Reference: FOI.ICB-2627/181

Subject: Supported Living Commissioning, Brokerage and Live Availability

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
Please provide the information below in relation to adult supported living placements only, that were commissioned, funded, arranged or brokered by your organisation throughout the period 1 July 2025 to 30 June 2026. For this request, "supported living" means accommodation-based support where the person's housing and care or support arrangements are legally separate. It excludes registered residential and nursing care homes. Where information is not held, please state "not held". Where figures are requested, please provide information already held in a reportable form; no new analysis or calculation is required.	
1. Does your organisation commission, fund, arrange or broker adult supported living placements? If yes, please identify the team or department responsible and briefly describe how referrals are circulated to providers, including how out-of-area searches are undertaken.	Bristol and South Gloucestershire supported living packages are commissioned via the Funded Care Brokerage Team, based within the ICB. Communication with providers is via email; bnssg.brokerage@nhs.net North Somerset supported living packages are commissioned via the Brokerage Team, based within North Somerset Council. Communication with providers is via email; brokerage.team@n-somerset.gov.uk Referrals for both in area and out of area are circulated to providers via email, we obtain the provider list from our 3 Local Authorities (LAs).
2. Do you use a Dynamic Purchasing System, framework, e-brokerage portal, care marketplace or	BNSSG ICB does not use a Dynamic Purchasing System, framework, e-brokerage portal, care marketplace or other digital system to source or match supported living placements

other digital system to source or match supported living placements? If yes, for each system please provide: a) its name; and b) the number or proportion of supported living placements for which it is used, where recorded.	Providers new to the area are encouraged to contact the ICB's Brokerage Team at the following: bnssg.brokerage@nhs.net
3. Do you maintain a list or database of: a) supported living providers; and b) individual supported living schemes or properties? If yes, please provide: i. the number of providers and schemes or properties recorded; and ii. the information fields held for each scheme or property, including whether capacity, location and provider details are recorded. Individual addresses are not requested.	a) The ICB does not maintain a list or database specifically for supported living providers b) The ICB does not participate in individual supported living schemes or properties
4. Do you hold current or live information on vacancies or available capacity in supported living services? If yes, please explain: a) how providers submit or update the information; b) how frequently it is expected to be updated; and c) who can access it. If no live information is held, please briefly describe how vacancies are identified.	No, the ICB does not hold current or live information on vacancies or available capacity in supported living services

5. For the period 1 July 2025 to 30 June 2026, please provide the following where recorded: a) the number of supported living placement searches or referrals undertaken; b) the number or proportion resulting in an out-of-area placement; c) the average or median time from the start of a search to suitable provider options being identified; and d) the average or median time from the start of a search to the person moving into the service.	a) The ICB does not record the numbers of searches or referrals undertaken. b) In the timeline requested, 16 out of area placements were made. c) The ICB does not break down data in this way so are unable to provide the data requested d) The ICB does not break down data in this way so are unable to provide the data requested
6. Please provide copies of the following current documents, with all personal information removed: a) any standard supported living referral form, assessment summary or referral passport; and b) any written policy, guidance or process document covering supported living brokerage, matching, provider engagement or out-of-area placements.	The ICB's clinical team uses the following: Care Needs Summary (CNS) or Personalised Care Plan (PCP), please refer to the enclosed documents. 01 CNS v3 June 2025.pdf 02 Personalised Care Plan - v8.pdf We may also seek a therapy guided assessment of environmental needs related to the individual and this would be provided by the Occupational Therapist (OT) or Physio involved in the case (through Sirona or LA who hold their own templated docs). If the individual's capacity needs assessing in order to conclude if they have capacity to decide their care and location of care, we would assess using the Mental Capacity Act and Best interest templates. Please refer to enclosed documents.

	03 Best Interests Decision- Sept 2022 v We would then make a decision in their best interest if no OPG (Office of Public Guardian) legal representative is identified via an LPA (Lasting Power of Attorney). The ICB's Brokerage team do not currently have any formal forms but are in the process of creating the following: Supported living pro forma (for the CHC nurse to complete with details of the request) Supported Living Provider Service Specification form (for the provider to complete when responding to a Supported Living Request) The brokerage team also uses a SHEA (Safe Homes Environment Assessment) tool which is completed by the OTs that provides a breakdown of the environment needed. Home - SPFT SHEA Portal Please also refer to the Commissioning Policy for All Age Continuing Care

The information provided in this response is accurate as of 28 August 2026 and has been approved for release by Rosi Shepherd, Chief Clinical Leadership and Delivery Officer (Nursing) for NHS Bristol, North Somerset and South Gloucestershire ICB.

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

NHS Continuing Healthcare Assessment Form

ABOUT ME – Please gather protected characteristic details and record at end of form	
Name:	
Address:	
Admission date	
DOB:	
CT number:	
NHS No:	
GP and Surgery:	

PEN PORTRAIT **For example, social situation, previous employment and interests**

PAST MEDICAL HISTORY **Include where information was sourced**

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

MY CONTACT PREFERENCES – Please record any accessible information standard responses in this section and ensure these are also documented on Caretrack.		
I would like to be contacted by:		
Phone		My number is:
Email		E-mail is the preferred method of contact for documents and outcome letters, unless otherwise requested. My email address is:
Post		

I would like someone else to act on my behalf.

Their name:

Their contact details: as above

Their relationship to me:

Legal authority to act:

(copy required if POA for health and welfare)

NB. This section also applies if the individual does not have capacity regarding this decision.

IMPORTANT CONTACT DETAILS			
Name	**Profession/ Relation/ Involvement**	**Contact details**	**Involved in assessment? Date**

CURRENT / RECENT HOSPITAL ADMISSIONS		
Admission date	**Reason for Visit**	**Discharge date**

MOST RECENT GP INTERVENTIONS	
Date	**Reason for Visit including Treatment/Plan/Outcome**

OTHER PROFESSIONAL VISITS	
Date	**Reason for Visit, including Treatment/Plan/Outcome**

Evidence Used to Support Assessment / Review:
Type, date and source:

RISKS	
Evidence of all appropriate risk assessments documenting potential impact and likelihood to consider relevant risks to the patient carers care workers and society should be attached to patient database. Use boxes below to indicate which, if any, are present.	
Areas to consider	**Record details, severity, frequency, whom it invloves**
Risk to Self • Suicide • Deliberate self-harm • Accidental self-harm • Self neglect • Addiction (alcohol/drugs) • Wandering • Falls	
Risk to others • Physically violent • Threat of violence • Verbally abusive • Sexually inappropriate behaviour	
Vulnerability from Others • Financial Abuse • Physical Abuse • Emotional Abuse • Sexual Abuse • Social Isolation	
Unstable Mental State • Mental health likely to deteriorate quickly or unpredictably	
Is the person subject to any Section of the Mental Health Act? If yes ensure you understand guidance before considering Continuing Healthcare Funding. Refer to National Framework for Continuing Healthcare (refer to section 112 'Links to other policies'.	
Compliance Problems • Refusing nursing/ therapy/ care interventions	

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)	
Is the individual currently subject to DoLS? If yes, please request copy of either completed DoLs or the urgent authorisation from the care home. **Are deprivations proportionate and reasonable?** Any concerns please discuss with clinical lead/complex case lead	**Details:**
Does the individual meet the criteria for a community DoLS? Clinical Lead to inform ICB DoLS Team at point of decision making if a Community DoL Order from the Court of Protection is required for CHC funded individuals.	**Details:**

BREATHING **Level of need at previous DST:**	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
History / Diagnosis affecting breathing including COPD, PE, asthma	.
Normal no issues	
Shortness of breath on exertion / at rest / frequency & severity	
Able to speak in full sentences	
Too breathless to leave house/ breathless dressing / undressing etc.	
Does it respond to rest/ treatment	
Does it limit activities if yes to what extent	
Any medications prescribed inhalers/ nebulisers/ steroids	
Any additional breathing support / equipment e.g. Tracheostomy / CPAP / BiPAP/ ventilation / Oxygen / suction	
Any cough / wheeze/ recurrent chest infections	
Other management measures	

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

NUTRITION **Level of need at previous DST:**	**Detail needs** (including weight – history & current weight , BMI & nutritional risk assessment tool e.g. MUST) Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Specialist input	
Oral intake	
Normal diet / fluids	
Modified diet / fluids (specify)	
Artificial / enteral feeding/ Nil by mouth	
Problematic PEG?	
Independent eating / drinking	
Requires supervision / prompting / assistance	
Fed – record length of time to feed	
Good appetite / poor appetite	
Weight stable / weight loss	
Supplements prescribed	
Nutritionally at risk / malnutrition	
Diagnosis affecting gut function	
Nausea / Vomiting	
Aspiration risk? Choking? Dysphagia?	

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

Continence **Level of need at previous DST:**	**Detail needs** (including management and products and level of assistance & no. of staff) Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Continent	
Occasional incontinence	
Incontinent / frequent urinary incontinence	
Double incontinence	
Diarrhoea / constipation	
Prescribed medications	
Catheter / Stoma – type (independent or dependent)	
Problematic catheter or stoma care?	
Bowel support/ digital rectal/ manual evacuation	
Independent (if no specify assistance needed)	
Urine infections? Management plan?	

SKIN **Level of need at previous DST:**	**Detail needs** (including management interventions and level of assistance & no. of staff) Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Specialist input	
Wound type/ grade/ site/ dressing & regime	
Responding to treatment	
Skin intact / low risk of breakdown	
Equipment in place/ needed to maintain skin integrity- specify	
Skin condition	
Prescribed medications/ creams / lotions – frequency	
Pressure ulcer score i.e. Waterlow	
Preventions in place (specify)	
Able to reposition independently in chair / bed	
Repositioning required include frequency & no. of staff	

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

MOBILITY (including falls risk and manual handling) **Level of need at previous DST**	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Any diagnosis affecting mobility	
Has sitting balance	
Weight bearing (consistent)	
Mobile independent?	
Mobile independent (supervision required)	
How far can the person mobilise?	
Climb stairs?	
Get on / off chair / toilet?	
Get in / out of bed?	
Require positioning / turning in bed?	
Mobilise with assistance of one / two people and / or equipment : Specify	
Immobile / unable to weight bear?	
Transfers independently?	
Transfers with assistance / aids (specify)	
Risk of falls as documented in risk assessment?	
Spasms / contractures?	
Careful positioning required?	
Stable/unstable/deteriorating	
Mobility / manual handling equipment used: e.g. Hoist / stand aid/ slide sheets	

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

COMMUNICATION **Level of need at previous DST:**	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Ability to express their needs, including verbal and non-verbal methods / interventions / support.	
Any specialist input i.e. SALT? (if yes include copies of assessments)	
Reliable verbal communication?	
Limited verbal communication?	
Communication by gestures, body language?	
Unable to reliably communicate?	
Aids used (pictures/ symbols)?	
Answer questions appropriately? How often?	
Able to ask for care/ help? How often? What care?	
Can staff anticipate needs through non-verbal signs?	
Sensory Hearing & Sight	
Any impairments?	
Complete loss of sight?	
Partial loss of sight?	
Complete loss of hearing?	
Partial loss of hearing?	
Aids used (specify)?	

PSYCHOLOGICAL & EMOTIONAL **Level of need at previous DST:**	**Detail needs** (Please comment on the person's mood, any periods of distress and anxiety symptoms, including identified triggers) Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Any diagnosis / history:	
Any medications or interventions prescribed?	
Any specialist input / assessment?	
Mood appropriate?	
Withdrawn?	
Depressed?	
Low in mood?	
Sad / tearful?	
Anxious?	
Distressed?	
Responsive to pleasant events?	
Responsive to reassurance?	
Does the problem / need: Impact on health / well being? Impact on usual activities? Impact on sleep?	

SOCIAL INTERACTION	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
No difficulties?	
Requires support to participate?	
Enjoys visitors?	
Enjoys activities / interacting with others?	
Struggles activities / interacting with others?	
Struggles to initiate conversation?	
Difficulty with usual activities?	
Anger or sadness over lost roles?	

SLEEP	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Normal sleep?	
Change from usual pattern but satisfactory?	
Disturbed sleep and unsatisfactory?	
Major disruption with frequent waking periods?	
Turning required?	
Night sedation required?	

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

COGNITION **Level of need at previous DST:**	**Detail needs** (Please comment on the person's ability to make decisions day to day (capacity); comprehension and ability to receive and understand information) Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Has a cognitive assessment been completed (If yes please attach a copy)	
Any diagnosis affecting cognitive functioning?	
Any specialist input?	
Orientated to time?	
Orientated to place?	
Orientated to person?	
Confused?	
Forgetful?	
Asks for care interventions?	
Able to call for help?	
Understand / use the call bell?	
Simple choices?	
Requires help to make most decisions?	
Able to make complex decisions?	
Evidence of short term memory loss?	
Evidence of long term memory loss?	
Able to identify risk? Basic or complex?	
Are there any factors making this difficult to assess? Eg communication / psychological & emotional needs, behaviour etc.	

Personal Hygiene (washing / dressing / grooming)	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Independent?	
Dependent?	
Hand on hand support required?	
Requires supervision / prompting / minimal Assistance?	
Able to assist in limited ways (please record)	

BEHAVIOUR **Level of need at previous DST:**	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Verbal aggression	**Behaviours**
Physical aggression	
Disinhibition	
Persistent noisiness	
Persistent restlessness	
Socially inappropriate	
Interference with others	
Sexually inappropriate	**Triggers**
Inappropriate elimination	
Compliant with care/interventions	
Triggers	
Positive behavioural management plan in place?	**Interventions**
Management of behaviours	
Number of carers needed	**Incidences**

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

DRUG THERAPIES and MEDICATIONS **Level of need at previous DST:**	**Detail needs** (Include type of medication, route & frequency & list of current medication) Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Self-medicates	
Requires prompting / supervision	
Carer/ Care worker gives medications	
Medications administered by a registered nurse (specify reasons)	
Always compliant with regime	
Occasional non- compliance / non-concordance (specify frequency of episodes)	
Regular episodes of non- compliance (specify)	
Liquid medications	
Covert medications (include care plan etc.	
Monitoring of medication regime e.g. Insulin / warfarin	
Other monitoring i.e. Blood sugars / blood tests (specify frequency & if stable/ unstable	
Any PRN (as required) medications	
Is skill needed to recognise symptoms & administer as required	
Allergies	

PAIN and SYMPTOM CONTROL	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
No pain	
Intermittent pain	
Mild pain	
Moderate pain	
Severe pain	
Medication prescribed: ensure type, strength, frequency, route recorded here **or** in medications section.	
Is analgesia effective/ is pain controlled	
Other interventions to reduce / minimise pain	
Any other symptoms affecting care delivery i.e. nausea	

ALTERED STATES OF CONSCIOUSNESS **Level of need at previous DST:**	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
No History / Diagnosis	
Occasional episodes/ history	
Diagnosis of CVA / TIA / Epilepsy / coma / syncope/ vasovagal	
Frequent episodes of unconsciousness	
Type of episodes and frequency	
Prescribed medications/ treatments & route	
High risk of harm/ skilled / lengthy input required	

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

ANY OTHER NEEDS **Level of need at previous DST:**	**Detail needs** Have there been any material changes in this care domain? Has there been a need to update the care plan since it was implemented? Does the quality and quantity of care required remain the same as was required at the previous DST/checklist?
Recurrent chest infections Diagnosis affecting needs not already documented Other needs that require monitoring	

Referrals to Other Professionals or Services Either completed or requested by the nurse assessor		
Referral	**Rationale**	**Date completed**

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

End of Life Care Needs (complete if end of life care needs have been identified)	
ReSPECT and Treatment Escalation Is there a treatment escalation plan/ReSPECT form in place? What is the ceiling of treatment? What is the resuscitation decision? Has an EPAACs template been completed on Connecting Care?	**Details:**
Have end of life preferences been discussed and by whom? Who had that discussion? Are family aware? Who has the right to speak on behalf of the person if they lose capacity or the ability to communicate?	**Details:**
Does the individual have an end of life care plan in place?	**Details:**
Are there anticipatory medications and a palliative care drug chart in the home? If not who is taking responsibility for this	**Details:**
How often does the care package need to be reviewed in line with deterioration/changing need? Karnofsky scoring	**Details:**
Appropriate services in place for support? Any referrals required?	**Details:**

Outcome and Rationale		
Domain	**Current level of need** (if applicable)	**Previous level of need (indicated on the DST or checklist)**
Breathing		
Nutrition		
Continence		
Skin		
Mobility		
Communication		
Psychological and emotional		
Cognition		
Behaviour		
Medication		
Altered states of consciousness		
Other		

FNC Review – Remains FNC Eligible ☐

FNC Review – No Longer FNC Eligible ☐

FNC Review – Triggered CHC Assessment ☐

New CHC assessment- DST to be completed ☐

CHC Review – Change in needs - Eligibility review required - DST to be completed ☐

CHC Review - No change in needs/remains eligible ☐

Rationale:
(Utilise the four key indicators: nature, intensity, complexity and unpredictability)

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

Completed by	
Name:	
Role:	
Profession:	
I confirm that I have provided the patient / representative [please delete] with the following information (where appropriate): ☐NHS Continuing Healthcare Patient Information leaflet ☐Information on PHBs ☐Explained what can reasonably be provided in accordance with the ICB's choice and equity policy ☐Signposted to the local authority for carers assessment (if applicable) ☐Other:	
Signature:	
Date:	

Is this a CHC review, or CHC newly eligible individual?

☐**Yes:** complete care provision section, accessible information and equality monitoring

☐**No:** complete accessible information and equality monitoring form

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

CARE PROVISION

Placement

Nursing/residential home placement		
Name		**Details/requirements:**
Address		
Telephone Number		
Email		

At Home

Care Agency	
Name	
Address	
Telephone Number	
Email	

Secondary/Respite Provider Details	
Name	
Address	
Telephone Number	
Email	

Time of Visit		Mon	Tues	Weds	Thurs	Fri	Sat	Sun	Duration of visit	Number of carers
Morning										
Lunch										
PM										
Evening										
Waking Nights										
Sleep-ins										
Welfare Checks										
Live in care										
Other visits										

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

Summary of Services Required	AM	Lunch	PM	Evening	Overnight Care	Other
Assist with full bed bath/showering including intimate areas, hair, foot and oral care						
Shave						
Freshen up, washing intimate areas, hands and face						
Assist to change clothing						
Continence, assist onto toilet or commode						
Catheter care, emptying and changing catheter bags as required						
Stoma Care						
Check and change incontinence products, including personal hygiene						
Reposition and make comfortable						
Assist with transfers						
Skin care – observe skin for signs of redness, report to district nurse as needed						
Meal and drink preparation, clearing up afterwards						
Assistance with feeding of food and drink						
PEG feed						
Prompt medication						
Change bedding as required						
Check Visit						
Special instructions / Additional duties: (please specify)						

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

Is The Care Provision Meeting the Individual's Needs? Include provider, nurse assessor and patient/representative views. Details any adjustments required Detail next review period of care provision

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

Providing accessible information for you

We want to make sure our patients feel safe and are treated with dignity and respect. The information you give will be recorded safely and securely alongside your patient notes.

We have a legal and moral duty to meet the communication and information needs of all patients with a disability, impairment or sensory loss. By collecting this information from you, we can ensure that any care or communication you receive is provided in a way that is accessible to you.

The information we receive about you may be shared with other health and adult social care providers to ensure your needs are met.

1a. Do you consider yourself to have a disability? ☐ Yes ☐ No ☐ Prefer not to say

1b. If yes, please specify:

☐ Sight impairment ☐ Hearing impairment ☐ Speech impairment

☐ Learning difficulties ☐ Learning disability ☐ Mental health

☐ Physical disability ☐ Progressive conditions and physical health

2. Do you need any extra help with your communication? You may have a learning disability or a difficulty with your eyes or hearing, you may need to use type talk or a communication aid or you may want us to communicate with someone on your behalf. Please tell us what works for you.

☐ Yes ☐ No

If you answered 'yes' to question 2, please answer the following questions so we can understand more about your communication and information needs.

3. How would you prefer us to keep in touch with you?

☐ No preference ☐ Home telephone ☐ Work telephone

☐ Mobile telephone ☐ Letter to home address ☐ Fax

☐ Email address ☐ Text message/SMS ☐ Letter to temporary address

Please State:

4. If you need large print, which font size is best?

☐ Font size 20 ☐ Font size 24 ☐ Font size 28

5. If you use Braille, which code do you need information in?

☐ Braille Grade 1 ☐ Braille Grade 2 ☐ Moon

6. If you use sign language, which kind of interpreter do you need?

☐ British Sign Language ☐ Makaton ☐ Sign-supported English

7. If you are deafblind, which kind of interpreter do you need?

☐ Deafblind block alphabet ☐ Hands on signing interpreter

☐ Deafblind manual alphabet ☐ Visual frame

8. Do you have any other hearing needs?

☐ I wear a hearing aid in my: ☐ Right ear ☐ Left ear ☐ Both ears

☐ I require the use of a hearing loop

9. Do you need information to be in an easy read format? ☐ Yes, I use easy read

10. Do you need a lip speaker or note-taker?

☐ Lip speaker ☐ Note-taker (paper) ☐ Note-taker (electronic)

11. Do you need information in a digital format?

☐ Audio recording ☐ Speech to text reporter

12. If you need someone with you when we visit, who might this be?

☐ Carer/family member ☐ Citizen advocate (volunteer) ☐ Legal advocate

13. Do you need a longer appointment so we can accommodate your communication needs?

☐ Yes, I need a longer appointment

If you are a parent or carer completing this form on behalf of a patient and you have a communication or information need you'd like us to be aware of, please record it here:

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

About you — equality monitoring

We collect equalities information to meet our duties under the Equality Act 2010 and develop our insights into CHC patients and ensure we provide appropriate care. The categories included in the questions may not be exhaustive or reflect how you feel or identify. We will be reviewing these to align with approaches across Government. Filling these in is optional, and you do not have to provide an answer if you do not wish to do so.

Please provide us with some information about yourself. We collect information to help us understand whether people are receiving fair and equal access to NHS Continuing Healthcare (CHC) via the NHS CHC Patient Level Data Set (PLDS) which is used to help achieve better patient outcomes, better experiences and better use of resources in CHC. The lawful basis for collecting this information is Article 6 (1) (c) of the GDPR enacted by the Data Protection Act 2018. Please note that NHS CHC PLDS data is pseudonymised for analysis purposes. This means that identifiers such as names, NHS numbers and dates of birth are removed. Detailed information about the use of individual's identifiable data is publicly available at https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/gdpr/gdpr-register

1 What is your gender?

Tick one box only

☐ Male
☐ Female
☐ Indeterminate (unable to be classified as either male or female)
☐ I prefer not to answer

2 Which age group applies to you?

Tick one box only

☐ 18-24
☐ 25-34
☐ 35-44
☐ 45-54
☐ 55-64
☐ 65-74
☐ 75-84
☐ 85+
☐ I prefer not to answer

3 Do you have a disability as defined by the Equalities Act 2010?

Tick one box only.

The Equality Act 2010 defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

☐ No
☐ Yes
☐ I prefer not to answer

4 What is your ethnic group?

Tick one box only.

A White
☐ British
☐ Irish
☐ Any other White background, write below
Click here to enter text.

B Mixed
☐ White and Black Caribbean

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

☐ White and Black African
☐ White and Asian
☐ Any other Mixed background, write below

Click here to enter text.

C Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi

☐ Any other Asian background, write below

Click here to enter text.

D Black, or Black British
☐ African
☐ Caribbean
☐ Any other Black background, write below

Click here to enter text.

E Other ethnic group
☐ Chinese
☐ Any other ethnic group, write below
Click here to enter text.

Prefer not to say
☐ I prefer not to answer

5 What is your religious or other belief system affiliation?

Tick one box only

☐ Baha'i
☐ Buddhist
☐ Christian
☐ Hindu
☐ Jewish
☐ Muslim
☐ Pagan
☐ Sikh
☐ Zoroastrian
☐ Other
☐ None
☐ Prefer not to answer
☐ Unknown

6 Which of the following best describes your sexual orientation?

Tick one box only

☐ Heterosexual or Straight
☐ Gay or Lesbian
☐ Bisexual
☐ Other sexual orientation
☐ Prefer not to answer

Other, write below

Click here to enter text.

Name: CT: DOB: NHS No:

Nurse Assessor: Assessment Date:

NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

Personalised Care Plan: Continuing Healthcare

My Details	
Name:	
Address:	
Admission date (if applicable)	
DOB	
Caretrack number	
NHS No	
GP and Surgery	

ALL ABOUT ME **Please use this space to tell us more about yourself, for example social situation, previous employment and interests.**

PAST MEDICAL HISTORY **Please use this space to tell us about your diagnoses and about how your conditions impact on your lifestyle**

WHAT IS IMPORTANT TO ME **Tell us about what is important to you, and what you'd like to achieve.**

MY CONTACT PREFERENCES		
I would like to be contacted by:		
Phone		My number is:
Email		My email address is:
Post		

Someone else acts on my behalf

Their name:

Their contact details:

Their relationship to me:

Legal authority to act:

(Copy of LPA/deputyship or OPG100 search is required to ascertain whether an LPA/court appointed deputy/EPA is in place)

NB. This section also applies if the individual does not have capacity regarding this decision.

IMPORTANT CONTACT DETAILS
Please use this space to record any significant people in your life

Name	Profession/ Relation/ Involvement	Contact details

Accommodation & Environment:

Current accommodation circumstances (please highlight as appropriate)

(In case of transport, adaptation or equipment needs)

House	Owner occupier	Living alone
Bungalow	Council tenant	Living with spouse
Sheltered Housing	Housing Association Tenant	Living with offspring
Ground Floor Flat	Private Tenancy	Living with siblings
Flat above ground floor	Lodgings	Living with other relative
Residential Home	Other:	Living with friend
Nursing Home		Other:
Other:		

Further details and any environment concerns?

MY HEALTH OUTCOMES

BREATHING	**Assessed Needs:** **Level of need at previous DST:**		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**
Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

Patient: NHS number: Caretrack:
Nurse assessor: Date:

NUTRITION	**Assessed Needs:** **Level of need at previous DST:**		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**
Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

CONTINENCE	Assessed Needs: Level of need at previous DST:		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**
Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

SKIN	Assessed Needs: Level of need at previous DST:		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**

Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			
PERSONAL HYGIENE	**Assessed Needs:** **No level required.**		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**
Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

MOBILITY	**Assessed Needs:** **Level of need at previous DST:**		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**

Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

COMMUNICATION	**Assessed Needs:** **Level of need at previous DST:**		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**
Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

PSYCHOLOGICAL, EMOTIONAL, SLEEP AND SOCIAL	Assessed Needs: Level of need at previous DST:		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**
Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

COGNITION	Assessed Needs: Level of need at previous DST:		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**

Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			
BEHAVIOUR	**Assessed Needs:** **Level of need at previous DST:**		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**
Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

DRUG THERAPIES, MEDICATIONS, PAIN AND SYMPTOM CONTROL	**Assessed Needs:** **Level of need at previous DST:**
List of medications:	

My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**
Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

ALTERED STATES OF CONSCIOUSNESS	**Assessed Needs:** **Level of need at previous DST:**		
My Agreed health outcome	**What will need to happen? How will you reach your goals?**	**Who will help you? Eg family, friend, professional**	**When**

Please consider if this care approach is appropriate and proportionate the needs? Is this restrictive for the individual? Is this clinically effective? Any concerns to be highlighted to the DoLS team. Details:			

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)	
a) Does the placement meet the threshold for the acid test, i.e. do the care arrangements amount to continuous supervision and control and the service user is not free to leave? **b) If yes, has the care home (if appropriate) submitted a DOLS application to the relevant local authority Supervisory Body?** **c) If at home, please see section below.** **d) Outcome of the DOLS application.**	Yes/No Yes/No (If the answer is no, you should request the care home to submit a DOLS application to the relevant local authority as a matter of urgency) 1) Standard authorisation granted: • Date of authorisation: • Date of expiry: 2) Application rejected 3) Awaiting assessment
Do the care arrangements meet the criteria for a Community Deprivation of Liberty (DoL)	

order from the Court of Protection? **a) Does the care provision meet the threshold for the acid test, i.e. do the care arrangements amount to continuous supervision and control and the service user is not free to leave?**	Yes/No
If yes, has an application for a Community DoL order been commenced?	Yes/No If yes: a) Date application submitted to Court of Protection or b) Date of the court order authorising DoL: c) Date of expiry of the court order: (If the answer is no, contact the Clinical Lead to determine further actions. It is the duty of the ICB to apply to the Court of Protection for a Community DoLS order if someone's being deprived of their liberty in their own home.)

CLINICAL RISKS

Risk Identified	**How likely is this to happen**	**Will this put others supporting me at risk**	**How could I reduce this risk so that I can achieve my goal** (mitigation against risk)	**Acceptable risk** **Yes / No**

ENVIRONMENTAL RISKS

Risk Identified	**How likely is this to happen?**	**Will this put others supporting me at risk?**	**How could I reduce this risk so that I can achieve my goal?** (Mitigation against risk)	**Acceptable risk** **Yes/No**
1. Power Failure (power cuts for extended length of time)	Low	No	My utilities company to be notified to put me on the priority list and to be given a priority telephone number to contact in times of power loss for any extended period of time. Priority Number: - 0800 032 0311	Risk reduced

Patient: NHS number: Caretrack:
Nurse assessor: Date:

2. Equipment breakdown (delete if not applicable)	Low	No	Regular servicing of equipment Maintenance contracts in place and current at time of this care plan Ensure that telephone numbers of contractors who support my equipment are visible on my equipment and are listed in my folder to ensure that prompt action can be taken to repair	Risk reduced after mitigation action is in place
3. To be able to access emergency care if I need it due to environmental issues i.e. power cut, equipment failure or other home emergency.	Low	No	Contact details for community nursing team to be shared with patient and their representatives. Contact SWAST (Ambulance service) to advise of my health difficulties so that Paramedics in an emergency situation are aware of my condition and specific needs e.g. communication, mobility.	Risk reduced after mitigation action is in place

End of Life Care Needs (Complete if end of life care needs have been identified)	
ReSPECT and Treatment Escalation Is there a treatment escalation plan/ReSPECT form in place? What is the ceiling of treatment? What is the resuscitation decision? Has an EPAACs template been completed on Connecting Care?	**Details:**
Have end of life preferences been discussed and by whom? Who had that discussion? Are family aware? Who has the right to speak on behalf of the person if they lose capacity or the ability to communicate?	**Details:**
Does the individual have an end-of-life care plan in place?	**Details:**
Are there anticipatory medications and a palliative care drug chart in the home? If not, who is taking responsibility for this?	**Details:**
How often does the care package need to be reviewed in line with deterioration/changing need? Karnofsky scoring if available.	**Details:**
Appropriate services in place for support? Any referrals required?	**Details:**

Referrals to Other Professionals or Services Either completed or requested by the nurse assessor		
Referral	**Rationale**	**Date completed**

CARE PROVISION

Placement

Nursing/residential home placement		
Name		**Details/requirements:**
Address		
Telephone Number		
Email		

Is The Care Provision Meeting Assessed Needs? Include provider, nurse assessor and patient/representative views. Details any adjustments required will be made against assessed needs and with consideration of commissioning policy. Care can be increased or decreased on review to ensure it is effective.

At Home

Care Agency	
Name	
Address	
Telephone Number	
Email	

Secondary/Respite Provider Details	
Name	
Address	
Telephone Number	
Email	

CQC report of the above care providers					
Name of agency	**Is report available?** **Yes**	**No**	**Outcome of report:**	**Date of last inspection:**	**Any special measures or recommendations?**

Please detail what care is in place currently:

Time of Visit		Mon	Tues	Weds	Thurs	Fri	Sat	Sun	Duration of visit	Number of carers
Morning										
Lunch										
PM										
Evening										
Waking Nights										
Sleep-ins										
Welfare Checks										
Live in care										
Other visits										

Summary of Services Delivered	AM	Lunch	PM	Evening	Overnight Care	Other
Assist with full bed bath/showering including intimate areas, hair, foot and oral care						
Shave						
Freshen up, washing intimate areas, hands and face						
Assist to change clothing						
Continence, assist onto toilet or commode						
Catheter care, emptying and changing catheter bags as required						
Stoma Care						
Check and change incontinence products, including personal hygiene						
Reposition and make comfortable						

Patient: NHS number: Caretrack:

Nurse assessor: Date:

Assist with transfers						
Skin care – observe skin for signs of redness, report to district nurse as needed						
Meal and drink preparation, clearing up afterwards						
Assistance with feeding of food and drink						
PEG feed						
Prompt medication						
Change bedding as required						
Check Visit						
Special instructions / Additional duties: (please specify)						

Is The Care Provision Meeting Assessed Needs? Include provider, nurse assessor and patient/representative views. Details any adjustments required will be made against assessed needs and with consideration of commissioning policy. Care can be increased or decreased on review to ensure it is effective.
If changes are required, please fill in the next section detailing what alterations are indicated to the package of care.

Please detail what care is required (if changes are indicated):

Time of Visit		Mon	Tues	Weds	Thurs	Fri	Sat	Sun	Duration of visit	Number of carers
Morning										
Lunch										
PM										
Evening										
Waking Nights										
Sleep-ins										
Welfare Checks										
Live in care										
Other visits										

Summary of Services Required	AM	Lunch	PM	Evening	Overnight Care	Other
Assist with full bed bath/showering including intimate areas, hair, foot and oral care						
Shave						
Freshen up, washing intimate areas, hands and face						
Assist to change clothing						
Continence, assist onto toilet or commode						
Catheter care, emptying and changing catheter bags as required						
Stoma Care						
Check and change incontinence products, including personal hygiene						
Reposition and make comfortable						

Patient: NHS number: Caretrack:

Nurse assessor: Date:

Assist with transfers						
Skin care – observe skin for signs of redness, report to district nurse as needed						
Meal and drink preparation, clearing up afterwards						
Assistance with feeding of food and drink						
PEG feed						
Prompt medication						
Change bedding as required						
Check Visit						
Special instructions / Additional duties: (please specify)						

Recommendation: (please indicate which outcome)

1. No requirement to proceed to full CHC eligibility consideration as no identified changes in domain levels, or the nature, intensity, complexity or unpredictability of the presenting primary health need. Care arrangements have been reviewed and there is no indication to change care provision identified from this review.

or

2. No requirement to proceed to full CHC eligibility consideration as no identified changes in domain levels, or the nature, intensity, complexity or unpredictability of the presenting primary health need. Care arrangements have been reviewed and there are identified changes required which will be supported by the Funded Care Team.

or

3. Changes identified in level of need, or the nature, intensity, complexity or unpredictability of the previously identified primary health need. A DST will be completed from information gathered and considered with the Local Authority as to whether eligibility criteria are still present.

Additional Rationale (if required):

Completed by	
Name:	
Role:	
Profession:	
I confirm that I have provided the patient / representative [please delete] with the following information: ☐NHS Continuing Healthcare Patient Information leaflet ☐Information on PHBs ☐Explained what can reasonably be provided in accordance with the ICB's choice and equity policy ☐Signposted to the local authority for carers assessment (if applicable) ☐Other:	
Signature:	
Date:	

Patient Agreement	
I confirm that I have read, and I am in agreement with the plan detailed above and have signed below to confirm agreement with this.	
Name:	
Signature:	
Date:	
Status:	Service User/Representative

Providing accessible information for you

We want to make sure our patients feel safe and are treated with dignity and respect. The information you give will be recorded safely and securely alongside your patient notes.

We have a legal and moral duty to meet the communication and information needs of all patients with a disability, impairment or sensory loss. By collecting this information from you, we can ensure that any care or communication you receive is provided in a way that is accessible to you.

The information we receive about you may be shared with other health and adult social care providers to ensure your needs are met.

1a. Do you consider yourself to have a disability? ☐ Yes ☐ No ☐ Prefer not to say

1b. If yes, please specify:

☐ Sight impairment ☐ Hearing impairment ☐ Speech impairment

☐ Learning difficulties ☐ Learning disability ☐ Mental health

☐ Physical disability ☐ Progressive conditions and physical health

2. Do you need any extra help with your communication? You may have a learning disability or a difficulty with your eyes or hearing, you may need to use type talk or a communication aid or you may want us to communicate with someone on your behalf. Please tell us what works for you.

☐ Yes ☐ No

If you answered 'yes' to question 2, please answer the following questions so we can understand more about your communication and information needs.

3. How would you prefer us to keep in touch with you?

☐ No preference ☐ Home telephone ☐ Work telephone

☐ Mobile telephone ☐ Letter to home address ☐ Fax

☐ Email address ☐ Text message/SMS ☐ Letter to temporary address

Please State:

4. If you need large print, which font size is best?

Patient: NHS number: Caretrack:

Nurse assessor: Date:

☐ Font size 20 ☐ Font size 24 ☐ Font size 28

5. I**f you use Braille, which code do you need information in?**

☐ Braille Grade 1 ☐ Braille Grade 2 ☐ Moon

6. **If you use sign language, which kind of interpreter do you need?**

☐ British Sign Language ☐ Makaton ☐ Sign-supported English

7. **If you are deafblind, which kind of interpreter do you need?**

☐ Deafblind block alphabet ☐ Hands on signing interpreter

☐ Deafblind manual alphabet ☐ Visual frame

8. Do you have any other hearing needs?

☐ I wear a hearing aid in my: ☐ Right ear ☐ Left ear ☐ Both ears

☐ I require the use of a hearing loop

9. Do you need information to be in an easy read format? ☐ Yes, I use easy read

10. Do you need a lip speaker or note-taker?

☐ Lip speaker ☐ Note-taker (paper) ☐ Note-taker (electronic)

11. Do you need information in a digital format?

☐ Audio recording ☐ Speech to text reporter

12. If you need someone with you when we visit, who might this be?

☐ Carer/family member ☐ Citizen advocate (volunteer) ☐ Legal advocate

13. Do you need a longer appointment so we can accommodate your communication needs?

☐ Yes, I need a longer appointment

If you are a parent or carer completing this form on behalf of a patient and you have a communication or information need you'd like us to be aware of, please record it here:

Patient: NHS number: Caretrack:
Nurse assessor: Date:

About you – Equality Monitoring

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

1 What is your sex? Tick one box only.

- Male ☐
- Female ☐
- In another way ☐
- Prefer not to answer ☐

2 Which age group applies to you? Tick one box only.

- 18-24 ☐
- 25-34 ☐
- 35-44 ☐
- 45-54 ☐
- 55-64 ☐
- 65-74 ☐
- 75-84 ☐
- 85+ ☐
- Prefer not to answer ☐

3 Do you have a disability as defined by the Equalities Act (2010)? Tick one box only

The Equalities Act (2010) defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

- Yes ☐
- No ☐
- Prefer not to answer ☐

4 What is your ethnic group? Tick one box only.

A White

English/Welsh/Scottish/Northern Irish/ British ☐

Irish ☐

Gypsy or Irish Traveller ☐

Any other White background – write below

B Mixed

White and Black Caribbean ☐

White and Black African ☐

White and Asian ☐

Any other Mixed background - write below

C Asian or Asian British

Indian ☐

Pakistani ☐

Bangladeshi ☐

Chinese ☐

Any other Asian background, write below

D Black or Black British

Caribbean ☐

African ☐

Any other Black background – write below

E Other Ethnic Group

Arab ☐

Patient: NHS number: Caretrack:
Nurse assessor: Date:

Prefer not to answer ☐

Any other ethnic group – write below

5 What is your religion or belief?

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

Christian ☐
Buddhist ☐
Hindu ☐
Jewish ☐
Muslim ☐
Sikh ☐
No Religion ☐

Any other religion – write below

6 Which of the following best describes your sexual orientation? Tick one box only

Heterosexual or Straight ☐
Gay or Lesbian ☐
Bisexual
Prefer not to answer ☐

Other, write below

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Best Interests Decision

1. SERVICE USER DETAILS	
Name	
Address	
DOB & Age	
Caretrack ID	

2. Details of capacity assessment	
Date of the capacity assessment in relation to this decision	

Outcome of the capacity assessment:
(Please note best interests cannot be used for people who have capacity to make their own decisions. A best interest decision can only be made once the person has been assessed as lacking capacity for the decision in question and evidence is provided in accordance with the best interests checklist.)

3. What is the decision being considered?
(Note: An act or decision made for or on behalf of a person who lacks the relevant mental capacity must be done, or made, in his/her best interests.)

4. Is there a valid Lasting Power of Attorney/Enduring Power of Attorney or a Court of Protection Deputy? (If yes, they will be the decision maker/s)

Yes	No
If yes, name of the individual/s:	
Has the decision maker verified the LPA/EPA/Deputyship? (A copy of LPA/EPA/Deputyship or OPG100 search result is required to ascertain whether an LPA/EPA/court appointed deputy is in place)	Yes/No
Date LPA/EPA registered:	

5. Will the person regain capacity if the decision-making is delayed? (tick most appropriate)	
• Yes	
• Not likely to regain capacity	
• Not appropriate to delay	
Evidence: (If the person will regain capacity, state when this might be and defer decision-making unless it's not appropriate to delay)	

6. Is there a valid and applicable Advance Decision to Refuse Treatment (ADRT)	
Yes	No
Details of this:	
Is there an Advance Care Plan or statement regarding this decision	Yes/No
Details of this:	

7. Details of people consulted as part of the decision-making

Name	Relationship	Consulted – Yes/No	If No, provide reasons

8. Relevant Circumstances
(Try to identify all the issues and circumstances relating to the decision in question which are most relevant to the person who lacks capacity to make this decision.)

9. What are the available options?
(Consider all available options and list the advantages and disadvantages of the proposed actions having regard to medical, welfare, social, emotional and any ethical aspects of the proposed measures. Where the choice is being made on behalf of the person, that choice can only be between options which are actually available to them)

Option 1:
Benefits:
-
-
-

-
-

Burdens:

-
-

Option 2:
Benefits:

-
-

Burdens:

-
-
-
-

Option 3:
Benefits:

-
-

Burdens:

-
-
-
-

(If no alternative arrangement other than Option 1 is being considered, please state why)

10. Views of the person in relation to this decision

(What are the person's past and present wishes and feelings relevant to the proposed decision. Does the person have any beliefs and values relevant to the proposed measures (e.g. religious or cultural factors) that would be likely to influence the decision? Evidence what steps you have taken to ensure that you have encouraged and enabled the person, who lacks capacity, to take part in the decision-making process.)

11. Views of interested parties:

(e.g. family, friends, carers, professionals involved, IMCA, Lasting Power of Attorney, Court of Protection Deputy etc.)

12. Document what decision has been made in the person's Best Interests (Outcome of the best interests process: Having considered all the relevant circumstances and views of all interested parties, please now document the outcome of your decision, how it was reached, reasoning behind the decision and why this is in the person's best interests. In having a reasonable belief that you are acting in the person's best interests, you need to complete the above assessment with necessary detail pertaining to the decision using the information available and gathered at the time of the decision made.)
13. Any disagreements regarding the decision, give details if any

14. Details of the decision maker	
Name of the decision maker	
Signature	
Designation	
Date	