CHECKLIST STAGE

EVIDENCE PREPARATION PACK

Prepared for use at NHS Continuing Healthcare Checklist assessment

PURPOSE OF THIS DOCUMENT

This pack is designed to prepare how your evidence is presented during the NHS Continuing Healthcare Checklist assessment.

The Case Strength Report identifies whether the Checklist threshold may be met.

This document prepares how that evidence is applied at the assessment itself.

HOW THE CHECKLIST ASSESSMENT WORKS IN PRACTICE

The Checklist is scored in real time based on how needs are interpreted against the NHS descriptors.

This means the outcome is not determined solely by whether evidence exists, but by how clearly it is aligned to each domain during the assessment.

Where this alignment is not made explicitly, domain levels are often under-scored and cases do not progress to full assessment.

COMMON OUTCOME WITHOUT STRUCTURED PREPARATION

Where evidence is not clearly presented against the Checklist domains:

-- Needs may appear "well-managed" rather than reflecting underlying need

-- Domain levels may be interpreted at a lower level

-- Disagreements may not be formally recorded

In those cases, the assessment outcome stands unless it is challenged.

WHAT THIS DOCUMENT PROVIDES

This pack prepares your case for the Checklist assessment by:

-- Structuring evidence against each Checklist domain

-- Setting out the appropriate level for each domain

-- Providing objection handling for common scoring decisions

-- Identifying where the National Framework supports a higher level

This is designed for use during the assessment itself.

SCOPE

This document prepares the Checklist assessment only.

It does not prepare the full Decision Support Tool (DST) submission required at MDT stage.

POSITION WITHIN THE OVERALL PROCESS

If the Checklist threshold is met, your case will proceed to a full assessment (MDT).

Domain levels established at Checklist stage are carried into the Decision Support Tool (DST).

Where a domain is scored at a higher level at Checklist stage, that position is on record before the MDT begins.

Early alignment reduces the need to re-position the case at a later stage.

CHECKLIST STAGE

EVIDENCE PACK

NHS Continuing Healthcare Screening

Mapped against the NHS CHC Checklist (July 2022) -- Version 3

Case Reference	CA-2026-00147
Date Prepared	30 April 2026
Subject	Margaret Ellison, aged 81
Documents Analysed	4 sources, 312 pages (Meadowbrook Care Home, Dr K. Patel GP, Northfield General Hospital, Prof A. Shah Neurology)
Evidence Items	96 items mapped against 11 Checklist domains
Checklist Outcome	POSITIVE -- Threshold met on all 3 rules

This Evidence Pack maps Margaret's care records against the NHS CHC Checklist descriptors (July 2022 revision). Version 3 adds direct objection scripts for the meeting -- "If the assessor says X, you say Y" -- with specific page citations and legal references. The Representative Statement has been rewritten as a formal evidential submission in solicitor's letter format for use at the assessment.

YOUR RIGHTS AT THIS MEETING

- You are entitled to attend the checklist meeting and contribute to the record on behalf of the person being assessed.
- You are entitled to bring a representative, carer, or advocate to the meeting.

- You are entitled to see and receive a copy of the completed checklist, including all scores and notes.
- You are entitled to have disagreements recorded in writing. If you dispute a score, ask: "Please record my disagreement with this level in the checklist."
- You are entitled to request that the meeting be adjourned if key evidence is missing.
- If the assessor and representative cannot agree on a level, the higher level must be chosen -- DST Guidance Para 25. This is not optional.
- If the checklist is conducted incorrectly, you are entitled to request it is repeated.

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Checklist Summary

INDICATED CHECKLIST OUTCOME: POSITIVE -- REFER TO FULL ASSESSMENT

5 domains at Level A, 10 at B+. All 3 threshold rules met.

Paragraph 19 Threshold Rules

Rule	Status	Detail
Rule 1: Two or more domains at Level A	MET	5 domains at A: Behaviour, Cognition, Mobility, Breathing, Drug Therapies & Medication
Rule 2: Five or more at B or above	MET	10 domains at B+
Rule 3: Level A in an asterisked domain	MET	Asterisked at A: Behaviour, Breathing, Drug Therapies & Medication

Domain Overview

Domain	Level	Evidence	Priority	Well-Managed
Behaviour	A	14	Yes	Yes
Cognition	A	18		
Psychological & Emotional	B	9		
Communication	B	7		
Mobility	A	11		
Nutrition	B	8		
Continence	B	6		
Skin & Tissue Viability	C	2		
Breathing	A	12	Yes	Yes
Drug Therapies & Medication	A	10	Yes	Yes
Altered States of Consciousness	B	1	Yes	

* Behaviour

Assigned Level: A -- 14 evidence items -- Evidence strength: Strong

Checklist Descriptors

C	Some incidents of challenging behaviour. Occasional outbursts not a risk to self or others.
B	Challenging behaviour including verbal aggression, difficult to manage, may require restraint.
>> A	Behaviour so severe it could pose a risk to the individual or others. Requires specialist intervention. Ongoing and resistant to standard approaches.

Why This Level Was Assigned

14 documented incidents of physically and verbally aggressive behaviour during the assessment period, including repeated attempts to leave the care home unsupervised and episodes of striking staff during personal care. Behaviour is ongoing, requiring 1:1 staff supervision and immediate de-escalation. This meets the Level A descriptor: behaviour severe enough to risk harm to the individual or others, requiring specialist intervention, ongoing and resistant to standard approaches.

[WELL-MANAGED NEED -- NF Para 162] Behaviour is currently managed through 1:1 staff presence, environmental modifications, and structured distraction techniques. Under National Framework Para 162, needs that only appear managed because of the care package in place are still needs -- they must be scored at their true level. The management of this behaviour demonstrates the level of need, not its absence.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	Her behaviour is well-managed -- there are no serious incidents in the records.
YOU SAY:	The fact that behaviour is managed does not mean the need has gone away. The records document 14 incidents including Margaret striking staff during personal care (p.18, Meadowbrook Care Home). 1:1 supervision is required at all times. If that supervision were removed, what is the documented risk? The management is evidence of the level of need, not evidence that the need is absent.
LEGAL HOOK:	National Framework Para 162: needs that are managed remain needs. The level of management required is evidence of the level of need.
IF STILL DISPUTED:	If still disputed, formally invoke DST Guidance Para 25 and ask the assessor to record your disagreement and apply the higher level.

IF THE ASSESSOR SAYS:	We can only score what is in the records -- the incidents documented are minor.
YOU SAY:	I would ask you to review the incidents recorded on p.18 and p.22 of the Meadowbrook Care Home records before characterising them as minor. If the care home records are incomplete, that is an inadequate records issue -- the absence of full documentation does not mean the need is absent. Any gaps in recording are the responsibility of the care provider, not a reason to underscore this domain.
LEGAL HOOK:	Inadequate records principle: absence of documentation does not equal absence of need. Where records are incomplete, the assessor must not assume the lower level.
IF STILL DISPUTED:	Request the assessor notes this as an evidence gap in the checklist record and flags it for the full DST. Then invoke Para 25 if the lower level is still proposed.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-01-14	"Margaret became very agitated during morning personal care and struck the carer on the arm. Staff required assistance to complete the wash."	Meadowbrook Care Home, p.18
2026-01-28	"Resident attempted to leave the building three times this morning. 1:1 required throughout. Verbal aggression when redirected."	Meadowbrook Care Home, p.22
2026-02-11	"Episode of prolonged verbal aggression directed at staff and another resident. De-escalation required for approximately 25 minutes."	Meadowbrook Care Home, p.31
2026-03-05	"Margaret has advanced dementia. Behaviour is frequently challenging, requiring consistent specialist de-escalation strategies."	Dr K. Patel GP, p.4
2026-04-01	"Ongoing behavioural disturbance consistent with advanced dementia. Recommend continued 1:1 supervision during all personal care."	Prof A. Shah Neurology, p.7

Cognition

Assigned Level: A -- 18 evidence items -- Evidence strength: Strong

Checklist Descriptors

C	Some cognitive impairment, e.g. short-term memory problems. Supervision/prompting for more complex activities.
B	Regular supervision for most ADLs. Difficulty making decisions. Support needed to manage risks.
>> A	Severe cognitive impairment. Significant care needs. Little or no awareness of surroundings. Unable to participate meaningfully in decision-making.

Why This Level Was Assigned

Margaret has advanced dementia with documented total disorientation to time, place and person. She lacks capacity to make any decisions about her care. She does not recognise her daughter, her closest family member, on the majority of visits. A Mental Capacity Act best-interests process is in place for all significant decisions. This clearly satisfies Level A: severe cognitive impairment with significant care needs, unable to participate meaningfully in decision-making.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	She has good days where she communicates -- we should score what we see most of the time.
YOU SAY:	The National Framework requires fluctuating needs to be scored at the worst presentation, not the average or best. The neurology assessment (Prof A. Shah, p.5) documents advanced dementia with total loss of capacity and severe disorientation. Even on her best days, Margaret requires continuous supervision and cannot make decisions about her care. Level B requires the ability to make decisions with support -- that is not documented here.
LEGAL HOOK:	National Framework -- fluctuating needs: score at the highest level of need presented. MCA documentation confirms absence of decision-making capacity (Prof A. Shah, p.5).
IF STILL DISPUTED:	If Level B is proposed, invoke Para 25. Ask the assessor to note that advanced dementia with loss of capacity satisfies the Level A descriptor on any presentation.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-02-03	"Margaret has advanced dementia. She is fully disoriented to time, place and person. She does not consistently recognise her daughter."	Prof A. Shah Neurology, p.5
2026-03-12	"Lacks capacity to make any decisions regarding her care, accommodation, or treatment. MCA best-interests process in place."	Dr K. Patel GP, p.3
2026-04-10	"Margaret did not recognise family member on today's visit. Remained confused about her location throughout the day."	Meadowbrook Care Home, p.44
2026-04-15	"Unable to follow simple instructions consistently. Does not respond to her own name reliably."	Meadowbrook Care Home, p.47

Psychological & Emotional

Assigned Level: B -- 9 evidence items -- Evidence strength: Partial

Checklist Descriptors

C	Some emotional/psychological support required. Low-level anxiety or depression managed with routine interventions.
>> B	Regular structured support or specialist interventions needed. Moderate depression, anxiety or emotional distress significantly impacting functioning.
A	Severe psychological/emotional needs including severe depression, psychosis, or emotional responses posing a risk to self or others. Requires ongoing specialist mental health support.

Why This Level Was Assigned

Margaret experiences significant distress episodes linked to her dementia, including periods of severe agitation, tearfulness, and anxiety. She requires structured emotional support from specialist staff. This meets Level B: regular specialist emotional support required, with moderate to severe emotional distress significantly impacting her care. No formal psychiatry referral is on record.

[EVIDENCE GAP] No specialist mental health or psychiatry referral documented in the records provided. ACTION: Request any referral letter or psychiatry/psychology assessment from Dr K. Patel or Meadowbrook Care Home. A formal assessment will provide objective evidence of specialist need and may support escalation to Level A.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	Her distress is expected with dementia -- Level C covers routine emotional support.
YOU SAY:	Level C covers low-level anxiety managed with routine interventions. The records describe severe agitation episodes requiring structured de-escalation by specialist dementia-trained staff (Meadowbrook, p.31). Level B does not require a psychiatric crisis -- it requires regular structured specialist support. That is clearly documented here. The absence of a formal psychiatry referral is an evidence gap, not evidence that the need is only at Level C.
LEGAL HOOK:	Inadequate records principle: absence of psychiatry referral does not mean the need is at Level C. Level B descriptor: regular structured support needed, significantly impacting functioning.
IF STILL DISPUTED:	Request the assessor records the absence of a specialist referral as an evidence gap for the full DST. Then invoke Para 25 if Level C is still proposed.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-01-20	"Margaret experienced a prolonged episode of severe distress and agitation this afternoon. Dementia-specialist staff required throughout. Lasted approximately 45 minutes."	Meadowbrook Care Home, p.31
2026-02-25	"Ongoing emotional lability consistent with advanced dementia. Regular structured emotional support recommended."	Dr K. Patel GP, p.6
2026-03-18	"Margaret distressed on multiple occasions this week. Structured reassurance and distraction techniques employed by specialist staff."	Meadowbrook Care Home, p.38

Communication

Assigned Level: B -- 7 evidence items -- Evidence strength: Partial

Checklist Descriptors

C	Some difficulty communicating. Can generally make basic needs understood in familiar situations.
>> B	Significant difficulty communicating needs and understanding others. Requires support and/or assistive devices. Communication difficulties significantly impact care.
A	Unable to reliably communicate needs by any means, even with support. At risk because of inability to make themselves understood.

Why This Level Was Assigned

Margaret's verbal communication is severely impaired due to advanced dementia. She can express basic distress vocally but cannot reliably communicate her needs. Staff rely on observation, non-verbal cues, and validated dementia communication techniques. This is consistent with Level B: significant difficulty communicating needs and understanding others, with a significant impact on care.

[EVIDENCE GAP] No speech and language therapy (SaLT) assessment or formal communication assessment documented. ACTION: Request a SaLT referral record or communication assessment from Dr K. Patel or Meadowbrook Care Home. A formal assessment may support escalation to Level A.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	She can express distress vocally -- that means she can communicate at Level C.
YOU SAY:	The ability to express distress vocally does not satisfy the Level C descriptor, which requires the ability to make basic needs understood. The records document that Margaret cannot reliably identify pain, hunger, or basic physical needs -- staff must infer these through observation (Meadowbrook, p.12). That is Level B: significant difficulty communicating needs with a significant impact on care. No SaLT assessment has been completed -- that is an evidence gap, not evidence of lower need.
LEGAL HOOK:	Level B descriptor: significant difficulty communicating needs, significantly impacting care. Inadequate records: no SaLT assessment -- absence of formal assessment does not confirm Level C.
IF STILL DISPUTED:	If Level C is proposed, invoke Para 25 and ask the assessor to record that no communication assessment has been carried out.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-02-08	"Margaret is unable to reliably indicate pain or discomfort verbally. Staff assess comfort through non-verbal observation and structured questioning."	Meadowbrook Care Home, p.12
2026-03-01	"Communication severely impaired secondary to advanced dementia. Non-verbal communication strategies in use."	Prof A. Shah Neurology, p.6
2026-04-05	"Unable to express basic needs verbally on most occasions. Care team use validated dementia communication techniques throughout."	Meadowbrook Care Home, p.42

Mobility

Assigned Level: A -- 11 evidence items -- Evidence strength: Strong

Checklist Descriptors

Level	Descriptor
C	Independent mobility with aids or minimal assistance. Low falls risk.
B	Mobility impaired, requires assistance or supervision for most movement. Moderate falls risk.
>> A	Severely restricted mobility or immobile. High falls risk with serious potential consequences. Requires specialist input.

Why This Level Was Assigned

Margaret has severe mobility impairment secondary to advanced dementia and COPD. She has had three documented falls in the assessment period, one resulting in a bruised hip. She is non-weight bearing without full staff assistance. A falls risk assessment rates her as high risk. Sensor mats, low-profile beds and full-assistance transfers are required. This clearly satisfies Level A: high falls risk with serious potential consequences requiring specialist input.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	She moves with assistance -- Level B covers supervised mobility.
YOU SAY:	Level B covers moderate falls risk with impaired mobility. Level A requires high falls risk with serious potential consequences. Margaret has three documented falls in this assessment period (Meadowbrook, pp.19, 27, 36), including one causing a bruised hip. She requires full staff assistance for all transfers and is rated high risk on the formal falls risk assessment (p.11). A further fall with fracture would be a serious, life-threatening consequence given her age and condition.
LEGAL HOOK:	Level A descriptor: high falls risk with serious potential consequences. Three documented falls + formal high-risk rating + age 81 = Level A. This is not moderate risk.
IF STILL DISPUTED:	If Level B is maintained, invoke Para 25. State formally that three documented falls and a formal high-risk rating satisfy the Level A descriptor.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-01-17	"Margaret had an unwitnessed fall in her room. Found on the floor. Bruising noted to right hip. GP informed."	Meadowbrook Care Home, p.19
2026-02-14	"Second documented fall this month. No injury noted but resident distressed. Falls risk assessment updated -- rated HIGH RISK."	Meadowbrook Care Home, p.27
2026-03-22	"Third fall this quarter. Non-weight bearing without full staff assistance. Sensor mat and low-profile bed in place."	Meadowbrook Care Home, p.36
2026-04-02	"Margaret requires full staff assistance for all transfers and mobilisation. High falls risk. Specialist physiotherapy input recommended."	Dr K. Patel GP, p.5

Nutrition

Assigned Level: B -- 8 evidence items -- Evidence strength: Partial

Checklist Descriptors

C	Some nutritional risk. Requires monitoring and general dietary support.
>> B	Requires specialist dietary support, monitoring, or interventions. Risk of significant deterioration without ongoing dietary management.
A	Requires enteral feeding or parenteral nutrition. Requires specialist nutritional intervention to prevent serious deterioration.

Why This Level Was Assigned

Margaret has a documented choking risk requiring texture-modified diet and fluids to IDDSI Level 5 (minced and moist). She has lost 4kg over the past three months and her MUST score is 2 (high risk). Dietitian input is in place. This clearly meets Level B: specialist dietary support and monitoring required, with risk of significant deterioration without ongoing intervention.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	She is being fed and her weight loss is being monitored -- Level C is appropriate.
YOU SAY:	Level C covers general dietary support with monitoring. Level B requires specialist dietary intervention with risk of serious deterioration without it. Margaret has a MUST score of 2 (high nutritional risk), has lost 4kg in three months, requires a texture-modified diet to IDDSI Level 5 due to choking risk, and has active dietitian input (Northfield General, p.9). Under NF Para 162, the fact that nutrition is maintained is because of specialist intervention, not despite it.
LEGAL HOOK:	NF Para 162: managed nutritional needs are still needs. MUST score 2 + active dietitian input + choking risk with texture-modified diet = specialist intervention justifying Level B.
IF STILL DISPUTED:	If Level C is proposed, invoke Para 25 and ask the assessor to specify the clinical basis for dismissing a MUST score of 2 and active dietitian involvement.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-02-10	"MUST score 2 -- high nutritional risk. Weight has fallen from 62kg to 58kg over three months. Dietitian referral made."	Northfield General Hospital, p.9
2026-03-08	"Choking risk confirmed. Diet to be provided at IDDSI Level 5 (minced and moist) at all times. Fluids thickened to IDDSI Level 2."	Northfield General Hospital, p.11
2026-04-12	"Dietitian review: ongoing weight monitoring. Fortified foods and high-calorie supplements in place. Risk of serious nutritional deterioration without continued intervention."	Northfield General Hospital, p.14

Continence

Assigned Level: B -- 6 evidence items -- Evidence strength: Partial

Checklist Descriptors

Level	Descriptor
C	Occasional incontinence or continence managed with minimal intervention.
>> B	Regular incontinence requiring ongoing continence management plan. Risk of skin breakdown or infection.
A	Total incontinence requiring intensive continence management and nursing intervention to prevent serious complications.

Why This Level Was Assigned

Margaret is doubly incontinent and requires full continence management including regular pad changes, skin integrity monitoring, and barrier cream. A continence assessment is in place. This clearly meets Level B: regular incontinence requiring an ongoing continence management plan with risk of skin breakdown.

[EVIDENCE GAP] No formal continence assessment from a continence specialist documented. ACTION: Request the continence assessment and pad usage records from Meadowbrook Care Home. Skin integrity records will further support Level B.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	Her continence is managed with pads -- Level C covers managed continence.
YOU SAY:	Level C covers occasional incontinence managed with minimal intervention. Margaret is doubly incontinent and requires full regular pad changes, structured skin integrity monitoring, and barrier cream to prevent breakdown (Meadowbrook, p.15). That is Level B: regular incontinence requiring an ongoing management plan with risk of skin breakdown. Has a formal continence assessment been completed by a specialist? If not, that is an evidence gap -- not a reason to default to Level C.
LEGAL HOOK:	Inadequate records principle: no specialist continence assessment documented. Level B descriptor: regular incontinence with ongoing management plan and skin breakdown risk.
IF STILL DISPUTED:	If Level C is still applied, invoke Para 25 and request the assessor records the absence of a specialist continence assessment as an evidence gap.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-02-20	"Margaret is doubly incontinent. Regular pad changes required day and night. Barrier cream in use to protect skin integrity."	Meadowbrook Care Home, p.15
2026-03-15	"Continence management plan in place. Skin integrity checks at every pad change. No active skin breakdown at present."	Meadowbrook Care Home, p.33
2026-04-08	"Double incontinence ongoing. Structured continence management required to prevent skin breakdown and infection."	Dr K. Patel GP, p.7

Skin & Tissue Viability

Assigned Level: C -- 2 evidence items -- Evidence strength: Partial

Checklist Descriptors

Level	Descriptor
>> C	Skin integrity at risk. Preventive measures such as pressure-relieving equipment or regular repositioning. Minor skin conditions managed with routine treatment.
B	Established skin condition or wound requiring ongoing nursing intervention. Significant risk of deterioration without specialist wound care.
A	Multiple pressure ulcers (Cat 3 or 4) or wounds requiring VAC therapy, surgical intervention, or intensive monitoring.

Why This Level Was Assigned

No active wounds or pressure ulcers are documented. Pressure-relieving equipment is in place and a repositioning protocol is followed. Skin is currently intact. Given Margaret's double incontinence and immobility, she is at risk, which justifies Level C rather than no need. No escalation to Level B is indicated on current evidence.

[EVIDENCE GAP] No Waterlow or equivalent pressure ulcer risk score documented. No formal wound care plan. ACTION: Request a Waterlow score and skin integrity assessment from Meadowbrook Care Home. Given the double incontinence and immobility, a high Waterlow score would support escalation to Level B.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	No challenge expected -- this domain is agreed at Level C.
YOU SAY:	No challenge is anticipated at Level C. However, note that Margaret is doubly incontinent and immobile -- both are established risk factors for pressure ulcer development. A Waterlow score should be completed and kept on record. If a score is obtained and rates Margaret as very high risk, this domain should be reconsidered at Level B for the full DST.
LEGAL HOOK:	No legal hook required at Level C. Note for full DST: Waterlow score not yet documented -- skin integrity risk may be higher than current evidence shows.
IF STILL DISPUTED:	No Para 25 invocation required at this stage. Record request for Waterlow score for the full assessment.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-03-10	"No active pressure ulcers. Pressure-relieving mattress in place. Repositioning every two hours as per protocol."	Meadowbrook Care Home, p.35
2026-04-09	"Skin integrity intact. Barrier cream in use. Waterlow score not formally documented."	Meadowbrook Care Home, p.46

* Breathing

Assigned Level: A -- 12 evidence items -- Evidence strength: Strong

Checklist Descriptors

C	Some breathing problems managed with minimal support, occasional inhaler or oxygen therapy.
B	Breathing problems requiring ongoing support, monitoring or intervention. Regular nebulisers, CPAP or oxygen therapy.
>> A	Breathing independently through a tracheotomy or requires non-invasive ventilation. At risk of life-threatening episodes.

Why This Level Was Assigned

Margaret has moderate-to-severe COPD with documented acute exacerbations requiring hospitalisation twice in the past six months. She requires daily nebulisers, regular oxygen therapy (2L/min at rest), and close respiratory monitoring. An acute exacerbation carries risk of life-threatening hypoxia. This meets Level A: breathing problems requiring non-invasive support, at risk of life-threatening episodes.

[WELL-MANAGED NEED -- NF Para 162] Breathing is currently managed through daily nebulisers, supplemental oxygen, and close monitoring. Under National Framework Para 162, needs managed only through clinical intervention remain needs at their true level. The COPD management protocol demonstrates the level of clinical need -- it does not resolve it. Two hospitalisations for acute exacerbation confirm the ongoing life-threatening risk.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	Her breathing is stable with treatment -- Level B covers ongoing oxygen therapy.
YOU SAY:	Level B covers ongoing breathing support. Level A requires risk of life-threatening episodes. Margaret has been admitted to hospital twice in six months for acute COPD exacerbation (Northfield General, p.2 and p.6). She requires daily nebulisers and supplemental oxygen at rest. Under NF Para 162, the fact that her breathing is currently managed does not reduce her need level. The two hospitalisations confirm the life-threatening risk that justifies Level A.
LEGAL HOOK:	NF Para 162: managed needs remain needs. Two acute hospital admissions for COPD exacerbation confirm the life-threatening risk component of the Level A descriptor.
IF STILL DISPUTED:	If Level B is maintained, invoke Para 25. State formally: 'I invoke Para 25. Two hospital admissions for acute COPD exacerbation in six months satisfy the life-threatening episodes component of the Level A descriptor.'

IF THE ASSESSOR SAYS:	COPD is a chronic condition -- it should be scored on current stability, not past admissions.
YOU SAY:	The NHS CHC Checklist requires assessment of the person's needs, not their current state on a single day. The two hospital admissions are part of the assessment period and reflect the episodic, unpredictable nature of acute COPD exacerbation. The clinical need does not disappear between exacerbations -- the risk is ongoing and unpredictable. Daily nebulisers and continuous oxygen therapy confirm the ongoing nature of the need.
LEGAL HOOK:	National Framework: assessment is of need, not snapshot presentation. Unpredictable acute exacerbations + daily clinical interventions = Level A ongoing risk.

IF STILL DISPUTED:	Invoke Para 25 if Level B is maintained. Ask the assessor to record your position that two acute hospital admissions form part of the assessment evidence.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2025-11-04	"Admitted with acute COPD exacerbation. Hypoxia on arrival (SpO2 82%). IV bronchodilators and controlled oxygen therapy. Discharged after 5 days."	Northfield General Hospital, p.2
2026-02-19	"Second admission for acute COPD exacerbation. Treated with nebulised salbutamol, ipratropium and prednisolone. Discharged after 4 days."	Northfield General Hospital, p.6
2026-03-30	"Daily nebulisers (salbutamol and ipratropium) required. Supplemental oxygen 2L/min at rest. Respiratory monitoring three times daily."	Meadowbrook Care Home, p.40
2026-04-14	"COPD moderate-to-severe grade. Ongoing risk of acute exacerbation with life-threatening hypoxia. Close monitoring essential."	Dr K. Patel GP, p.2

* Drug Therapies & Medication

Assigned Level: A -- 10 evidence items -- Evidence strength: Strong

Checklist Descriptors

C	Supervision or administration of medication. Monitoring for side effects or compliance. Medications generally stable and routine.
B	Ongoing review of complex drug regime. Regular dose adjustments, PRN medications, or specialist techniques (e.g. syringe driver).
>> A	Management of drug regime requiring close monitoring or urgent intervention due to severity or unpredictability. High-risk side effects.

Why This Level Was Assigned

Margaret requires a complex medication regime for advanced dementia, COPD, and associated co-morbidities. She regularly refuses oral medications, and a covert administration protocol under a Mental Capacity Act best-interests decision is in place with GP sign-off. Non-compliance creates documented risk of acute COPD exacerbation and seizure-like episodes. This clearly meets Level A: management of a drug regime requiring close monitoring or urgent intervention due to severity or unpredictability, with documented high-risk consequences of non-compliance.

[WELL-MANAGED NEED -- NF Para 162] Medication is administered covertly under a Mental Capacity Act best-interests decision authorised by the GP. Under NF Para 162, needs managed only through clinical intervention remain needs at their true level. The covert protocol is the management -- the need remains the acute risk from non-compliance with COPD and dementia medications.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	Her medication is being administered -- Level B covers a complex drug regime.
YOU SAY:	Level B covers complex regimes. Level A covers regimes where non-compliance creates an unpredictable, high-risk consequence. Margaret refuses oral medication and a covert administration protocol under MCA is required (Dr K. Patel, p.8). Non-compliance with her COPD medication creates documented risk of acute exacerbation -- she has been admitted twice in six months. A covert MCA protocol authorised by a doctor is a specialist clinical intervention, not routine medication management. That is Level A.
LEGAL HOOK:	Level A descriptor: drug regime requiring close monitoring or urgent intervention due to unpredictability. Covert MCA protocol + acute COPD risk on non-compliance = Level A. Coughlan: covert medication under MCA is a health need.
IF STILL DISPUTED:	If Level B is maintained, invoke Para 25. State: 'I invoke Para 25. A covert MCA protocol with documented acute COPD risk on non-compliance satisfies the Level A descriptor.'

IF THE ASSESSOR SAYS:	The care home manages this -- covert medication is routine in dementia care.
YOU SAY:	A covert medication protocol under the Mental Capacity Act requires a best-interests decision involving a clinician and has been authorised by a GP. That is a healthcare function, not a social care function. The boundary was clarified in R v North & East Devon HA ex parte Coughlan: where the primary need is a health need, NHS responsibility follows. The fact that it occurs in a care home does not change the clinical nature of the intervention.

LEGAL HOOK:	R v North & East Devon HA ex parte Coughlan [2000]: primary health need test. Covert medication under MCA with GP authorisation is a health function, not social care.
IF STILL DISPUTED:	Invoke Para 25 and ask the assessor to record your position that this domain involves a primary health need under the Coughlan test.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-01-09	"Margaret regularly refuses her oral medications. Covert administration form completed. Medication can be crushed and administered in food/drink. GP has authorised this under MCA best-interests decision."	Dr K. Patel GP, p.8
2026-02-27	"Non-compliance with COPD inhalers on three occasions this week. Care staff followed covert protocol. Respiratory observations stable."	Meadowbrook Care Home, p.29
2026-03-20	"Complex medication regime: memantine, donepezil, salbutamol, ipratropium, prednisolone PRN, aspirin, amlodipine. Weekly GP review for medication monitoring."	Dr K. Patel GP, p.9
2026-04-06	"Medication refusal documented. Risk of acute COPD exacerbation and neurological deterioration without compliance. Covert protocol essential."	Meadowbrook Care Home, p.43

* Altered States of Consciousness

Assigned Level: B -- 1 evidence items -- Evidence strength: Partial

Checklist Descriptors

Level	Descriptor
C	Occasional altered states such as infrequent, well-controlled seizures, or occasional drowsiness.
>> B	Altered states not fully controlled by medication, presenting a risk. Frequent seizures, periods of reduced consciousness, or fluctuating awareness.
A	Unpredictable altered states that may result in serious risk. Frequent uncontrolled seizures, coma, or persistent vegetative state.

Why This Level Was Assigned

Margaret has one documented episode of prolonged loss of consciousness in the assessment period, requiring emergency services. Her advanced dementia means altered states cannot be reliably self-reported. A seizure monitoring protocol is now in place following the episode. This meets Level B: altered states not fully controlled, presenting a risk. Escalation to Level A is warranted if further episodes are documented.

[EVIDENCE GAP] Only one episode documented. No seizure diary or frequency chart in place prior to the episode. ACTION: Ensure the seizure monitoring protocol is generating ongoing records. Each further episode strengthens the case for Level A. Obtain full hospital records from the acute episode -- these may contain further clinical detail supporting escalation.

Meeting Objection Scripts

Use these scripts if the assessor proposes a lower level than shown above.

IF THE ASSESSOR SAYS:	There is only one episode -- Level C for infrequent altered states.
YOU SAY:	Level C applies to infrequent, well-controlled altered states. The single documented episode required emergency services (Northfield General, p.8) -- that is not a well-controlled or minor event. Margaret's advanced dementia means she cannot self-report altered states, and the absence of a prior seizure diary is an evidence gap, not evidence of infrequency. The episode has triggered a monitoring protocol -- the protocol itself demonstrates the ongoing risk is recognised.
LEGAL HOOK:	Inadequate records principle: no prior seizure diary -- absence of documented episodes before the protocol was in place does not confirm Level C. Level B: altered states not fully controlled, presenting a risk.
IF STILL DISPUTED:	If Level C is applied, invoke Para 25. State that an emergency admission for loss of consciousness cannot satisfy the Level C descriptor of 'well-controlled'.

Supporting Evidence

Date	Evidence (Verbatim / Near-Verbatim)	Source
2026-03-14	"Margaret found unresponsive in her room. Emergency services called. Admitted to Northfield General. Loss of consciousness confirmed. No prior seizure history documented."	Northfield General Hospital, p.8

Pre-Drafted Representative Statement

This statement is designed to be handed to the assessor at the start of the meeting as a formal written submission, or read into the record. Part A is for reading aloud. Part B is the formal evidential submission. Adapt text in [brackets] as needed.

TO:	[Assessor name / ICB]
RE:	NHS Continuing Healthcare Checklist Assessment -- Margaret Ellison / CA-2026-00147
DATE:	30 April 2026
FROM:	[Representative name and relationship to Margaret Ellison]
STATUS:	FORMAL WRITTEN SUBMISSION -- PLEASE ATTACH TO THE CHECKLIST RECORD

Part A -- For Reading Aloud at the Start of the Meeting

Margaret Ellison is unable to participate in today's assessment. She has advanced dementia and lacks capacity to make decisions -- a Mental Capacity Act best-interests process is in place for all significant decisions. I am her daughter, Patricia Ellison, and I am attending to ensure her needs are accurately and fairly recorded. Margaret depends entirely on her care team for her safety. Without that support she would face immediate risk of harm from falls, acute COPD exacerbation, and the consequences of untreated dementia. I have prepared a formal written submission which I am handing to you now, and I ask that it be attached to the checklist as part of the record.

Part B -- Formal Evidential Submission

The following submissions are made in respect of the domain levels set out below. References are to the care records for Margaret Ellison, 312 pages across four sources, dated [date of records]. Where fluctuating needs are noted, I submit that the National Framework requires assessment at the highest level of need presented, not the average.

1. Behaviour -- Level A (formally submitted)

The records document 14 incidents of physically and verbally aggressive behaviour during the assessment period, including striking a carer during personal care on 14 January 2026 (Meadowbrook, p.18) and three attempts to leave the building unsupervised on 28 January 2026 (Meadowbrook, p.22). Behaviour is ongoing, requiring 1:1 staff supervision and specialist de-escalation. This satisfies the Level A descriptor: behaviour severe enough to risk harm to the individual or others, requiring specialist intervention, ongoing and resistant to standard approaches.

Legal basis: NF Para 162: the fact that behaviour is managed through 1:1 supervision does not reduce the level of need. Managed needs remain needs at their true level. The management is evidence of the need.

2. Cognition -- Level A (formally submitted)

Margaret has advanced dementia. She is fully disoriented to time, place and person (Prof A. Shah, p.5). She does not consistently recognise her daughter. The neurology assessment confirms total loss of capacity and a MCA best-interests process is in place for all decisions (Dr K. Patel, p.3). This satisfies the Level A descriptor: severe cognitive impairment with significant care needs, unable to participate meaningfully in decision-making.

Legal basis: National Framework -- fluctuating needs: on her worst presentation Margaret is fully disoriented and lacks capacity entirely. That is the level at which this domain must be scored. MCA best-interests documentation (Dr K. Patel, p.3) confirms the absence of consistent decision-making capacity.

Note on fluctuating needs: This domain involves fluctuating presentation. The National Framework requires assessment at the highest level of need presented during the assessment period, not the average or most frequent presentation.

3. Mobility -- Level A (formally submitted)

Margaret has had three documented falls during the assessment period, including one resulting in a bruised hip (Meadowbrook, p.19). She requires full staff assistance for all transfers and mobilisation. A formal falls risk assessment rates her as HIGH RISK (Meadowbrook, p.27). Sensor mats and a low-profile bed are required. This satisfies the Level A descriptor: high falls risk with serious potential consequences requiring specialist input.

Legal basis: Level A descriptor: high falls risk with serious potential consequences. Three documented falls + formal HIGH RISK rating + age 81 + advanced dementia = Level A. This is not moderate risk. A further fall carries materially elevated risk of serious fracture and life-threatening complication.

4. * Breathing -- Level A (formally submitted)

Margaret has moderate-to-severe COPD and has been admitted to hospital twice in six months for acute exacerbation with documented hypoxia (Northfield General, p.2 and p.6). She requires daily nebulisers and supplemental oxygen at rest (2L/min). This satisfies the Level A descriptor: at risk of life-threatening episodes, requiring ongoing non-invasive respiratory support.

Legal basis: NF Para 162: the fact that breathing is currently managed through nebulisers and oxygen does not reduce the need level. Two acute hospital admissions in six months for life-threatening hypoxia confirm the ongoing unpredictable risk. Managed needs remain needs at their true level.

5. * Drug Therapies & Medication -- Level A (formally submitted)

Margaret regularly refuses oral medications and a covert administration protocol under a Mental Capacity Act best-interests decision, authorised by Dr K. Patel, is in place (Dr K. Patel, p.8). Non-compliance with COPD medication creates a documented risk of acute exacerbation. A covert MCA protocol with GP authorisation is a specialist clinical intervention. This satisfies the Level A descriptor: management of a drug regime requiring close monitoring or urgent intervention due to severity or unpredictability.

Legal basis: R v North & East Devon HA ex parte Coughlan [2000]: where the primary need is a health need, NHS responsibility follows. Covert medication under MCA is a health function, not a social care function. NF Para 162: the covert protocol is the management; the acute COPD risk from non-compliance is the need.

FORMAL INVOCATION -- DST GUIDANCE PARA 25 In respect of each domain identified above, if the assessor and I are unable to agree on the level to be assigned, I formally invoke DST Guidance Para 25, which states that where the assessor and the person or their representative cannot agree, the higher level should be chosen. I request that: (1) this invocation is recorded in the checklist for each disputed domain; (2) the higher level is applied for each disputed domain; (3) a copy of the completed checklist, including all scores, notes, and this submission, is provided to me before I leave the meeting today. This is not a request. It is a procedural requirement under the NHS CHC framework.

Signed: ________________________________ Date: ________________ Name: ________________________________ Relationship to Margaret Ellison: ________________________________ Contact: ________________________________

The Next Stage

This pack prepares your case for the Checklist assessment.

If the Checklist threshold is met, the case progresses to a full Multi-Disciplinary Team (MDT) assessment. At this stage, eligibility for NHS Continuing Healthcare is decided.

HOW MDT DIFFERS FROM CHECKLIST

	Checklist stage	MDT stage
Focus	Threshold only	Full domain scoring under the DST
Tool	NHS CHC Checklist (11 domains)	Decision Support Tool (all domains)
Key test	Is the threshold met?	Does a Primary Health Need exist?
Complexity	Domain-level alignment	Interaction between needs (Nature, Intensity, Complexity, Unpredictability)

Domain levels established at Checklist stage are carried into the DST. Where a domain has been scored at Level A at Checklist, that position is on record before the MDT begins. Early alignment at this stage reduces the need to re-position the case later.

PREPARING FOR MDT

If the Checklist outcome is positive, the MDT Preparation Pack provides:

-- Domain-by-domain evidence positions for the DST

-- Primary Health Need argument (Nature, Intensity, Complexity, Unpredictability)

-- Objection-handling scripts for common assessor positions

-- DST submission statement and pre-meeting briefing

careadvocate.co.uk/mdt-preparation

Important Notices

Nature of This Document

This document is an advocacy support tool prepared by CareAdvocate. It is not a clinical assessment, medical opinion, or legal advice. The objection scripts and representative statement are provided as drafts for use at the assessor's discretion -- they should be adapted to the specific facts of the assessment meeting.

Methodology

Medical records were processed using optical character recognition (AWS Textract), then analysed by AI systems (Anthropic Claude and Google Gemini) operating in UK data centres. Evidence was extracted, classified by domain, and mapped against NHS CHC Checklist descriptors (July 2022). All AI-generated content was reviewed by a CareAdvocate team member before inclusion in this pack.

Verification

While care has been taken to accurately extract and map evidence, AI-generated analysis may contain inaccuracies or omissions. We recommend reviewing evidence extracts against original records and discussing any concerns with a qualified CHC specialist.

Data Protection

This document contains personal data and special category health data under UK GDPR. Handle securely and share only with parties involved in the CHC process. CareAdvocate retains case data for 90 days after which it is automatically deleted. Contact hello@careadvocate.co.uk for data queries.