxygen, inhalers, nebulisers	Specialist intervention and/or equipment needs input Airway clearance techniques, BiPAP CPAP, tracheostomy, ventilation

Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Nutrition – food and drink: This domain includes but is not limited to: Nutritional status including weight, BMI, food and fluid type – Intervention times Assessment tools	Aids and adaptations Alternative feeding methods (please specify) likes or dislikes Can they eat and drink independently or require assistance? If requires assistance how long does it take?	Problems, for example swallow, aspiration Specialist intervention, needs input, SALT

Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Continence: This domain includes but is not limited to: Level of continence Level of dependence	Aids and equipment required, such as stoma, catheter – are they problematic? Recurrent UTIs	Specialist interventions and/or needs input Frequency of any required monitoring
Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Skin including tissue viability: This domain includes but is not limited to: Actual and potential problems Risk assessment, such as Waterlow Details of wounds and treatments, Pressure sore gradings, responding to treatment?	Skin conditions and treatment required Aids and equipment needs Related medical conditions	Positioning, turning Specialist intervention/needs input, TVN, dermatology Frequency of monitoring

Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Mobility: This domain includes but is not limited to: Level of independence, dependence Level of supervision/assistance –number of staff required Aids and equipment needed Moving and handling assessment Maintaining a safe environment Risk assessments, such as falls Specialist intervention/needs input/Physiotherapist/OT Contractures/spasms		
Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Communication: This domain includes but is not limited to: Verbal and non-verbal abilities/fluctuations Comprehension Can they understand instructions?	Can they make their needs known verbally/non-verbally? Or can they be anticipated? Aids used/needed Specialist input Sensory deficits	Extreme frustration associated with communication difficulties Hazards – insights into, are they able to request help? SALT assessment
Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Psychological and Emotional Needs: This domain includes but is not limited to: Mood Disturbance and anxiety symptoms – predictable/unpredictable	Withdrawn? Do they participate in activities of Daily Living and care planning (or is this due to cognitive impairment)? Medication required	Do they respond to prompts and reassurance? Specialist intervention/needs input

Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Cognition: This domain includes but is not limited to: Cognitive function – Memory/decisions and choices Awareness of needs and basic risks Insight into impairment?	Orientation – time/place/person Confusion Delusions/preoccupations/paranoia/ hallucinations	Specialist intervention Assessment tools/Mini Mental state examination undertaken

Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Behaviour:
Challenging behaviour in this domain includes but is not limited to:

Persistent noisiness
Persistent restlessness
Inappropriate interference with others
Inappropriate sexual behaviour
Inappropriate urination
Faecal Smearing
Severe disinhibition
Wandering
Physical violence
Threatening violence
Verbal abuse
Extreme frustration associated with communication difficulties
Resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance)
Risk to self and/or others
Identified high risk of suicide
What is the frequency of the behaviour?
Are there known triggers?
How is the behaviour managed?
Are skilled interventions required?
Is the person on medication to control behaviour?

Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Medication – reference only

Name of drug, /used for	Dose	Frequency	Route	Compliance	Frequency of review

Medication/Symptom control: This domain includes but is not limited to: Administration/compliance Aids & equipment Qualified input e.g. PRN medication Monitoring of medication in relation to fluctuating physical/mental conditions Are there strategies in place to aid compliance with medication? E.g. covert medication regime? And if so, has this been formally authorised?	Level of dependency, educational needs, physical abilities Ability of understanding Allergies Levels and location of pain and effectiveness of pain control measures	Pain assessment tools/assessment Equipment Compliance Specialist intervention needs input e.g. Macmillan

Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Altered States of Consciousness: This domain includes but is not limited to: Describe the type of ASC – e.g. seizures, hypotension, hypoglycaemia, Stroke, TIA Describe frequency, length and severity of episodes Describe resultant risk of harm	Are they predictable or unpredictable/are there triggers?	Outline intervention required – e.g. buccal midazolam for seizures Is any emergency input required and if so what and how often?
Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Other significant care needs: This domain includes but is not limited to: Actual sleep pattern Identifying any sleep deficits Need for intervention, such as continence needs, safety issues, moving and handling, feeding Mental function Equipment needs. Medication issue needs		
Date of record	Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order)	Source of information For example, care home records, GP records

Applicant's comments on the needs portrayal

Signature of the applicant:	_____Date: _____

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