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| **Consent to Screening for a 12 week Rapid Personalise Care Service (RPCS) Assessment and referral**  For NHS Funded Fast Track Referrals |
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On completion of this form it is essential that you email a signed / dated copy, together with the assessment / referral forms, to **westherts.RPCS@nhs.net** . Failure to complete this action will result in a referral being rejected.

A copy of this form will be retained by the **RPCS referral hub**.

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| **Patient Details:** | | | | | |
| Patient’s Name: |  |  | Date of Birth: |  |  |
| Home Address: |  |  | GP: | Dr |  |
| NHS Number: |  |  | Current Location: |  |  |

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| **Stage 1 – Assessment of Capacity** |
| **Under the Terms of the 2005 Mental Capacity Act, a person must be assumed to have capacity unless it is established that they lack capacity** |
| Question: |
| 1. Does the patient identified in the paperwork have capacity to give consent to screening assessment for the Rapid Personalise Care Service?   **Yes / No**   1. Is there an impairment of or disturbance in the functioning of the person’s mind or brain? **Yes/No** 2. Provide evidence / Comment on Source of impairment:   *(for example symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical condition)* |

* **If you have answered ‘Yes’ to Stage 1a), please proceed to Stage 2 – Consent.**
* **If you have answered ‘No’ to Stage 1a) above, the patient is considered to lack Mental Capacity within the meaning of the Mental Capacity Act. Please proceed to Stage 3 & 4 – Assessment of Capacity.**
* **If you have answered yes to 1b also proceed to stage 3 - Assessment of Capacity.**

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| Stage 2 – Patient’s Consent |

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| **Part A – Has Capacity** | | | | | | | | |
| This section can only be completed by the patient identified at Stage 1 and must be completed where they were determined to have capacity at Stage 2. (please tick as appropriate) | | | | | | | | |
| 1. **I have received** written information on the Rapid Personalised Care Service RPCS and the follow up assessment that may take place if required. This has been explained to me and I am aware that I can withdraw consent at any time. | | | | | | | Yes/ No | |
| 1. **I agree** to have a Rapid Personalised Care Service assessment being undertaken in order to establish eligibility for this care service. | | | | | | | Yes/ No | |
| 1. **I agree** to relevant information being gathered, collated and shared, where necessary, as part of the Rapid Personalised Care Service Assessment Process and also in the event of any potential dispute process which may occur. This will include the preparation of the case file for the CCG and for Independent Review Panel at NHS England / Parliamentary and Health Service Ombudsman (PHSO) | | | | | | | Yes/ No | |
| 1. **I agree that**, if indicated, a further assessment with be carried out within 6-8weeks after the start of the RPCS | | | | | | | Yes/ No | |
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| **Part B – Consent to Share / Protect Your Personal Information** (please tick as appropriate) | | | | | | | | |
| 1. **I agree** that the information provided in this assessment may be shared with Health and Social Care staff, Service Providers who contribute to my care. | | | | | | | | Yes/ No |
| 1. **I understand** that this information will be used in the assessment of my eligibility for Rapid Personalised Care Service and may be used for the purpose of providing a service, or care to me. | | | | | | | | Yes/ No |
| 1. **I understand** that I may withdraw my consent to share information at any time. | | | | | | | | Yes/ No |
| 1. **I understand** that I have the right to restrict what information may be shared and with whom but that this may affect the provision of care to me. | | | | | | | | Yes/ No |
| 1. I have made the following restrictions (if applicable): | | |  | | | | | |
| 1. **I understand** that my information will be held securely on paper and on computer in accordance with GDPR 2018 | | | | | | | | Yes |
|  | | |  | | | | |
| Signature of Patient | |  | | | Dated: |  | | |

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| **I would also like the following person(s) / representative(s) involved in the assessment, to act as a witness where necessary:** | | | |
| Name(1): |  | Name(2): |  |
| Relationship: |  | Relationship: |  |
| Contact Number: |  | Contact Number: |  |
| Email: |  | Email: |  |

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| Signature of Witness(1): |  | Dated: |  |
| Signature of Witness(2): |  | Dated: |  |

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| Stage 3 – Assessment of Capacity | | | | | | |
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| **Patient Impairment** (please tick as appropriate): | | | | | | |
| 1. What is the extent of the person’s impairment? | | | | | | |
| **Permanent** | |  | **Temporary** |  | **Fluctuating** |  |
|  | | | | | | |
| 1. Having determined that the person has impairment, please confirm whether you have given consideration to the ease, location, timing and cultural influences or social context of the Capacity Assessment that may affect the person’s ability to make an informed choice? | | | | | **Yes** | **No** |
|  |  |
| Comments: |  | | | | | |
| 1. Please confirm whether you have given consideration to the relevance of the information communicated; communication method/aids used; and other people’s involvement in the Assessment | | | | | **Yes** | **No** |
|  |  |
| Comments: |  | | | | | |

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| **Patient Impairment** (please tick as appropriate)**:** | | | |
| Please complete the following questions in order to form an opinion as to whether the impairment is sufficient to suggest that the person lacks the capacity to make the particular decision at this moment in time. | | | |
| 1. Do you consider the person is able to understand the information relevant to the decision and that this information has been provided in a way that the person is most likely able to understand? | | **Yes** | **No** |
|  |  |
| Comments: |  | | |
| 1. Do you consider the person is able to retain the information for long enough to be able to make the decision? | | **Yes** | **No** |
|  |  |
| Comments: |  | | |

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| 1. Do you consider the person is able to use or weigh that information as part of the process of making the decision? | | **Yes** | **No** |
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| Comments: |  | | |

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| 1. Do you consider the person is able to communicate their decision? | | **Yes** | **No** |
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| Comments: |  | | |

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| **Stage 3 – Outcome / Conclusion** | |
| Do you consider that the person identified in this form \* does / does not (\*please delete) have capacity to make this informed decision at this time? (please give reasons for your conclusion). | |
|  | |
| Name: | Position: |
| Signed: | Date: |
|  | |
| If you have answered ‘Yes’ to the questions above, then on the balance of probability, the person is likely to have capacity to make this particular decision at this time and therefore, is the only person who can consent to the same; please proceed to Stage 2 –Patient consent.  Conversely if you have answered ‘No’ to any of the questions then on the balance of probability the person is likely not to have capacity and therefore the decision will need to be made either as a best interests decision or consent must be sought from an individual with authority to act on behalf of the patients (i.e. someone who hold Lasting Power of Attorney); please proceed to Stage  4 below. | |

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| Stage 4 – Consent to Screening and Assessment for NHS Continuing Healthcare / NHS Funded Nursing Care – Best Interest / Lasting Power of Attorney |

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| **Patient does not have Capacity** | | | | |
| In many cases, continuing with the assessment process where a person is deemed to lack capacity to consent will be undertaken in line with one of the key principles of the Mental Capacity Act. This is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made in the person’s best interests. The exception to this is circumstances where a person has made an Advance Decision, consideration must be given to its applicability and validity in the circumstances | | | | |
| **Part A - Best Interest Checklist** (Please tick relevant statement) | | | | |
| 1. What arrangements have you made to ensure that as far as practicable the person is helped to participate as fully as possible in decision making? | | | | |
| Comments: |  | | | |
| 1. I have tried to find out the views of the person who lacks capacity, including part/present wishes and feelings, any beliefs and values and any other factors that the person themselves would be likely to consider if they were making the decision or acting for themselves. | | | **Yes** | **No** |
|  |  |
| Comments: |  | | | |
| 1. I confirm that I have not made assumptions about their best interests on the basis of the person’s age, appearance, condition or behaviour | | | **Yes** | **No** |
|  |  |
| Comments: |  | | | |
| 1. Is the person likely to regain capacity?  * If Yes, can the decision wait until then * If No, continue with the Best Interest Assessment | | | **Yes** | **No** |
|  |  |
| Comments: |  | | | |
| If it is practical and appropriate to do so, consult other people for their views about the person’s best interests. This may include:   * Any individual appointed under a lasting Power of Attorney * Any deputy appointed by the Court of Protection * Anyone previously named by the person as someone to be consulted on either the decision in question or similar issues * Anyone engaged in caring for the person * Close relatives, friends or others who take an interest in the person’s welfare * An Independent Mental Capacity Advocate (IMCA) | | | | |
| 1. Who have you consulted with? | |  | | |
| Where the patient has nobody to act for them other than paid carers, and a decision concerns serious medical treatment or a change in living arrangements (NHS accommodation for 28 days or more, or Local Authority/Care Home accommodation for 8 weeks or more), then a referral must be made to an IMCA. | | | | |
| 1. Is referral to IMCA required? | | | **Yes** | **No** |
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| 1. Who has referral been made to? | |  | | |
| Date of Referral: | |  | | |

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| --- | --- | --- | --- | --- |
| Print Name: |  | Signature: | Date: |  |
| Professional: |  | Contact Number | | |

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| **Part B – Either ‘Power of Attorney’ or ‘Best Interest Decision’** (please tick as appropriate) | | |
| Is a Power of Attorney in place?  If **‘Yes’** please proceed to **Part C**; if **‘No’** please proceed to **Part D** | **Yes** | **No** |
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| **Signature NOK/ LPOA/ Representative:** |  | Print Name: |  |
| Date: |  | Relationship: |  |

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| **Part D – Best Interest Decision** | | |
| 1. Taking all of above information into account, I confirm that proceeding with the assessment process is in the best interest of Mr/ Mr | **Yes** | **No** |
|  |  |
| 1. **I have** received written information on Rapid Personalised Care Service RPCS and the follow up assessment that may take place if required. This has been explained to me and I am aware that should my view change regarding the best interests (of the patient) in connection with this process, I should raise it at any time. | **Yes** | **No** |
|  |  |
| 1. **I confirm** that it is in the best interests of ……………………………….. to have a Rapid Personalised Care Service assessment undertaken in order to establish eligibility for this care service. | **Yes** | **No** |
|  |  |
| 1. **I confirm** that it is in the best interests of ……………………………….. for all relevant information to be gathered, collated and shared, where necessary, as part of the Rapid Personalised Care Service Assessment Process and also in the event of any potential dispute process which may occur. This will include the preparation of the case file for the CCG and for Independent Review Panel at the NHS England / Parliamentary and Health Service Ombudsman (PHSO) | **Yes** | **No** |
|  |  |
| 1. **I confirm that**, if indicated, it is in the best interests of ……………………………………………..A further assessment with be carried out within 6-8weeks after the start of the RPCS . | **Yes** | **No** |
| **N/A** |  |

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| Print Name: |  | Signature: | Date: |  |
| Professional: |  | Contact Number | | |
| Print Name: |  | Signature: Date: | | |
| Patient representative |  | Contact Number | | |