Sheffield Clinical Commissioning Group

CONTINUING HEALTH CARE
Care Package Pro Forma

Patient Information

Client Name		Client DOB	
CareFirst Number (if applicable)		NHS Number	
Diagnosis		QA Number (CCG office use)	

Permanent Residence	Own home/family home	☐
	Nursing home	☐
	Residential home	☐
	Independent Hospital	☐

Who is currently paying for the patient's care (tick all that apply)	NHS Continuing Healthcare	☐
	Joint package (social care with health elements)	☐
	Funded Nursing Care	☐
	LA Funded Social Care	☐
	Self-Funded	☐
	ILF	☐
	Supporting People	☐
	Other LA funded (eg appointeeship, housing, education)	☐
	Other NHS funded (eg in acute hospital)	☐

Current Care Provision	No care package in place currently	☐
	Nursing Home Placement	☐
	Personal Budget	☐
	Domiciliary Care (ie arranged by CCG or LA)	☐
	Supported Living (ie arranged by CCG or LA)	☐

Current Eligibility	CHC	☐
	Joint Package of Care	☐
	Funded Nursing Care	☐
Date of latest eligibility decision		

Reason for request	Change in eligibility	☐
	Change in needs	☐
	Other (state reason below)	☐

FOR OFFICE USE ONLY – DATE OF PANEL ……/……/……

<u>Brief</u> outline of client's needs, family situation and any history of safeguarding alerts.

FOR OFFICE USE ONLY – DATE OF PANEL ……/……/……

Current Care Provision (Regular Services): ***Please provide current SPSOR with this page if one has been completed***

	Type of service[1]	Provider	Ratio of staff to Client[2]	Days of care provision	Purpose	No of hours per week	Permanent or Temporary?	Cost per hour	Cost per week	Who funds? (eg NHS/LA/ILF/Client)
1										
2										
3										
4										
5										
6										
7										

TOTAL CURRENT WEEKLY COST OF REGULAR CARE	**£**	**PER WEEK**

Current Care Provision (episodic eg respite care, contingency plans, any one-off annual charges)

	Type of service[2]	Provider	Who provides care	How long is each episode?	How many times per year?	Purpose	Permanent or Temporary?	Cost per episode	Annual cost	Who funds?
1										
2										
3										

[1] See paragraph 5.8 of the Pro Forma Guidance
[2] See paragraph 5.7 of the Pro Forma Guidance

Summary Financial Contributions to Current Package: Joint Packages of Care Only

For joint packages of care only:	Weekly Amount		Non-Weekly Amount	Frequency
Sheffield CCG CHC	£			
Sheffield City Council Social Care	£			
Sheffield City Council Education	£			
Other (ie not Sheffield CCG CHC or Sheffield City Council)(specify)	£			
Total	**£**			

Description of Current Services:

Please describe the interventions which are funded by NHS CHC including the intended outcomes.	

Please describe the services being funded by 'other' agencies or people, eg charitable organisations, SCC, other health trusts.	

FOR OFFICE USE ONLY – DATE OF PANEL ……/……/……

Proposed Care Provision (Regular Services): Please Provide forms CHC 7, 15 or external F8 as appropriate

	Type of service[3]	Provider	Ratio of staff to Client[4]	Days of care provision	Purpose	No of hours per week	Permanent or Temporary?	Cost per hour	Cost per week	Who funds? (eg NHS/LA/ILF/Client)
1										
2										
3										
4										
5										
6										
7										

TOTAL PROPOSED WEEKLY COST OF REGULAR CARE	**£**	**PER WEEK**

Proposed Care Provision (episodic eg respite care, contingency plans, any one-off annual charges,)

	Type of service[3]	Provider	Ratio of staff to Client if applicable	How long is each episode?	How many times per year?	Purpose	Permanent or Temporary?	Cost per episode	Annual cost	Who funds?
1										
2										
3										

[3] See paragraph 5.15 of the Pro Forma Guidance
[4] See paragraph 5.14 of the Pro Forma Guidance

Summary Financial Contributions to Proposed Package

	Weekly Amount		Non-Weekly Amount	Frequency
Sheffield CCG CHC	£			
Sheffield City Council Social Care	£			
Sheffield City Council Education	£			
Other (ie not Sheffield CCG CHC or Sheffield City Council)(specify)	£			
Total	**£**			

Additional Privately Funded Care: All Packages

Will the client or a third party be paying for any additional services?		Yes	☐	No	☐
If yes, please describe these services.					
Please confirm that a separate contract will be put in place between the patient and the provider for services paid for by them or a third party.		Yes	☐	No	☐
If any patient or third-party contribution ceases, will the remainder of the package be viable?		Yes	☐	No	☐

Description of Proposed Services

Please describe the interventions which would be funded by NHS CHC including the intended outcomes.	

Please describe the services which would be funded by 'other' agencies or people, eg charitable organisations, SCC, other health trusts.	

Alternative Care Proposals

Please provide a brief description of two alternatives proposals for meeting your client's needs. You can either use copies of the continuations sheets or give a brief description in the box below. The description must give the weekly cost of any regular services and the annual cost of any episodic services. Realistic alternatives to your main proposals are required in every case that is presented to Commissioning of Care Panel in order to demonstrate to the Panel that alternative proposals have been identified and considered and why they are not proposed.

Please provide a brief justification of why you believe the proposed care plan is the best option and how this accords with NHS Sheffield's CHC Policy on the Commissioning of Care Provision. If you have a specific provider in mind, please also use this box to explain why.

Considerations – please answer all questions fully (for CHC or new JPOC packages only)

1.	**A. Has the patient previously accepted this package?**	
	Yes	☐
	No	☐
	B. Does the patient have capacity to agree to this care package?	
	Yes	☐
	No	☐
	C. If the answer to 1B is No, has the patient's capacity been tested?	
	Yes	☐ - attach Capacity Assessment to this form.
	No	☐
	D. Has a Lasting Power of Attorney for matters relating to the patient's health and welfare been registered with the Office of the Public Guardian	
	Yes	☐ **-** please state the Attorney's name and address and provide a copy of the document.
	No	☐
	E. Has the Court of Protection appointed a Deputy to make decisions for the patient, in respect of their personal welfare	
	Yes	☐ - please state the Deputy's name and address and provide a copy of the order**.**
	No	☐
	F. Has the patient made an Advanced Directive or Advance Decision that is relevant to the proposed offer of care?	
	Yes	☐ - attach a copy to this form.
	No	☐
	G. If patient is non-concordant with care, please give details below.	

2.	**Does the proposed package of care accord with NHS Sheffield's policy on the commissioning of care provision?**		
	Yes	☐	
	No	☐	
	Date policy explained to patient and family	……	
	Name of family members present		
3.	**A. Does the CQC website indicate the provider is meeting all required standards? (http://www.cqc.org.uk/)**		
	Yes	☐	Date Website Checked: …… (not required for packages arranged by RMT)
	No	☐	
	B. Is there an embargo on placements in force locally?		
	Yes	☐	Date Checked: …… (not required for packages arranged by RMT)
	No	☐	
4.	**A. Is the proposed care provision the patient's preference?**		
	Yes	☐	
	No	☐	
	B. If no, what is the patient's preference?		
	C. Date provider confirmed they can meet patient's health, social and cultural needs.	……	
	D. Approximate date of first review of care package	……	
5.	**A. Which risk assessment is provided with this pro-forma?**		
	BRAM (Brief Risk Assessment)	☐	
	DRAM (Detailed Risk Assessment)	☐	
	B. If neither of the above is available, please supply an alternative risk assessment with this form.		

6.	**A. What support are family members, friends or others providing to this package of care not funded by CHC?**	
	B. Has a Carer's Assessment been completed?	
	Yes	☐
	No	☐
7.	**A. Will the patient receive regular mainstream or secondary NHS services (eg District Nursing, CPNs, secondary specialism's) not funded by CHC?**	
	Yes	☐
	No	☐
	B. If yes, please state which services and how frequently they will be involved:	
8.	**A. Do you consider that the exceptional circumstances in NHS Sheffield's CHC Policy on the Commissioning of Care Provision apply?**	
	Yes	☐
	No	☐
	B. If yes, please explain why:	

Completed By		Job Title			
Employer		Contact Number			
Date sent to CHC Business Support Team		Email Address			
Joint packages only: Please stated who has been consulted from the LA and CHC team.		CHC:..... LA :.....			
Please indicate if they agree with the proposed cost share:		CHC	Agree ☐	Disagree ☐	
		LA	Agree ☐	Disagree ☐	

FOR OFFICE USE ONLY – DATE OF PANEL ……/……/……

Proposed/ Alternative Care Provision (Regular Services) Continuation Sheet

	Type of service (Appendix A)	Provider	Ratio of staff to Client if applicable	Days of care provision	Purpose	No of hours per week	Permanent or Temporary?	Cost		
								Cost per hour	Cost per week	Who funds? (eg NHS/LA/ILF/Client)
1										
2										
3										
4										
5										
6										
7										
8										

TOTAL PROPOSED WEEKLY COST OF REGULAR CARE	**£**	**PER WEEK**

Proposed Care Provision Current Care Provision (episodic eg respite care, contingency plans)

	Type of service (Appendix A)	Provider	Ratio of staff to Client if applicable	How long is each episode?	How many times per year?	Purpose	Permanent or Temporary?	Cost per episode	Annual cost	Who funds?
1										
2										
3										